May 2015

St. Louis Area Regional Hospital

Re-Entry Plan

Signatories

This regional plan is being endorsed by the following regional committees:

(Name), Co-chair Hospital Preparedness Committee	(Name), Co-chair Hospital Preparedness Committee
(Name), Co-chair Emergency Medical Services Committee	(Name), Co-chair Emergency Medical Services Committee
(Name), Co-chair St. Louis Area Regional Coalition of COADS	(Name), Co-chair St. Louis Area Regional Coalition of COADS
(Name), Co-chair Emergency Management Committee	(Name), Co-chair Emergency Management Committee
(Name), Co-chair Public Health Committee	(Name), Co-chair Public Health Committee

Approval and Implementation

This annex does not supersede any other state and local emergency plans. It is intended to work with and support individual local jurisdictional disaster and re-entry plans and procedures.

This plan will be managed and maintained by the Hospital Preparedness Committee. Modifications and changes to the plan are allowed with the consent and approval of the Hospital Preparedness Committee.

Record of Changes

Change Number	Date	Section Changed	Date Posted	Who Posted

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Section 1
Introduction

This plan describes how the healthcare organizations in the region will conduct re-entry operations following evacuation or operational interruption as a result of a disaster. This concept will discuss the coordination role of the St. Louis Medical Operations Center (SMOC) to coordinate re-entry into a single restricted perimeter or multiple restricted perimeters as well as how individual hospitals will conduct facility re-entry operations. It is understood that facilities may conduct facility re-entry individually following a facility-specific incident, but this plan is scalable to include wide area disasters, including large areas and multiple health systems and facilities.

1.1 Purpose

This plan describes the phased operational framework for re-entry into hospitals and medical facilities following a disaster. Because disasters can potentially affect a wide geographic area, this plan also discusses the role of the SMOC in coordinating the phased re-entry of facility and clinical personnel required to accomplish the tasks outlined in this plan.

1.2 Scope

This plan is intended to be used when isolated or large-scale incidents require the evacuation and subsequent re-entry of staff and patients to an affected healthcare facility. This plan is also intended to be used to guide the coordination among healthcare facilities, the SMOC, and jurisdictional authorities in managing identification, credentialing, and access management for healthcare facility personnel and clinical personnel returning to the hospital utilizing the phased approach outlined in this plan. Additionally, the plan is intended to assist hospitals with assessment of the facility and the phased return of personnel to allow the healthcare facility to efficiently and effectively begin providing services to the affected area.

This plan covers the following St. Louis Area Regional Response System (STARRS) Program grant jurisdictions:

- Urban Area Security Initiative (UASI) jurisdictions
  - ✓ Franklin County, MO
  - ✓ Jefferson County, MO
  - ✓ St. Charles, MO
  - ✓ Monroe County, IL
  - ✓ St. Louis County, MO
  - ✓ City of St. Louis, MO
  - ✓ Madison County, IL
  - ✓ St. Clair County, IL

- Assistant Secretary for Preparedness and Response (ASPR) jurisdictions
  - ✓ Franklin County, MO
  - ✓ Jefferson County, MO
  - ✓ Lincoln County, MO
  - ✓ Perry County, MO
  - ✓ Pike County, MO
  - ✓ St. Charles County, MO

- ✓ St. Louis County, MO
- ✓ City of St. Louis, MO
- ✓ St. Francois County, MO
- ✓ Washington County, MO
- ✓ Madison County, IL
- ✓ Monroe County, IL
- ✓ St. Clair County, IL
- ✓ St. Genevieve County, MO
- ✓ Warren County, MO

1.3 Situation Overview

Tornadoes, severe thunderstorms, waterway flooding (including flash flooding), earthquakes, wildfires, facility infrastructure failure, and dam compromise are all risks that affect the greater St. Louis region. All of these hazards may cause damage to healthcare facilities, roadways, critical infrastructure within the community, key healthcare partners, and ancillary services providers.

These threats present a unique challenge for local, regional, and state government to provide for the safety and security of the affected area and its citizens. These situations often require the evacuation of an isolated building, a specific geographical area, or several geographical areas. It is the responsibility of jurisdictional authorities to maintain access control of these secured perimeters and ensure the security of responders, citizens, and potential evidence.

To ensure the safety of returning citizens in these scenarios, governmental jurisdictions will require that critical infrastructure (such as water, power, sewer, lift stations, and other vital services) is in place prior to allowing the general public to return to an affected area. Healthcare delivery is often a component of the critical infrastructure required for general population re-entry. Jurisdictional re-entry plans often identify phases of re-entry and require coordination with providers of critical infrastructure to map the path to general re-entry.

Additionally, healthcare facilities must also conduct damage assessments following incidents where facilities or key stakeholders were affected. Healthcare facilities and regional healthcare coalitions must work to restore the regional healthcare delivery system quickly to meet the public need.

1.4 Assumptions

The following characteristics are assumed in order for this plan to be implemented. During an incident, if these assumptions are not evident, then adjustments to this plan are necessary.

1.4.1 Regional Coordination Assumptions

- Effective response and recovery requires a coordinated effort among public and private entities. Hospitals and healthcare facilities are critical during an emergency and therefore must be active participants in emergency preparedness efforts, including partnering with emergency management, law enforcement, fire, and other entities.

- The St. Louis regional response structure promotes inter- and intra-jurisdictional cooperation and coordination, but recognizes the autonomy, operational authority, and unique characteristics of each jurisdiction at the facility, local, regional, and state levels.

1.4.2 Planning Assumptions

- Intact healthcare infrastructure is vital to any community and is a vital part of any governmental re-entry plan. For this reason, it is mutually beneficial for governmental bodies and healthcare facilities, partners, and coalitions to work together in an organized fashion to expedite re-entry of the general public to any area after a disaster.
- Governmental jurisdictions will work with local, regional, and state partners as well as utility and service providers to prioritize and plan for restoration of critical infrastructure. The healthcare facility/SMOC will work closely with the authority-having jurisdiction to restore critical infrastructure to healthcare facilities and other critical partners (laundry, food service).
- Healthcare facilities maintain plans for disaster preparedness and response and therefore have systems in place to mitigate interruption of service to the community, such as emergency generator power, 96 hours of supplies, etc. These systems may be affected by the disaster and therefore may be inoperable, requiring evacuation or alternative care site activation.
- This plan works in conjunction with the regional coordination and concept of operations described in the STARRS Regional Resource Coordination System Plan and the St. Louis Regional Healthcare Coordination Plan.
- Each jurisdiction has an emergency operations plan (EOP) that describes roles and responsibilities and designates organizations to lead security and re-entry operations.
- Hospitals and other healthcare facilities are responsible for development of an EOP specific to their facility.

1.4.3 Operational Assumptions

- Emergencies are managed within the incident command structure as designated by the jurisdictional authority in accordance with the National Incident Management System (NIMS) and the Incident Command System (ICS).
- A large-scale regional incident may warrant the activation of the St. Louis Medical Operations Center and the St. Louis Multi-Agency Coordination Group (MAC-G) to coordinate regional threats and/or incidents as described in the STARRS Regional Resource Coordination System Plan. In these situations, the SMOC will receive and assimilate information and provide situational awareness to the emergency operations center (EOC) and MAC-G on acute health care issues.
- During small incidents, especially those where only one facility is affected, there may not be a secured perimeter limiting access nor may there be cause to activate the SMOC. In these situations, the affected healthcare facility is responsible to coordinate with the SMOC and the regional healthcare coalition through virtual means or directly with the authority-having jurisdiction.

- During large-scale disasters, law enforcement and jurisdictional authorities may establish secured perimeters as a function of security and safety, requiring authorization to enter.
- Depending on the size and scope of a particular disaster, specific regulatory agencies (local, state, and/or federal) may require specific inspections and approval before allowing occupancy in to the facility or clearance to provide clinical services.
- This plan is not intended to describe or limit medical decisions or to remove or add responsibility regarding the provision of and access to medical care.

Section 2
Concept of Operations

The purpose of this section is to detail the overall concept of operation for re-entry into a healthcare facility, including access to a secured governmental imposed cordon.

2.1 Organizational Structure

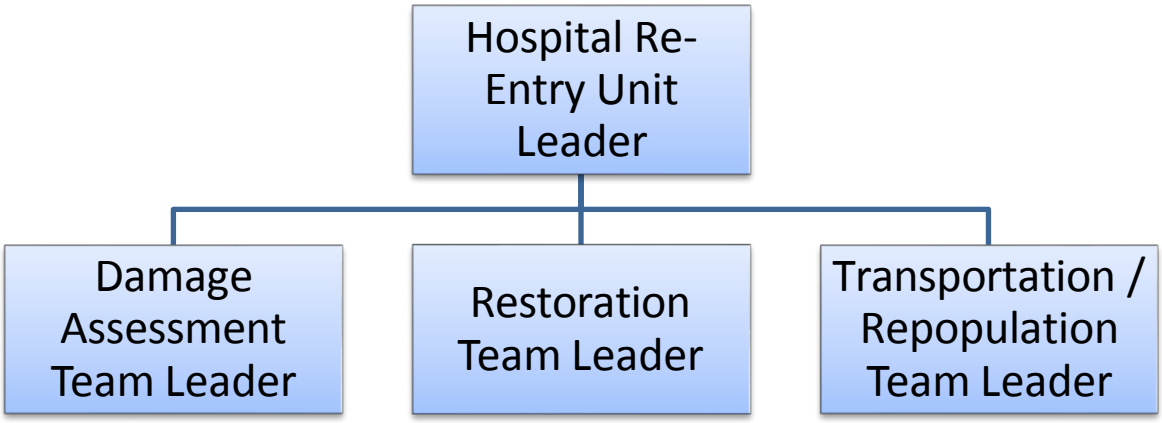
Hospital Command Centers (HCC) within each healthcare facility will identify initiation and completion of all phases of re-entry into the respective healthcare facility, utilizing their own internal chain of command, to include corporate guidance.

The authority-having jurisdiction is responsible for access control within a secured cordon following a disaster that affects a wider geographical area. Therefore, local jurisdictions must work together with healthcare facilities to ensure that appropriate personnel are granted access to conduct all phases of re-entry operations to get the healthcare system operational as quickly and efficiently as possible.

Simultaneously, the SMOC will facilitate communication among healthcare facilities and provide a common operating picture and real-time situational awareness regarding the status of re-entry operations across the region. Additionally, the SMOC may be charged with coordinating with EMS Liaison Officers to provide appropriate oversight and operational assignment of available transportation resources to accomplish the re-entry goals of the region in the most efficient method possible.

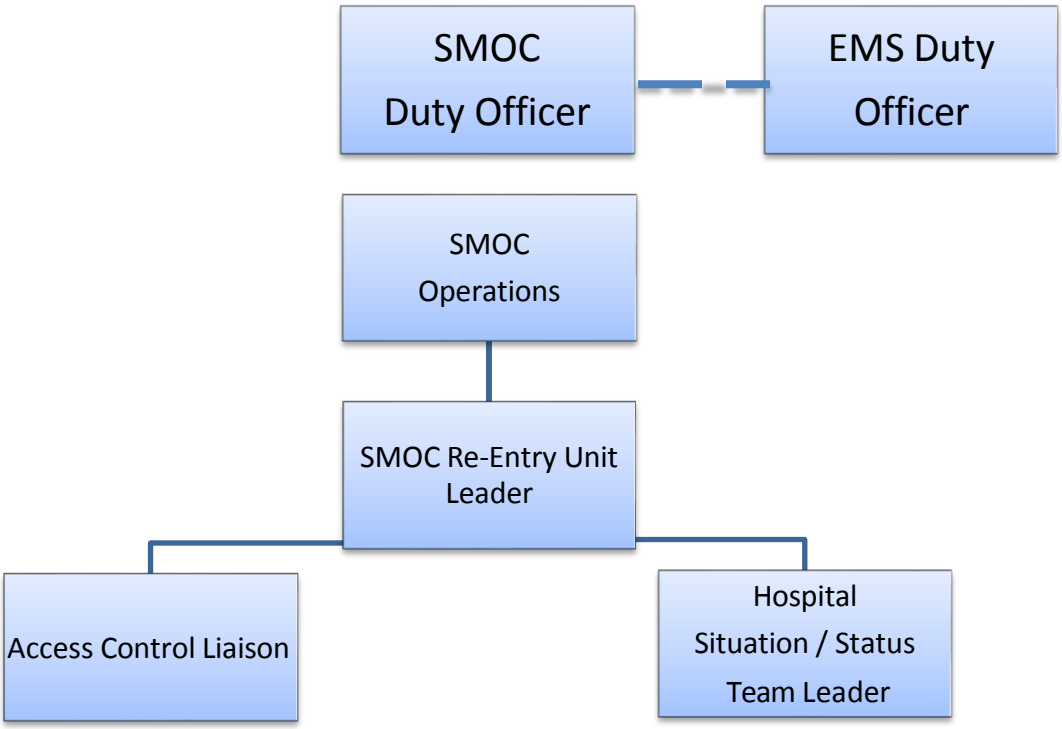
Ultimately, hospitals and healthcare facilities are responsible for the safe return of their patients and tracking patients through this process. The SMOC will serve as a coordination center for information on facility re-entry status, coordination of transportation resources, and operational information and may assist with centralized patient tracking.

All hospitals and healthcare facilities should have a pre-identified organizational structure or ICS that identifies all roles of emergency operations. In addition to those standard ICS Organizational Charts, hospitals should consider these re-entry specific roles and subsequent responsibilities.



Hospital ICS Organization Chart
The Hospital Re-Entry Unit Leader reports directly to the Hospital Operations Section, coordinating damage assessment, restoration, and repopulation operations. The Hospital Re-Entry Unit Leader communicates with the SMOC to ensure situational awareness across the region and coordination and fulfillment of unmet needs. The Damage Assessment, Restoration, and Transportation/Repopulation Team Leaders report to the Hospital Re-Entry Unit Leader.

Likewise, the SMOC should utilize the existing ICS, which identifies all roles of emergency operations. The SMOC should consider these re-entry specific roles and subsequent responsibilities to facilitate these operations.



The St. Louis Medical Operations Center Organization Chart
The SMOC Re-Entry Unit Leader reports to SMOC Operations or to the SMOC Duty Officer if SMOC is not fully activated. The SMOC Re-Entry Unit Leader coordinates activities within the SMOC dealing with information sharing and resource coordination to support hospitals during re-entry operations. The Access Control Liaison and Situation/Status Team Leader work for the SMOC Re-Entry Unit Leader.

2.2 Phased Re-Entry

Following an evacuation of a healthcare facility or several facilities following a significant regional disaster, the affected hospitals and healthcare facilities will work closely with the SMOC and the authority-having jurisdiction to conduct an organized and efficient phased re-entry operation. For the purpose of utilizing common language and communicating needs and activities at various points during the re-entry process, Re-Entry Operations will be conducted in three distinct phases, which follow the Emergency Response:

- Phase 1 – Damage Assessment Phase
- Phase 2 – Restoration Phase
- Phase 3 – Medically Operational Phase

Each phase will be laid out in this section for more detailed consideration.

This phased re-entry plan has been developed to allow all stakeholders in the process to conduct organized re-entry operations. Therefore, it is important to understand that different hospitals and healthcare facilities may be conducting operations within different phases at the same time. Likewise, specific geographical areas may be operating under different phases based upon damage, accessibility, and security considerations. The identification of phases is at the discretion of the healthcare facility leadership for individual hospitals and healthcare facilities and by the authority-having jurisdiction as it pertains to a geographical cordon or secured area.

Finally, the activities conducted in phases 1–3 are to occur during the recovery process within a jurisdiction. It is important to note that re-entry operations should not be a priority during emergency response, when municipal authorities are actively engaged in life safety operations such as firefighting, search and rescue, or similar activities intended to save lives and property.

During the initial response to a disaster, law enforcement, fire, EMS, and search and rescue operations are ongoing in the community. Likewise, hospital or healthcare facility personnel on site at an affected healthcare facility should take measures to ensure the safety and security of personnel and the facility, as well as attempt to compile a list of any obvious damage for consideration during the first phase of re-entry. It is important to note that hospitals may need to establish alternate care sites outside of the facility if damage is significant enough to warrant evacuation.

The process of re-entry begins when all emergency response and life safety operations have been completed. At this point, government officials may identify specific geographic areas where this criterion has been met, while other areas within a jurisdiction may still be engaged in emergency response operations. Re-entry operations will commence within a designated area when the authority-having jurisdiction deems it safe to transition from Emergency Response to Damage Assessment and Restoration Operations.

2.2.1 Phase 1 – Damage Assessment Phase

This phase of operation is when limited personnel are allowed within the secured perimeter or healthcare facility for the purpose of damage assessment to compile information necessary to formulate a recovery plan.

Triggers for Initiation of This Phase

This phase is initiated when emergency response operations are complete and when personnel can enter the facility for the purpose of damage assessment. Preliminary information may be obtained from personnel present in the facility when the disaster occurred or remaining during the emergency response phase, but the phase formally begins as noted above.

Goals and Activities in This Phase

The goal of this phase is for hospitals and healthcare facilities to conduct an in-depth assessment of damage and other impacts of the disaster on the facility. Additionally, the leadership of the healthcare facility, along with the SMOC and potentially other representatives from local government, develop a plan to address the issues identified and work toward overall recovery of the facility from the disaster.

During this phase of re-entry operations, healthcare facilities will conduct internal damage assessments, similar to the document found in Appendix B, to establish a recovery plan. The St. Louis Medical Operations Center will provide situational awareness to the EOC and the Multi-Agency Coordination Group (MAC-G) as well as serve as the primary conduit for information sharing between hospitals, healthcare facilities, and EMS within the region. The facility will communicate any unmet needs to the SMOC and the local jurisdiction, if necessary, to assist with coordination of recovery resources, such as power restoration, security issues, and infrastructure repair. Additionally, the facility will continue to update the SMOC on their situation in order to facilitate a common operating picture across the region and allow the SMOC to coordinate resource needs.

End State

This phase is complete when the facility completes the damage assessment and provides situational awareness information to the SMOC and authority-having jurisdiction, as necessary.

2.2.2 Restoration Phase

This phase of re-entry operations includes the repair and restoration of services to the affected area or facility, including power, water, sewer, and logistical needs required to make the facility function.

Triggers for Initiation of This Phase

Within each affected healthcare facility, this phase is initiated upon completion of the previous phase, when the damage and facility assessments are submitted to its HCC and a recovery plan is developed. This phase can be initiated for part or all of a facility based on isolated damage and recovery needs. For example, if one portion of a facility is damaged more severely than another, a specific portion of the facility can begin the restoration phase in order to facilitate at least partial restoration of services to the community.

Goals and Activities in This Phase

The goal of this phase is to complete repairs in order to render the facility functional and allow the hospital to provide services to the community. During this phase, the HCC may make efforts to restore critical services to allow for provision of specific services as a priority while working to complete other repairs. This type of tiered approach to recovery could speed the process of patient repopulation or restoration of emergency services to the community.

Activities in this phase can include structural or cosmetic repairs to the physical facility or primary systems. Additionally, this phase also includes contract services, such as electrical repair, water system repair, sewage and waste disposal repairs, or infrastructure to include medical oxygen or communications. Finally, the activities in this phase focus on facility-specific measures such as housekeeping, medical equipment and supplies, sterile processing, and laundry, all of which is necessary for the continuity of operations within the facility.

End State

This phase is complete when repairs have been completed and services have been restored. Upon completion of this phase, the facility would be capable of caring for patients and beginning the patient repopulation process.

It is important to note that a hospital or healthcare facility may elect to focus on restoration of critical services first, meaning that these activities have been completed for portions of the hospital but repairs continue on more heavily damaged systems or secondary priorities. In this case, hospital capability should be communicated to the SMOC and the authority-having jurisdiction to ensure dissemination to EMS providers and other stakeholders so that patients can be directed to facilities with intact capabilities.

2.2.3 Phase 3 – Medically Operational

This phase describes partial or complete capability to provide patient care within a hospital or healthcare facility. Initiation of this phase of re-entry does not necessarily imply that a hospital or healthcare facility is open to the general public but instead that some level of services is available at the discretion of the facility leadership. For example, if a hospital is able to provide emergency room services only and not admit patients into the hospital but instead transfers all admission to another facility, that facility is still considered medically capable with described limitations.

Triggers for Initiation of This Phase

This phase is initiated when the hospital or healthcare facility completes the restoration phase of re-entry for either the facility as a whole or a portion of the facility that provides critical services to the community.

Goals and Activities in This Phase

The goal of this phase of re-entry is for the hospital or healthcare facility to return to normal operations or at least provide critical access services such as emergency services.

Activities undertaken during this phase include provision of patient care services in a full or limited capacity based on status of infrastructure and availability of resources. Additionally, if capability is limited as noted above, the hospital or healthcare facility may continue to conduct restoration or assessment activities as necessary to continue to the recovery process.

End State

This phase is complete when the hospital becomes fully operational and is able to provide patient care at the same level prior to the disaster.

2.3 Phased Re-Entry Coordination with the Authority-Having Jurisdiction

The description above provides basic details about hospital and healthcare facility re-entry. Following a large-scale disaster, it is assumed that several facilities may be impacted and that the incident also caused widespread damage to a larger geographical area. Therefore, the authority-

having jurisdiction may impose a cordon or establish a secure, limited access area to prevent citizens from entering a dangerous site.

This cordon would likely cause a disruption in the ability of hospital or facility personnel to access the facility for the purpose of assessment, restoration, or provision of patient care services. It is vital that the HCC and hospital leadership communicate with the SMOC as detailed below to facilitate communication with law enforcement so that approved personnel can be granted access through an efficient process.

For this purpose, the SMOC will identify an Access Control Liaison position to serve as a liaison with law enforcement or other identified position that manages credentialing and access control for the secured cordon area.

2.3.1 Interaction with the Emergency Operations Center and Law Enforcement

Hospitals and healthcare facilities have specific responsibilities when planning for or conducting re-entry operations. To ensure timely and appropriate access for hospital personnel, HCCs and facility leadership must identify personnel or roles that would participate in each phase of re-entry operations, developing an access roster for each facility. This roster should be provided to the SMOC to facilitate coordination with law enforcement or the representative from the authority-having jurisdiction who is charged with cordon or perimeter security.

Included in this access control roster should be basic information, to include name, title, or position and contact information.

Personnel should be instructed to carry facility or state-issued identification with them in order to gain access through access control points. It may also be helpful for facilities to include a sample identification card for law enforcement to ensure that private citizens do not attempt to gain access to a secured area under the guise of healthcare facility personnel.

Likewise, the SMOC Access Control Liaison should provide information to the hospitals and healthcare facilities regarding locations and operation of access control points, any special instructions for personnel attempting to gain access, and information on any possible curfew information.

2.4 Healthcare Facility Repopulation

This portion of the plan provides a framework to return evacuated patients to their original facility in a timely fashion when the evacuating facility achieves appropriate medical capability.

It is a fundamental expectation in this plan that patients will ultimately return to the evacuating facility unless they are discharged prior to repopulation or they choose to stay at the receiving facility, by either their own request or a family request. Case management is key in this process.

2.4.1 Patient Consent

Understanding that transport of any ill or injured patient may expose patients to some risk or complication, it is vital that patients and families are given the opportunity to choose whether to

return to their original healthcare facility or remain at the receiving facility. Rationale that may factor into patient decisions includes:

- Patient condition
- Pending discharge or transfer
- Proximity to home and/or family
- Discomfort or pain
- An untoward event upon initial evacuation

It is important to remember that a patient's family should also be included in this decision making process, if available.

Repopulation is conducted in a much different environment than evacuation due to an impending disaster. Unlike emergent evacuation, there is an absolute expectation of standard of care and use of appropriate medical resources. For this reason, patient repopulation should be conducted in a more deliberate and attentive fashion. Additionally, healthcare facilities may elect to utilize standard transfer procedures, used daily for routine inter-facility transfers. Since patient movement for repopulation is not emergent, all applicable laws and regulations are in effect and should be observed.

Family should be kept well informed of repopulation plans and should be updated frequently during the actual repopulation movement.

2.4.2 Patient Tracking

Patients are tracked during the evacuation process and should be followed by case management during their stay at the receiving facility. Case management personnel will be integral to the decision making process as it pertains to repopulation and will be key players in the decision to discharge a patient, transfer them back to the original evacuating facility, or remain at the receiving facility.

Hospitals and healthcare facilities are responsible for maintaining situational awareness of all patients that were evacuated from their facilities. This will be extremely important for reimbursement, patient safety, and continuity of care. Additionally, it ensures that patients return to the appropriate facility of their choice in a timely fashion following a disaster.

2.4.3 Patient Movement

This plan assumes that patients will essentially be moved in a reverse process from their initial evacuation. However, as discussed above, this movement must be careful and deliberate in nature, ensuring for the safety and security of the patient.

Re-entry personnel will work closely with EMS providers or with the SMOC to facilitate transportation resources for the movement of patients back to the evacuating facility. Once patients are identified for movement and all appropriate paperwork is complete, a transportation resource will be identified and dispatched to the sending facility. Patients will be packaged for transport in accordance with physician orders or standard protocols. The receiving hospital will work with EMS personnel to establish a plan to bring the patient directly to a patient room or

transfer care in a separate area, such as the emergency room, or other point of entry into the facility.

EMS is responsible for providing care during transport and transferring care back to the evacuating hospital unless the patient is accompanied by a specialty care team from the healthcare facility. Personnel providing patient care during transport should ensure that a detailed patient care report is provided to the staff receiving the patient and that medical records accompany the patient during the transport, if available.

Patients will continue to be tracked during the movement process to maximize patient safety and situation awareness for the SMOC and the healthcare facilities involved in the patient movement.

2.5 Transportation Coordination for Healthcare Facility Repopulation

Coordination of patient repopulation may be complex due to several factors, such as:

- Patients evacuated to several different locations, including alternate care sites.
- Patients may be discharged from receiving facilities prior to repopulation.
- Patients discharged early may have presented to different facilities for follow-up or change in condition.
- Limited transportation resources are available, and different facilities may have contracts for transfers with the same private EMS provider(s).

For the reasons stated above as well as other potential reasons, case management must be involved with these patients throughout the evacuation and repopulation process, to include follow-up at home after discharge.

Additionally, unlike during the evacuation phase, non-standard transportation platforms are highly discouraged. Repopulation movement is being undertaken during the recovery phase, not the response phase, and life safety is not necessarily at risk. Therefore, hospitals and EMS providers have a duty to ensure patient safety during transport, minimizing risk to the patient.

The SMOC will work closely with all hospitals and healthcare facilities that are engaged in repopulation efforts to provide resource coordination among the region, to include any resources provided to the local jurisdiction by the state or federal government for the purpose of evacuation or repopulation. The SMOC EMS Liaison will work closely with private providers as well as 911 EMS resources to assign the most appropriate transportation resources to the repopulation of these patients to their original location, as stated above. This may also include the use of aeromedical resources.

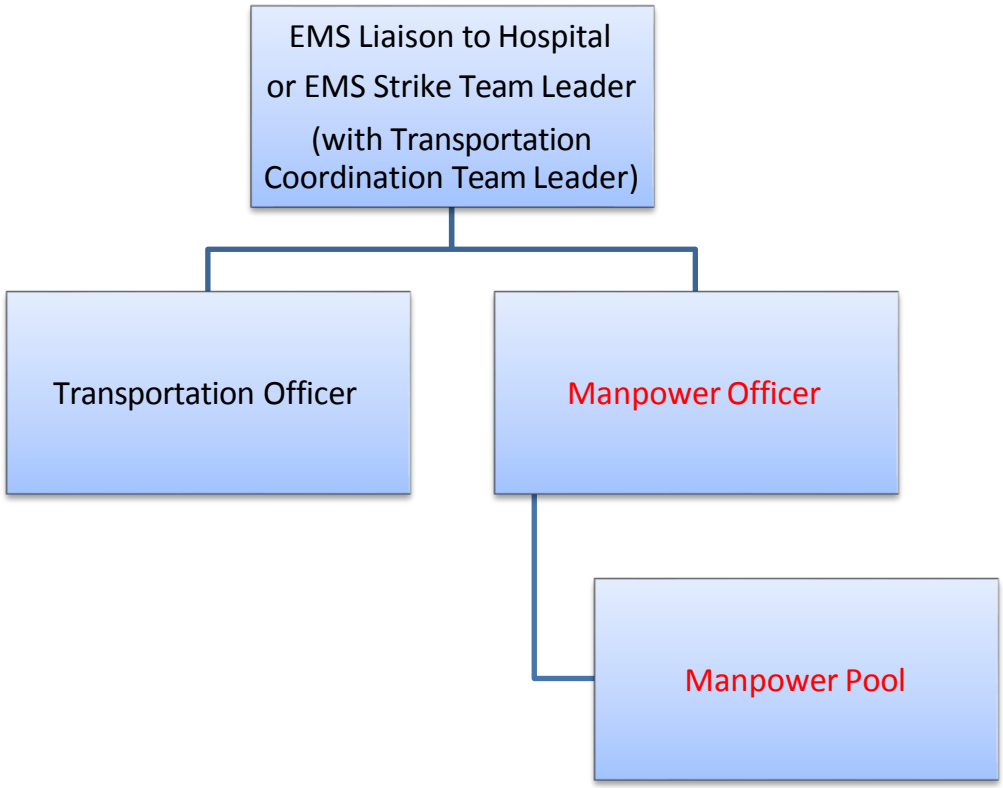
If more than one facility is affected and if activated, the SMOC will work with HCCs within affected healthcare facilities to ascertain resources needs and assign resources to meet those needs. The SMOC will maintain situational awareness of patient movement to ensure that repopulation is proceeding as planned.

During protracted incidents or situations where repopulation may continue after the initial response and re-entry operations are completed, the SMOC, hospitals, and healthcare facilities will work to develop a plan to coordinate transportation resources and facilitate situational

awareness for all stakeholders involved in the operation prior to demobilization of the SMOC. Communication will be facilitated through the SMOC Duty Officer at least daily during the duration of any re-entry operations.

2.5.1 Patient Reception at Healthcare Facility during Repopulation

The hospital will formulate a plan to receive patients from EMS during repopulation. If patients are transported one at a time, the Hospital Transportation Unit Leader may elect that have EMS personnel transfer care at the bedside in the patient care unit. If patients are being moved in more substantial numbers, the decision may be made to transfer care at the facility reception site, such as a lobby area, loading dock, or emergency department. The Transportation/Repopulation Unit Leader may identify a Manpower Officer and Manpower pool to facilitate movement and accountability of patients as they return to the facility. This is identical to the EMS Resource Coordination Group identified in the Medical Facility Evacuation Plan.



Section 3
Resources, Roles, and Responsibilities

This section describes the resources, roles, and responsibilities that various stakeholders will provide to support re-entry operations.

3.1 St. Louis Medical Operations Center

The role of the St. Louis Medical Operations Center will depend largely on the size and scope of the disaster, ultimately relating to the number of hospitals and facilities affected by the incident. In general, the SMOC will be responsible for:

- Establishing a Re-Entry Unit to aid with communication between healthcare facilities, the SMOC, and the authority-having jurisdiction
- EMS Liaison activities and transport coordination
- Coordination with authority-having jurisdictions pertaining to restoration of critical infrastructure, such as power, water, sewer, and the like
- Maintaining situational awareness and providing a common operating picture to all hospital and EMS partners that represent regional healthcare capability
- Communicating diversion and hospital capability to EMS providers
- Assisting with coordination and control of state or federal resources assigned to the incident, to include EMS staging and utilization

3.1.1 New Roles within the SMOC

Re-Entry Unit Leader

Regional personnel assigned to coordinate and oversee all re-entry operations from the regional level. Communicates with affected healthcare facilities and hospitals to gather information on patient movement, case management progress, transportation needs, and patient tracking. This position is similar to the Evacuation Officer, but exists in the recovery phase.

Hospital Situation/Status Unit Leader

Regional personnel assigned to gather information on damage assessments, resources needs, infrastructure requirements, recovery timelines, and clinical capability. Provides common operating picture to the SMOC and stakeholders on effects of the disaster on the regional healthcare infrastructure as well as expected impacts on the community.

Access Control Liaison

This position maintains a close working relationship with the law enforcement or jurisdictional representative responsible for access control to cordon areas. The Access Control Liaison works with HCC personnel in affected facilities to obtain an access roster to facilitate rapid passage

through secured cordon/access control points. Additionally, the Access Control Liaison provides information to healthcare organizations regarding locations and procedures for access control points.

3.2 Healthcare Organizations

The healthcare organizations have a responsibility to maintain preparedness capability to backup power production, fuel supplies, and 96 hours of medical supplies and material. The healthcare organizations must have a functional EOP that addresses evacuation and hospital operations during a disaster. Additionally, the healthcare organization must be familiar with the regional disaster plan and how to integrate with the SMOC and the local authority-having jurisdiction.

The healthcare facility should also maintain information on contractors and services to repair, replace, or recover from infrastructure damage/failure. Additionally, healthcare organizations should maintain information on contractors that could provide temporary services platforms, such as mobile radiology or mobile laboratory capability.

Healthcare organizations have a responsibility to maintain a HCC to provide information and feedback to the SMOC if a large incident occurs or manage their own processes if the hospital is affected by a local or isolated disaster. This includes providing up-to-date information on progress across each re-entry phase as well as clinical capability as recovery continues.

The healthcare organization must also have much of this information contained within their EOP and exercise this plan regularly.

3.3 Authority-Having Jurisdiction

The authority-having jurisdiction has the responsibility to provide access control for an area that has been affected by disaster. Therefore, they are also responsible for maintaining an access control roster to authorize approved personnel access to conduct re-entry operations. Additionally, the authority-having jurisdiction works closely with utility providers, state agencies, and other partners to assess and repair critical infrastructure and prioritize recovery operations within the affected area.

The authority-having jurisdiction should provide:

- A point of contact for access control rosters and cordon information
- Coordination point for infrastructure restoration and resource needs

Section 4
Plan Development and Maintenance

This section describes the process used to develop the St. Louis Regional Medical Facility Re-Entry Annex, identifies who is responsible for reviewing and maintaining the annex, and explains how the annex will be reviewed and maintained.

4.1 Planning Process

The St. Louis Regional Medical Facility Re-Entry Annex was developed through funding provided by the U.S. Department of Health and Human Services (HHS) ASPR Program. A task force of law enforcement, healthcare, public health, EMS, and emergency management personnel met over the course of six months to assess gaps and capabilities to provide for continuity of healthcare services and identification, credentialing, and access management following a disaster that affected any specific geographical area within the region. Additionally, the healthcare facilities and partners within the region met to define a system for facility assessment, re-entry, and recovery following a disaster, either isolated/internal or area-wide. Following this assessment, the task force developed this plan with the aid of a consultant. The task force developed a rough draft of the plan using the results of the gaps and capabilities assessment. Tables, charts, and appendices were added as the task force worked through successive drafts. Two drafts were circulated to obtain comments from the organizations that are responsible for implementing the annex.

4.2 Plan Review and Maintenance

The St. Louis Regional Medical Facility Re-Entry Annex will be managed and maintained by the Hospital Preparedness Committee. Participating hospitals, emergency management agencies, EMS agencies, public health departments, and governmental representatives are responsible for updating their respective EOPs.

The St. Louis Regional Medical Facility Re-Entry Annex should be reviewed every two years and after incidents that require annex implementation. Lessons learned from emergencies and exercises should be incorporated into the annex. Changes in capabilities, procedures, and systems should be incorporated in the annex.

4.3 Testing, Training, and Exercises

The development of a comprehensive and ongoing testing, training, and exercise program to inform and educate healthcare facility personnel, regional partners, and emergency management representatives is essential for effective response and implementation of this annex. A tabletop exercise was held on May 19, 2015 immediately following the development of this annex.

The St. Louis Regional Medical Facility Re-Entry Annex will be tested in coordination with the regional exercise plan.

Appendix A
Shelter Medical Support Group
Job Action Aids Sheet Templates

Section 1
St. Louis Medical Operations Center (SMOC)

1.1 Re-Entry Unit Leader

Position: **Re-Entry Unit Leader**

Reports to: SMOC Operations Section Chief

Section: Operations

Mission: Regional personnel assigned to coordinate and oversee all re-entry operations from the regional level. Communicates with affected healthcare facilities and hospitals to gather information on patient movement, case management progress, transportation needs, and patient tracking. This position is similar to the evacuation officer identified in the healthcare facility evacuation plan, but exists in the recovery phase.

Pre-deployment Procedures	
☐	Ensure that all contact information for hospitals, healthcare facilities, and emergency medical services (EMS) providers is current.
☐	Maintain a list of recovery contractors, temporary service providers, and any other pertinent resources in the area for rapid activation in order to allow facilities to provide services following a disaster.
☐	Maintain appropriate contact information for State Fire Marshal's resources, facility and plant engineering resources, and other State and Federal agencies that may need to inspect a facility and certify that facility is safe and medically capable of caring for patients.
☐	Review Regional Healthcare Facility Re-Entry Plan.

Initial Actions	
☐	Receive assignment and obtain a briefing from the SMOC.
☐	Review job action sheet for assigned position and review the organizational chart.
☐	Identify facilities that required evacuation (partial or full) and confirm current status.
☐	Identify technology systems utilized for patient tracking and information sharing during the emergency response phase of the disaster, including the evacuation of affected healthcare facilities. If no systems were utilized, work with SMOC Operations to identify systems that will be utilized for re-entry and repopulation operations. Ensure all account information and logins are current and functional.
☐	Obtain a current list of contact information for all participating healthcare facilities and regional stakeholders. Establish distribution lists as needed.

☐	Establish a plan for tracking resource utilization and centralized patient tracking.

Preparatory Actions	
☐	Receive information from all affected Hospital Command Centers regarding current status and medical capability.
☐	Assist healthcare facilities with logistical resource needs, as appropriate. Provide information on support resources available within the operational area.
☐	Maintain situational awareness of all repopulation movement occurring during this operational period. Obtain transportation resource information from Transportation Officer or EMS Duty Officer and ensure that resources will meet needs of repopulation movement scheduled.
☐	Compile a list of patients who require repopulation during the next 24-48 hours.
☐	Work closely with the SMOC Planning and Operations staff to complete the operational planning worksheet (ICS Form 215) to ensure proper staffing and equipment levels for the next operational period.

Daily Operations	
☐	Continue to monitor patient movement operations to address issues that arise.
☐	Continue to account for all resources (personnel, equipment, and supplies) that have been deployed to support re-entry. Assess resource utilization for each operational period to determine when resources can be demobilized or reassigned.
☐	Work closely with the SMOC Operations staff to provide updates on census, facility status, repopulation operations, demobilization plans, and other pertinent information.

Closing Actions	
☐	Work with SMOC Operations and Planning staff to continuation of transportation efforts by individual facilities following demobilization of the SMOC. Provide reference or resource to enable completion of mission after demobilization.
☐	Complete all documentation and forward to the Planning Unit – Documentation.
☐	Provide detailed briefing to the SMOC Duty Officer or SMOC Operations staff about any continuing efforts and potential gaps to re-entry and repopulation operations.
☐	Ensure that hospital command centers, stakeholders, and EMS Coordination personnel are aware of operational changes, including demobilization of Re-Entry Unit. Assist with alternative planning to ensure that the needs of the hospitals and healthcare facilities are being met.

Demobilization Procedures	
☐	Complete appropriate demobilization documentation. Ensure that all financial and administrative documentation has been completed for reimbursement.
☐	Meet with the SMOC Finance/Administration staff to ensure that the incident documentation file is complete.
☐	Debrief any staff members to identify lessons learned during the incident.

☐	Upon deactivation, brief the SMOC Operations staff on continuing issues and the status of any open procurement requests or unmet needs on behalf of the healthcare facilities. Brief any repopulation operations planned for upcoming operational periods.
☐	Inform the SMOC that the Re-entry Unit has been successfully demobilized.

1.2 Hospital Situation/Status Unit Leader

Position: **Hospital Situation/Status Unit Leader**

Reports to: SMOC Re-Entry Unit Leader

Section: Operations

Mission: Regional representative tasked with liaising with hospitals and healthcare facilities to communicate damage assessment, restoration status, and regional logistics needs to the SMOC. Maintain real-time operating picture of the healthcare capability within the region and provides information to the Emergency Operations Center and MAC-G, as appropriate. May be tasked with assisting hospitals and healthcare facilities with obtaining information on resources to assist facilities with restoration to expedite return to full medical operations.

Pre-deployment Procedures	
☐	Ensure that all contact information for hospitals, healthcare facilities, and EMS providers is current.
☐	Maintain a list of recovery contractors, temporary service providers, and any other pertinent resources in the area for rapid activation in order to allow facilities to provide services following a disaster.
☐	Maintain appropriate contact information for State Fire Marshal's resources, facility and plant engineering resources, and other state and federal agencies that may need to inspect a facility and certify that the facility is safe and medically capable of caring for patients.
☐	Review Regional Healthcare Facility Re-Entry Plan.

Initial Actions	
☐	Receive assignment and obtain a briefing from the SMOC.
☐	Review job action sheet for assigned position and review the organizational chart.
☐	Identify facilities that required evacuation (partial or full) and confirm current status.
☐	Create a database or spreadsheet to track damage assessment, restoration, and medical capability of each affected facility.
☐	Ensure access to Hospital Diversion System to ensure timely updates to medical capability.

Preparatory Actions	
☐	Receive information from all affected Hospital Command Centers regarding current status and medical capability.
☐	Assist healthcare facilities with logistical resource needs, as appropriate. Provide information on support resources available within the operational area.

☐	Maintain database of damage assessments and ongoing restoration activities in each of the affected facilities. Provide report to the SMOC Duty Officer or SMOC Operations each operational period.
☐	Liaise with emergency operations center (EOC) personnel to expedite restoration of critical infrastructure as requested by facilities.

Daily Operations	
☐	Update damage assessment and restoration status of each facility at least once every operational period.
☐	Provide report to SMOC Operations and EOC as directed in the Incident Action Plan.
☐	Update hospital diversion and report capability to regional EMS agencies to ensure patient care is not negatively impacted due to hospital restoration status.

Closing Actions	
☐	Work with SMOC Re-Entry Unit Leader to develop a plan for communication of healthcare facility assessment and restoration after demobilization of this position.
☐	Complete all documentation and forward it to the Planning Unit – Documentation.
☐	Provide detailed briefing to the SMOC Re-Entry Unit Leader or SMOC Operations staff about any continuing efforts and potential gaps to re-entry and repopulation operations.
☐	Ensure that hospital command centers and restoration/recovery contractors are aware of operational changes, including demobilization of Re-Entry Unit. Assist with alternative planning to ensure that the needs of the hospitals and healthcare facilities are being met.

Demobilization Procedures	
☐	Complete appropriate demobilization documentation. Ensure that all financial and administrative documentation has been completed for reimbursement.
☐	Meet with the SMOC Re-Entry Unit Leader to ensure that the incident documentation file is complete.
☐	Debrief any staff members to identify lessons learned during the incident. Provide debriefing for Re-Entry Unit Leader
☐	Upon deactivation, brief the SMOC Re-Entry Unit Leader on continuing issues and the status of any open procurement requests or unmet needs on behalf of the healthcare facilities. Brief plan for continuation of reporting and communication of status through the SMOC Re-Entry Unit Leader or SMOC Duty Officer (following demobilization of the SMOC).

1.3 Access Control Liaison

Position: **Access Control Liaison**

Reports to: SMOC Re-Entry Unit Leader

Section: Operations

Mission: Work with local EOC and Law Enforcement staff to communicate access control information to the healthcare facilities and provide access control information to local jurisdiction officials to facilitate access for appropriate healthcare facility staff.

Pre-deployment Procedures	
☐	Ensure that all contact information for hospitals and healthcare facilities is current.
☐	Identify points of contact within the EOC and law enforcement that would be responsible for maintaining access control points during a disaster.
☐	Review Regional Healthcare Facility Re-Entry Plan.

Initial Actions	
☐	Receive assignment and obtain a briefing from the SMOC.
☐	Review job action sheet for assigned position and review the organizational chart.
☐	Identify an access control zone and identify the authority-having jurisdiction. Define any healthcare facilities or other critical healthcare infrastructure within the cordon area.
☐	Establish deadlines for submission of access control rosters from hospitals to the SMOC Re-Entry Unit as well as from the Re-Entry Unit to the EOC or law enforcement (LE) point of contact.
☐	Identify any computerized system that may be used for maintenance of the access control roster and ensure login information is current.

Preparatory Actions	
☐	Work with EOC and/or LE contact to identify access control points and perimeters of secured areas. Provide that information to SMOC Re-Entry Unit Leader for dissemination to healthcare facilities and EMS providers within the region.
☐	Receive information from all affected Hospital Command Centers regarding personnel requiring access to the cordon area.

Daily Operations	
☐	Communicate with EOC and LE contacts to update secured perimeters and locations of access control points. Additionally, gather information on the expected duration of cordons to provide updates to healthcare facilities about the return of the general public.
☐	Establish reporting requirements for healthcare facilities to provide or update names on the

	access roster. Compile access control information in to desired format and forward to perimeter security personnel.
☐	Continue to document critical activities and decisions in the unit log (ICS Form 214). Ensure that all operational teams continue to do the same.

Closing Actions	
☐	Upon demobilization of the last security cordon, advise the SMOC Re-Entry Unit Leader of security status and plan for demobilization.
☐	Work with SMOC Re-Entry Unit Leader to develop a plan for communication of healthcare facility assessment and restoration after demobilization of this position.
☐	Complete all documentation and forward it to the Planning Unit – Documentation.
☐	Ensure that healthcare facilities are aware of the closure of access control points and return to normal traffic flow in the area.

Demobilization Procedures	
☐	Complete appropriate demobilization documentation. Ensure that all financial and administrative documentation has been completed for reimbursement.
☐	Meet with the SMOC Re-Entry Unit Leader to ensure that the incident documentation file is complete.
☐	Debrief any staff members to identify lessons learned during the incident. Provide debriefing for Re-Entry Unit Leader

2.1 Re-Entry Unit Leader

Position: **Re-Entry Unit Leader**

Reports to: HCC Operations

Section: Operations

Mission: Work for the Operations Section within the Hospital Incident Command System to coordinate all aspects of facility re-entry and patient repopulation. Delegate responsibility for patient tracking, facility damage assessment, restoration activities, and repopulation. Work with the SMOC to provide regional entities with situational awareness on facility status and potential patient movement.

Pre-deployment Procedures	
☐	Ensure points of contact with SMOC and EOC to ensure rapid ability to communicate planning information and resource needs.
☐	Maintain a list of recovery contractors, temporary service providers, and any other pertinent resources in the area for rapid activation in order to allow facilities to provide services following a disaster.
☐	Maintain appropriate contact information for State Fire Marshal's resources, facility, and plant engineering resources and other state and federal agencies that may need to inspect a facility and certify that facility is safe and medically capable of caring for patients.
☐	Review Regional Healthcare Facility Re-Entry Plan.

Initial Actions	
☐	Receive assignment and obtain a briefing from the Hospital Incident Commander.
☐	Review job action sheet for assigned position and review the organizational chart.
☐	Identify units that required evacuation (partial or full) and confirm current status.
☐	Ensure connectivity with regional communications and information sharing platforms.
☐	Establish a plan for tracking resource utilization and centralized patient tracking.

Preparatory Actions	
☐	Receive information from facilities personnel and impacted clinical/non-clinical units regarding

	damage assessment and restoration activities. Provide situational awareness to the SMOC.
☐	Assist hospital departments with logistical resource needs, as appropriate. Provide information on support resources available within the operational area. Communicate unmet needs to the SMOC for regional assistance, if necessary.
☐	Maintain situational awareness of all repopulation movement occurring during this operational period. Obtain transportation resource information from Transportation Officer or EMS Duty Officer and ensure that resources will meet needs of repopulation movement scheduled.
☐	Compile list of patients that require repopulation during the next 24-48 hours.
☐	Work with Hospital Incident Commander and Incident Command System (ICS) Staff to ensure that optimal support for assessment or restoration activities.

Daily Operations	
☐	Continue to monitor patient movement operations to address and issues that arise.
☐	Continue to account for all resources (personnel, equipment, and supplies) that have been deployed to support re-entry. Assess resource utilization each operational period to determine when resources can be demobilized or reassigned.
☐	Work closely with the SMOC Re-Entry Unit Leader to provide updates on census, facility status, repopulation operations, demobilization plans, and other pertinent information.

Closing Actions	
☐	Work with SMOC Operations and Planning staff to document and communicate transportation resource coordination plan following demobilization of the SMOC.
☐	Complete all documentation and forward it to the Hospital Planning Section.
☐	Provide detailed briefing to the SMOC Duty Officer or Hospital Operations Section staff about any continuing efforts and potential gaps to re-entry and repopulation operations.
☐	Ensure that the SMOC, hospital command center, stakeholders, and EMS Coordination personnel are aware of operational changes, including demobilization of Re-Entry Unit. Assist with alternative planning to ensure that the needs of the hospitals and healthcare facilities are being met.

Demobilization Procedures	
☐	Complete appropriate demobilization documentation. Ensure that all financial and administrative documentation has been completed for reimbursement.
☐	Meet with the SMOC Finance/Administration staff to ensure that the incident documentation file is complete.
☐	Debrief any staff members to identify lessons learned during the incident.
☐	Upon deactivation, brief the Hospital ICS Staff on continuing issues and the status of any open procurement requests or unmet needs. Brief any repopulation operations planned for upcoming operational periods.
☐	Inform the Hospital Incident Commander that the Re-entry Unit has been successfully demobilized.

2.2 Assessment Team Leader

Position: **Assessment Team Leader**

Reports to: HCC Operations

Section: Operations

Mission: Provide sufficient information regarding the operational status of the facility for the purpose of decision/policy making, including those regarding full or partial evacuation. Manage damage assessment operations and assist with formulation of a recovery plan.

Pre-deployment Procedures	
☐	Review Regional Re-Entry Plan and Healthcare Facility/Healthcare System Emergency Operation Plan.
☐	Maintain list of contractors and specialists to assist with damage assessment activities.

Initial Actions	
☐	Receive assignment and obtain a briefing from the Hospital Incident Commander.
☐	Review job action sheet for assigned position and review the organizational chart.
☐	Obtain a briefing from the Re-Entry Unit Leader.
☐	Assign teams to check systems within the facility to determine damage and critical infrastructure status.
☐	Provide situational awareness to the Hospital Command Center and Incident Commander.

Preparatory Actions	
☐	Identify priorities for restoration of services.
☐	Arrange for subject matter experts to assess the facility or critical systems, such as structural engineers, electricians, plumbers, HVAC specialists, etc.
☐	Inspect areas of reported damage and obtain photographs of damage, if able.
☐	Identify opportunities to salvage equipment and supplies to mitigate losses.

Daily Operations	
☐	Assign staff to conduct ongoing damage assessments and salvage operations.
☐	Provide briefing to Re-Entry Unit Leader and Hospital Command Center regarding the status of the damage assessment phase and findings in this phase.
☐	Provide information on experts who are conducting damage assessments, such as structural engineers, plumbers, electricians, etc. Provide timeline for all such visits to Hospital Command Center and Incident Commander.

Closing Actions	
☐	Notify HCC and Incident Commander at conclusion of the Damage Assessment Phase and transition to the Restoration Phase.
☐	Ensure all documentation, including photographs and reports from contractors and specialists are compiled and submitted to the Hospital Command Center for continuity purposes.

Demobilization Procedures	
☐	Transition to Restoration Phase.

2.3 Restoration Team Leader

Position: **Restoration Team Leader**

Reports to: Hospital Re-Entry Unit Leader

Section: Operations

Mission: Responsible for coordinating the facility clean up and restoration/recovery activities required to make the healthcare facility functional and able to care for patients. The Restoration Phase begins when the Damage Assessment Phase is complete and the Recovery Plan is developed.

Pre-deployment Procedures	
☐	Review Regional Re-Entry Plan and Healthcare Facility/Healthcare System Emergency Operation Plan.
☐	Maintain list of contractors and specialists to assist with restoration and disaster recovery activities.

Immediate	
☐	Receive assignment and obtain a briefing from the Hospital Incident Commander.
☐	Review job action sheet for assigned position and review the organizational chart.
☐	Obtain a briefing from the Re-Entry Unit Leader.
☐	Assign teams to restore critical systems and clean damaged areas of the facility. Work with private contractors and disaster restoration services to expedite the restoration process.
☐	Provide situational awareness to the Hospital Command Center and Incident Commander.
☐	Provide information to the Hospital Command Center regarding areas of the facility that are capable of normal operations.
☐	Work with local, state and federal agencies responsible for inspection and accreditation of facilities to ensure rapid return to full operational capability.

Intermediate	
☐	Provide information to the Hospital Command Center regarding areas of the facility that are capable of normal operations.
☐	Work with local, state, and federal agencies responsible for inspection and accreditation of facilities to ensure rapid return to full operational capability.

Extended	
☐	Assign staff to conduct ongoing restoration and recovery activities.
☐	Provide briefing to Re-Entry Unit Leader and Hospital Command Center regarding the status of

	the restoration phase and expected return to full operational capability.
☐	Provide information on experts that are conducting recovery operations, such as structural engineers, plumbers, electricians, disaster recovery specialist, IT Services, etc. Provide timeline for all such visits to Hospital Command Center and Incident Commander. Provide cost estimates to Hospital Command Center.

Closing Actions	
☐	Notify HCC and Incident Commander at conclusion of the Restoration Phase in any part of the facility or the entire facility and transition to normal operations.
☐	Ensure all documentation, including photographs and reports from contractors and specialists are compiled and submitted to the Hospital Command Center for continuity purposes.
☐	Ensure that all invoices for costs associated with restoration phase, including contract services, are complete and submitted to Hospital Finance/Admin Section.

Demobilization Procedures	
☐	Transition to normal operations.

2.4 Transportation Coordination Officer

Position: **Transportation Coordination Officer**

Reports to: HCC Operations

Section: Operations

Mission: Works with EMS Liaison, the SMOC and/or private contract EMS providers to coordinate efficient scheduling of EMS units bringing patients back to the hospital. Ensures that patients arrive in an organized fashion by arranging specific times for patients to be moved from the sending facility so the arrival at the hospital is staggered, therefore improving patient care at the receiving facility.

Pre-deployment Procedures	
☐	Maintain familiarity with Regional Re-Entry Plan and Hospital Evacuation Plan.

Initial Actions	
☐	Receive assignment and obtain a briefing from the Hospital Incident Commander.
☐	Review job action sheet for assigned position and review the organizational chart.
☐	Obtain a briefing from the Re-Entry Unit Leader.
☐	Meet with Re-Entry Unit Leader to develop traffic flow and parking plan for EMS units to maximize congestion and rapid movement or resources while minimizing impact to ongoing restoration activities and normal medical operations.
☐	Ensure communications with EMS units and Hospital Command Center.

Preparatory Actions	
☐	Verify status of infrastructure and roadways to confirm traffic flow and parking plan.
☐	Provide situational awareness to the Hospital Re-Entry Unit Leader regarding any issues and pertinent updates.

Extended	
☐	Work with Strike Team Leaders to free up EMS units when transports are complete.
☐	Upon arrival in the facility, ensure that patients are brought to the correct patient room and that patients have had no changes during transport and are still appropriate for their room assignment.

Closing Actions	
☐	Consolidate documentation and ensure security of Private Health Information. Ensure security of personal belongings, durable medical equipment, and medical records/medications.
☐	Provide a detailed debriefing to the Re-Entry Unit Leader about any issues pertaining to the resources assigned or any issues with the demobilization process.

Demobilization Procedures	
☐	Complete appropriate demobilization documentation. Ensure that all financial and administrative documentation has been completed for reimbursement.
☐	Maintain communications with all assigned personnel to ensure that demobilization is occurring and address any issues.
☐	Debrief all staff to identify lessons learned during the incident and provide debriefing information to the Hospital Command Center.

2.5 Manpower Officer or Reception Area Manager

Position: **Manpower Officer or Reception Area Manager**

Reports to: HCC Operations

Section: Operations

Mission: Responsible for the overall management of patients and transportation resources within the reception area, including the communication between EMS and receiving hospital personnel and coordination of patient movement upon arrival at the hospital. Ensure patients are moved to their destination within the hospital in the most safe and efficient manner through coordination with the Re-Entry Unit Leader, Ambulance Strike Team Leaders, and clinical staff on the units.

Pre-deployment Procedures	
☐	Review the evacuation and re-entry plans prior to beginning of operations.
☐	Possess a working knowledge or clinical unit capabilities and multiple routes between the Reception Area and Nursing Units. Be able to provide instructions to EMS personnel on the most efficient and appropriate route to the patient's final destination.

Initial Actions	
☐	Ensure intact communications with the Hospital Command Center and EMS Units (when able) to maintain situational awareness.
☐	Coordinate with Re-Entry Unit Leader to receive list of patients that will be returning to the facility during the current operational period. Ensure that all patients are assigned a room and that communication with clinical units in maintained to provide updates as necessary.

Preparatory Actions	
☐	Brief any manpower/transportation personnel on priorities and resource needs.
☐	Identify team members specifically responsible for ensuring patient care equipment is available, patient medications and documentation is present and tracking system is updated.
☐	Monitor patients for any change in condition, and ensure that patients are going to an appropriate destination. Work with Re-Entry Unit Leader if change is identified as necessary.
☐	Monitor patient medical equipment and supply resources, as well as personal belongings, durable medical equipment and documentation.

Extended	
☐	Work with Re-Entry Unit Leader to continue to receive patients and move them to assigned beds as soon as possible.
☐	Monitor situation for possibility of demobilization or cessation of operations for this operational

	period.
☐	Coordinate personnel assignment and orientation as patient throughput increases/decreases.
☐	Monitor staff for signs of fatigue and stress. Rotate staff as needed.

Closing Actions	
☐	Consolidate documentation from the operational units and ensure the security of personal health information, durable medical equipment, and belongings.
☐	Provide detailed debriefing to the Re-Entry Unit Leader.
☐	Meet with team members and Re-Entry Unit Leader to ensure all needs are met and transfers are being carried out as expected.

Demobilization Procedures	
☐	Complete appropriate demobilization documentation.
☐	Maintain communications with all assigned personnel to ensure that demobilization is occurring and address and issues.
☐	Ensure that all equipment and supplies utilized during operations have been properly accounted for and have been demobilized.

Section 3
Emergency Medical Services Personnel

3.1 EMS Duty Officer

Position: **EMS Duty Officer**

Section: Operations

Mission: Coordinates activities of EMS resources within the region during a disaster. Serves as the point of contact for activation of regional EMS resources when requested by the SMOC to assist with evacuation or re-entry. When EMS resources are activated, the EMS Duty Officer coordinates staging, assignment and utilization of ambulances to accomplish assigned patient movement tasks.

Pre-deployment Procedures	
☐	Maintain current contact information for all participating EMS providers within the region to quickly and efficiently activate EMS resources during a disaster. Information should include dispatch centers and leadership with authority to authorize sending units outside jurisdiction.
☐	Maintain contact information for the SMOC to facilitate communication with hospital resources.
☐	Review Regional Healthcare Facility Re-Entry Plan.

Initial Actions	
☐	Receive notification of need for EMS resources for patient movement. Tasking should include logistical information, such as date and time of transfer, as well as sending and destination facilities. Any additional information on special considerations, such as medication drips or advanced therapies would also be beneficial for unit identification and assignment.

Preparatory Actions	
☐	Obtain availability of regional resources (municipal or private) that are capable of transporting appropriate patients.
☐	Assign appropriate units to specific missions based on capability, patient condition and medical needs.
☐	Ensure sending facility has completed appropriate documentation and patient is stable to transfer.
☐	Notify the SMOC of EMS units assigned to each patient transport mission, and confirm time that transport will be conducted.
☐	Provide sending facility, receiving facility, patient condition, points of contact and other pertinent information to EMS units that will be conducting transport.

Daily Operations	
☐	Maintain situational awareness of all repopulation movement occurring during this operational period. Maintain communications with EMS resources and track status of all transports throughout the operational period.
☐	Provide updates to the SMOC on all patient transfers conducted during the operational period.
☐	Advise the SMOC of any untoward events or changes in patient status, as reported by EMS units.

Closing Actions	
☐	Once all transports are complete, ensure that units return to staging or home station safely and gather pertinent finance/administrative information, such as departure and demobilization time.
☐	Complete all appropriate documentation and forward to the SMOC.
☐	Provide detailed briefing to the SMOC Duty Officer about any continuing efforts and potential gaps to re-entry and repopulation operation, as well as plans for transports to be conducted in the next operational period.

Demobilization Procedures	
☐	Complete appropriate demobilization documentation. Ensure that all financial and administrative documentation has been completed for reimbursement.
☐	Meet with the SMOC Duty Officer to ensure that the incident documentation file is complete.
☐	Debrief any staff members to identify lessons learned during the incident.
☐	Upon deactivation, brief the SMOC Duty Officer on any continuing issues and the status of any open EMS Unit activations, transport requests or unmet needs. Brief any repopulation operations planned for upcoming operational periods.

General Awareness Information

Disaster Inspections of Medical Facilities

August 2002

U.S. Public Health Service
Engineer Professional Advisory Committee
Emergency Preparedness Subcommittee

Disclaimer

This document provides guidance on the Engineering Professional Advisory Committees (EPAC) current thoughts on the subject. An alternative approach may be used if such approach satisfies the situation. Periodically, EPAC will review this document and modify it according to comments submitted.

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Purpose

This document describes the factors that make healthcare facilities different from office buildings and discusses the need for careful planning and preparation when dealing with post-disaster situations. Healthcare facilities must be operational and have the capacity to deal with the undesirable effects of a disaster.

This document also reviews the knowledge required to make a preliminary safety inspection following a disaster event. Because disasters affect all facilities within a certain geographical area, a systematic review and inspection of critical facilities, such as hospitals, is needed to ensure continuation of service.

Background

Healthcare is an evolving industry that requires facility managers and engineers to know the latest healthcare planning, design and construction technologies, and related issues. Hospital accreditation involves compliance with the Ambulatory Healthcare and Business Occupancy building codes and standards, infection control standards and medical safety issues, and life safety standards (National Fire Protection Association [NFPA] 101, Life Safety Code) for patients and other occupants.

Healthcare facilities contain unique features and are more difficult to analyze than commercial buildings. For example:

- ☒ Healthcare facilities contain contaminated medical wastes, hazardous laboratory wastes, and regular solid wastes. Dealing with this waste is a formidable challenge.
- ☒ Specialized equipment and chemicals such as radiology equipment, medical diagnostic and treatment equipment, medical gases and piping (NFPA 99, Standard for Healthcare Facilities), and pharmaceuticals have critical storage requirements.
- ☒ The electrical system (NFPA 70, National Electric Code), especially related to patient care activities (NFPA 99), requires greater reliability (NFPA 110, Standard on Emergency and Standby Power Systems) and added redundancy within its power distribution system.
- ☒ Because of the risk of exposure to contagious patients, traffic patterns and indoor air pathways must be preserved as designed (AIA Guidelines, Hospital and Healthcare Facilities, Table 2, Ventilation Requirements for Areas Affecting Patient Care) to protect all the occupants.
- ☒ Most medical treatment and support spaces have specific adjacency criteria for optimal functionality and fire code safety requirements. However, not all engineers have the expertise to inspect and evaluate the complex safety issues unique to hospitals and clinics.

Healthcare Occupancy

Hospitals have a unique challenge related to evacuation of patients. Facility safeguards such as special construction features and materials, sprinklers, and strategically located fire barriers within the healthcare facility protect against fire or other disasters. Past experiences and corroborating fire safety research have shown that it is impractical to evacuate patients, especially if it involves a vertical movement. Therefore, fire codes have dictated the necessary physical protection needed to protect patients in case of fire, but without being evacuated.

Continuous Access to Hospital Following Disaster

A hospital is in great demand following a disaster. It serves as a treatment center and a command center during the recovery period. All hospitals and health centers with 24hour emergency rooms are structurally upgraded to withstand earthquakes and be fully operational within 24 hours. Because a hospital is an essential facility, it is seismically designed to a higher standard, which is referred to as immediate occupancy.

The fire safety upgrades mentioned earlier coupled with the seismic reinforcing enhances the suitability of hospitals to meet the continuous access requirement. This requirement would probably need additional security considerations, but probably could be implemented with a minimum of structural changes. Some scenarios would have to be evaluated for certain disasters such as floods or hurricanes but the building itself seems suited for the continuous access requirement.

The health facility must have an emergency operation/security plan in place to meet the demands placed on it in a post-disaster situation. The organized plan must contain sufficient detail to allow areas of the health facility to operate effectively and efficiently to meet these disaster emergency demands. Because the healthcare facility is designated as an essential facility for disaster recovery, coordination with local and regional emergency agencies should also be reviewed and made part of the emergency plan.

Codes and Standards

Specific building codes and standards must be followed by all healthcare facilities in order to retain Joint Commission on Accreditation of Healthcare Organizations (JCAHO) Accreditation. Following is a brief list of the major codes and standards that the healthcare facility must comply with under periodic review to maintain its JCAHO accreditation:

-NFPA Standards 70, 99, 101, 110 and 111
-ASHRAE Standards
-ANSI Standards
-AIA Guidelines for Design and Construction of Hospitals and Healthcare Facilities
-JCAHO Environment of Care Essentials for Healthcare

Attachments

Healthcare Facility Inspection

Attached are instructions and checklists for two separate post-disaster inspections, the preliminary Health Facility Rapid Safety Evaluation and the more comprehensive Health Facility Disaster Evaluation. The preliminary Rapid Safety Evaluation is intended for health facilities with slight damage or as a screening tool for hospitals exhibiting extensive visual damage. The more comprehensive Disaster Evaluation, performed by a professional engineer or registered architect, would contain a determination for each item on the checklist portion. The completed evaluation would then be used to determine the specific safety condition and serviceability of the health facility.

The following materials are provided:

• Health Facility Rapid Safety Evaluation (1 page)

-ATC-20 Rapid Evaluation Safety Assessment Form (1page)

-ATC-20 Fixed Equipment Checklist (1page)

•Health Facility Disaster Evaluation with checklist (3 pages)

HEALTH FACILITY RAPID SAFETY EVALUATION

1. The table below lists examples of systems failures that may be encountered in a rapid safety evaluation.
2. The following forms were developed by Applied Technology Council (ATC) for the ATC 20-1 Field Manual and include the following:
   - Rapid Evaluation Safety Assessment Form
   - Fixed Equipment Checklist

   These forms can be used as a guide for rapid preliminary inspection of a health facility after a disaster. These documents are not a comprehensive or detailed survey of conditions but a preliminary reference. The remarks columns should be used to alert more qualified specialists of potential problems.
3. The ATC form and checklist were developed primarily for a seismic disaster but can also be applied to all disasters where serious facility damage is anticipated (e.g., tornados, flooding, hurricanes).

EXAMPLES OF SYSTEM FAILURES IN A DISASTER TO ASSIST IN A RAPID SAFETY EVALUATION

Hospital System	Symptom of System Failure
Computer Systems, Hospital Network	No response, system down
Main Electrical Power & Emergency Gen.	Many lights out, only emergency (red) outlets work. All outlets in OR, ICU/PCU, and NICU are on emergency power.
Elevators Malfunctioning	Alarm indicates stoppage between floors
Fire Alarm System	No detectors or alarm operable
Sprinkler System	No water; non-operable
Medical Gases	Gas alarms; no oxygen, medical air, nitrous or nitrogen
Medical Vacuum	Vacuum alarm; no vacuum
Natural Gas Supply	Gas odor if leak; no flame at kitchen stoves
Nurse Call System	No contact on patient call system
Patient Care Equipment Systems	All equipment in non-function mode
Sewer/Drain System	Drain lines backing up/odor in lower areas
Steam Generation and Distribution	Absence of building heat and sterilizers inoperable
Telephone System	Local or regional network inoperable
Potable Water	Reduced or no pressure at faucets; potential flooding at lower areas of building/site
Ventilation System	No air movement; loss of temperature control

Block_____ Parcel No._____

ATC-20 Rapid Evaluation Safety Assessment Form

BUILDING DESCRIPTION:

Name: _____

_____

Address: _____

_____

No. of stories: _____

Basement: Yes ☐ No ☐ Unknown ☐

Primary Occupancy: Dwelling ☐
Other Residential ☐ Commercial ☐ Office ☐
Industrial ☐ Public Assembly ☐ School ☐
Government ☐ Emer. Serv. ☐ Historic ☐
Other_____

OVERALL RATING: *(Check One)*

INSPECTED (Green) ☐
___ Exterior only
___ Exterior and Interior
LIMITED ENTRY (Yellow) ☐
UNSAFE (Red) ☐

INSPECTOR:

Inspector ID_____

Affiliation _____

INSPECTION DATE:

Mo/day/year_____

Time _____ am pm

Instructions: Review structure for the conditions listed below. A "yes" answer to 1, 2, 3, or 5 is grounds for posting entire structure UNSAFE. If more review is needed, post LIMITED ENTRY. A "yes" answer to 4 requires posting AREA UNSAFE and/or barricading around the hazard. Hazards such as a toxic spill or an asbestos release are covered by 6 and are to be posted and/or barricaded to indicate AREA UNSAFE.

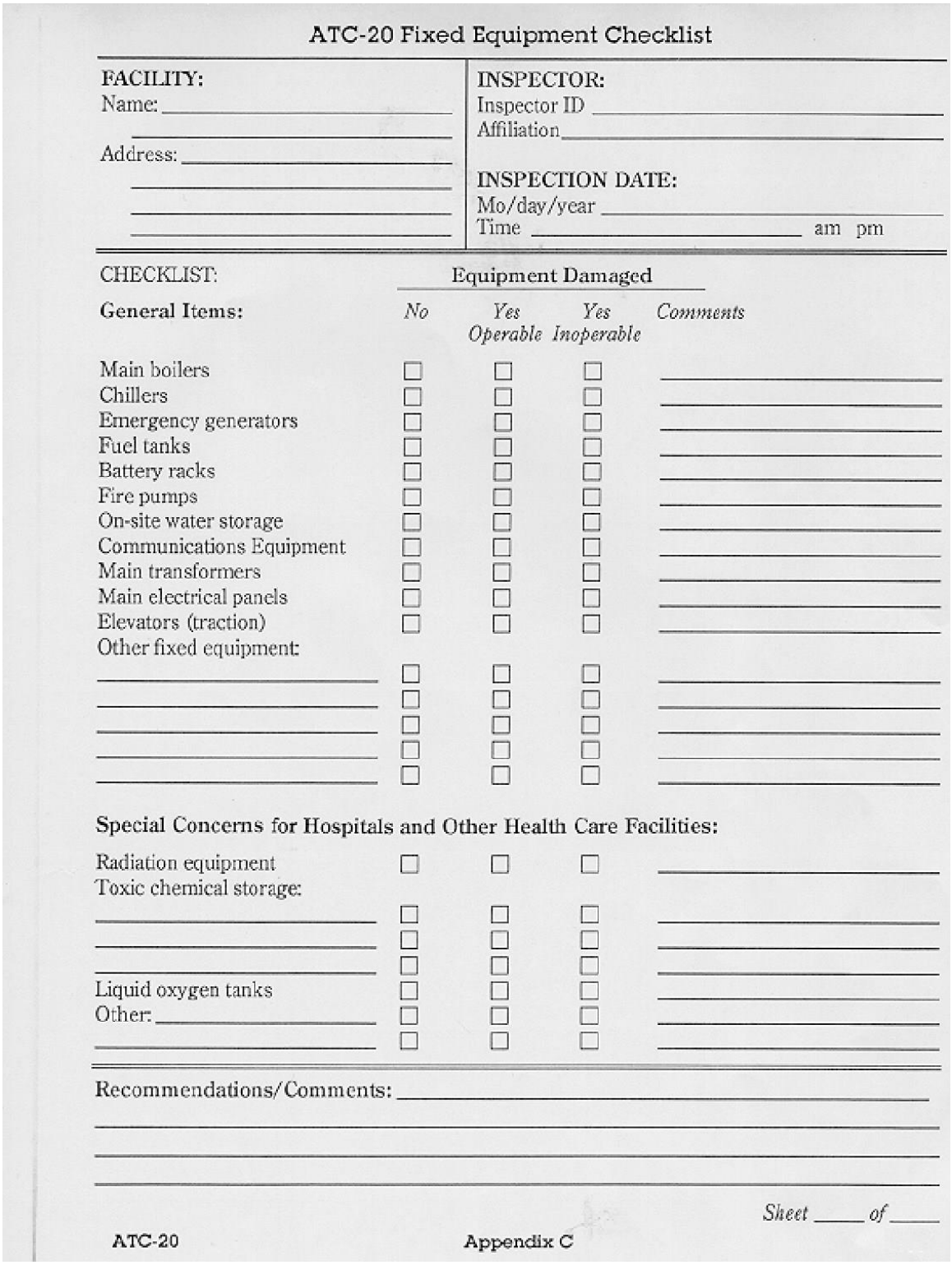
Condition	*Yes*	*No*	*More Review Needed*
1. Collapse, partial collapse, or building off foundation	☐	☐	☐
2. Building or story noticeably leaning	☐	☐	☐
3. Severe racking of walls, obvious severe damage and distress	☐	☐	☐
4. Chimney, parapet or other falling hazard	☐	☐	☐
5. Severe ground or slope movement present	☐	☐	☐
6. Other hazard present	☐	☐	☐

Recommendations:

☐ No further action required
☐ Detailed Evaluation required (circle one) Structural Geotechnical Other_____
☐ Barricades needed in the following areas: _____
_____
☐ Other: _____

Posted at this Assessment: ☐ Yes ☐ No

Comments: _____
_____
_____
_____
_____
_____



ATC-20 Fixed Equipment Checklist

FACILITY:
Name: _____
_____
Address: _____
_____
_____
_____

INSPECTOR:
Inspector ID _____
Affiliation _____

INSPECTION DATE:
Mo/day/year _____
Time _____ am pm

CHECKLIST: General Items:		Equipment Damaged: Yes Operable	Equipment Damaged: Yes Inoperable	Comments
Main boilers	☐	☐	☐	_____
Chillers	☐	☐	☐	_____
Emergency generators	☐	☐	☐	_____
Fuel tanks	☐	☐	☐	_____
Battery racks	☐	☐	☐	_____
Fire pumps	☐	☐	☐	_____
On-site water storage	☐	☐	☐	_____
Communications Equipment	☐	☐	☐	_____
Main transformers	☐	☐	☐	_____
Main electrical panels	☐	☐	☐	_____
Elevators (traction)	☐	☐	☐	_____
Other fixed equipment:				
_____	☐	☐	☐	_____
_____	☐	☐	☐	_____
_____	☐	☐	☐	_____
_____	☐	☐	☐	_____
_____	☐	☐	☐	_____
Special Concerns for Hospitals and Other Health Care Facilities:				
Radiation equipment	☐	☐	☐	_____
Toxic chemical storage:				
_____	☐	☐	☐	_____
_____	☐	☐	☐	_____
_____	☐	☐	☐	_____
Liquid oxygen tanks	☐	☐	☐	_____
Other: _____	☐	☐	☐	_____
_____	☐	☐	☐	_____

Recommendations/Comments: _____
_____
_____
_____

Sheet _____ of _____

ATC-20 Appendix C

HEALTH FACILITY DISASTER EVALUATION

Date_____
Facility Name_____ **Facility**
Location_____
Reviewer_____ **Purpose**

The following table is used to evaluate the condition of a health care facility after a disaster has occurred. Its purpose is to collect IMMEDIATE data after a specific disaster. Government staff will

use this data to determine the current condition of the facility and to help them determine if facility is operational and safe.

Evaluation

The table should be completed by a professional engineer/architect (PE/A) or a certified facility maintenance engineer should complete the table and then forward it to the local health care administrator (HCA). The PE/A should make a recommendation to the HCA if the facility should be either labeled as having "limited entry" or "no entry" to the public. For limited entry, the PE/A must define what areas should be limited. The PE/A must clearly post the signs with appropriate signage or plastic ribbon tape. Following are recommendations for appropriate signage:

LIMITED ENTRY
Warning: This structure/system/equipment has been damaged and its safety is questionable.

NO ENTRY
Warning: This structure/system/equipment has been seriously damaged and is unsafe.

After the completion of this table and appropriate signage posting, a thorough engineering evaluation of the facility is recommended. A team of registered architects and engineers with appropriate knowledge in their particular area of specialty should perform this investigation. The makeup of this team would be based upon the results that have been entered into table, and the need for repairing the damaged and/or securing the safety of the facility. This team should not only review the damage that has occurred throughout the facility, but also make appropriate contacts to all service contracts that the facility uses in its daily operation.

Inspection Items	**N/A**	**Structure/System/Equipment Damage**		
		NO	**YES**	
			Operable/Safe	**Inoperable/Unsafe**
CIVIL SYSTEMS CHECK LIST				
Domestic Water Supply Main				
Fire Supply Main				
On-Site Water Storage				
Sewer Line				
Storm Water Piping from Roof				
Surface Water Drainage				
Road Access				
Facility Parking				
Facility Sidewalks				
ELECTRICAL SYSTEMS CHECK LIST				
Electrical Service to Facility				
Main Power Transformer				

Main Electrical Panels				
Emergency Generator				
Communication Systems				
☒ Telephone				
☒ Computer Local Area Network				
☒ Public Address System				
☒ Fax Machines				
Fire Alarm System				
☒ Smoke Detectors				
☒ Strobe Lights				
Emergency Lighting System				
Normal Lighting System				
MECHANICAL SYSTEMS CHECK LIST				
Building HVAC Control System				
HVAC System Components				
☒ Main Boilers				
☒ Chillers				
☒ Pumps				
Fire Sprinkler System				
Fuel Supply (Oil, Propane, Natural Gas, Diesel)				
Medical Gas				
Vacuum Gas				
Fire Pumps				
Seismic Shut-Off Valves				
Motor Starters				
Inspection Items	**N/A**	**Structure/System/Equipment Damage**		
		NO	**YES**	
			Operable/Safe	**Inoperable/Unsafe**
STRUCTURAL SYSTEMS CHECK LIST				
Foundations				
☒ Building off foundation				
☒ Fractured foundation				
Vertical Support				
☒ Columns not Plumbed/Buckled				
☒ Bearing Walls				
☒ Beams/Trusses				
☒ Connections				
Horizontal Lateral Support				
☒ Shear Walls				

☒ Diaphragms				
☒ Cross Bracing				
☒ Connections				
Roof Support				
☒ Beams				
☒ Trusses				
☒ Connections				
NON-STRUCTURAL SYSTEMS CHECK LIST				
Exterior Facade				
☒ Bldg. Skin/Walls				
☒ Windows/Doors				
Roof System				
Elevators				
Fuel Tanks				
Toxic Chemical Tanks				
Liquid Oxygen Tanks				
Battery Racks				
MEDICAL EQUIPMENT CHECK LIST				
X-Ray Equipment				
CAT Scanner				
MRI Units				
Ultra Sound Units				
Laboratory Equipment				
Radiation Equipment				
Other Fixed Equipment				

REVIEWER RECOMMENDATIONS

* LIMITED ENTRY INTO FACILITY: Yes No

Authorized entry areas include _____

Off-limit areas include _____

* NO ENTRY TO FACILITY: Yes No

Appendix C
Additional Assessment and Restoration Resources

Additional Assessment and Restoration Resources

The Joint Commission – Available at http://www.jcrinc.com

The Joint Commission (TJC) standards for Accreditation of Hospitals and Healthcare Organizations are the gold standard used for Medicare and Medicaid funding. TJC is active in facilities affected by a disaster, assisting and eventually inspecting/accrediting the facility to file for federal funds.

The Joint Commission Standards, (2015).

NFPA Resources – Available at http://www.nfpa.org

The NFPA Website offers free access to view NFPA Standards with a valid email address. Additionally, inspection sheets for new and existing occupancies, including healthcare facilities are available online.

NFPA Standard 70, National Electrical Code, Chapter 5, Special Occupancies, Section 518, Healthcare Facilities, (2014 edition)

NFPA Standard 99, Healthcare Facilities Code, (2015 edition)

NFPA Standard 101, Life Safety Code, Chapter 19, Existing Healthcare Occupancies, (2015 edition)

NFPA Standard 110, Standards for Emergency and Standby Power Systems, (2013 edition)

ANSI/ASHE/ASHRAE Resources – Available at http://www.ashrae.org

The ASHRAE standards, which are ANSI approved, address the design, maintenance and inspection of HVAC systems in healthcare facilities.

ANSI/ASHE/ASHRAE Standard 170-2013, Ventilation of Healthcare Facilities, (2013)

Facilities Guidelines Institute – Available at http://www.fgiguidelines.org

The Facilities Guidelines Institute maintains the former AIA standards for Healthcare Facility Design. This document includes many of the other applicable codes used by architects and engineers in the design and construction of hospitals, and therefore is applicable to repairs and facility restoration.

FGI Guidelines for Hospitals and Outpatient Facilities, (2014)

Occupation Safety and Health Administration – Available at http://www.osha.gov/

OHSA Standards apply to many facets of healthcare, but the radiation standard touches a standard not found in other regulations. An all-encompassing resource is found at
https://www.osha.gov/dcsp/compliance_assistance/quickstarts/health_care/index_hc.html

OSHA Standard 29CFR 1910.1096, Ionizing Radiation, (1996 edition)