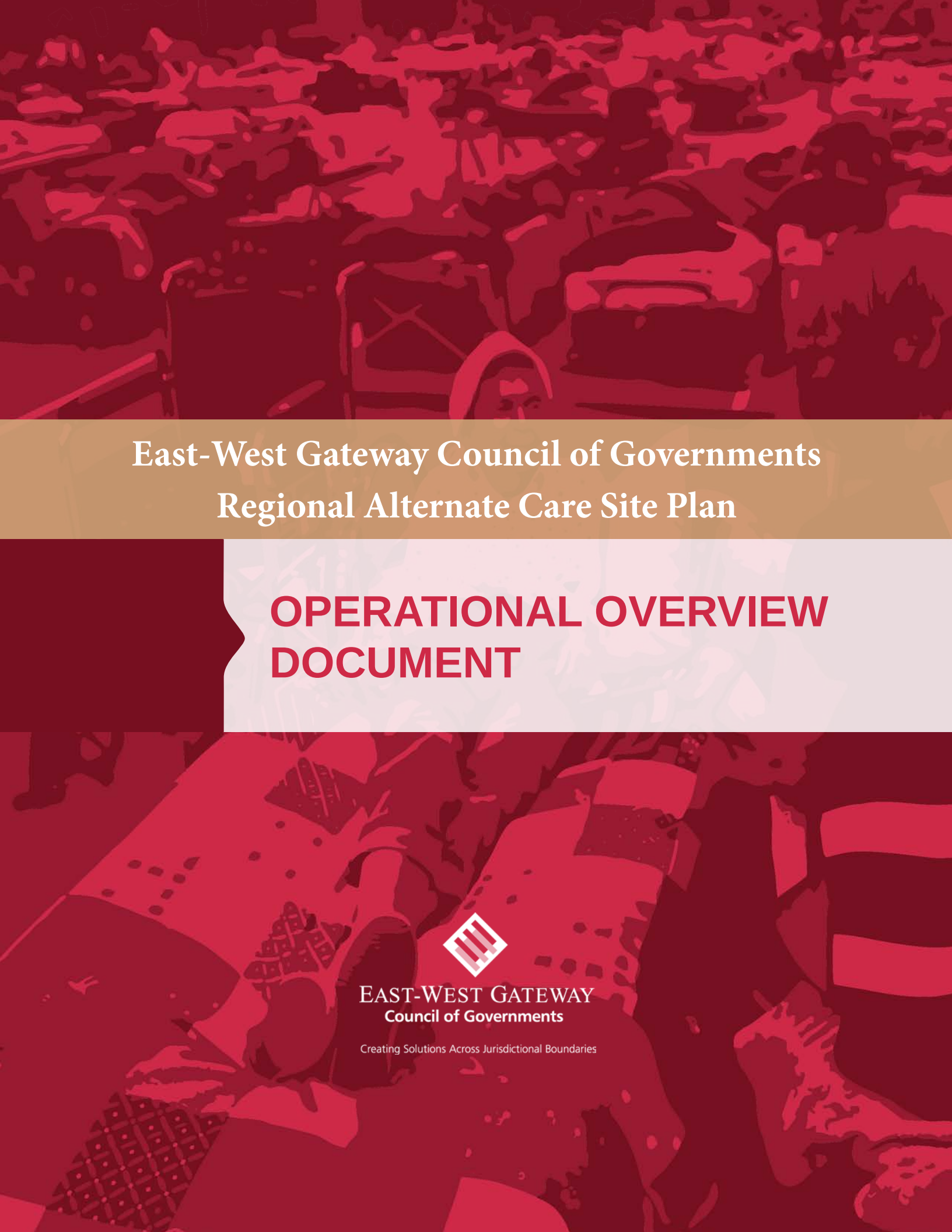


East-West Gateway Council of Governments
Regional Alternate Care Site Plan

OPERATIONAL OVERVIEW DOCUMENT

EAST-WEST GATEWAY
Council of Governments

Creating Solutions Across Jurisdictional Boundaries

The STARRS Regional Alternate Care Site Planning

A major disaster could significantly impact the ability of a community or the St. Louis Area Regional Response System (STARRS) Region as a whole to meet the health and medical needs of the impacted population or result in an increased demand for medical care. In these situations, it may be necessary to identify, convert, and activate a location not currently providing healthcare services to administer such services.

The following pages represent a collection of documents that fully detail the STARRS regional approach to Alternate Care Sites (ACS). The ACS concept is explored as a means of alleviating the burden caused by a surge of patients entering the healthcare system.

For ease of use, the plan is divided into three parts:

- Part 1: Regional ACS Plan – summarizes the overall approach to an ACS for the region.
- Part 2: Hospital-Specific Template – provides specific context to operating a hospital-based ACS.
- Part 3: Operational Tools and Support Template – a cadre of tools that allow both regional partners and hospital works to operationalize the concepts outlined in the Regional ACS Plan.

The intended audience for this document is planners, response agencies, and senior officials across the region and in local hospitals, who can read the material in advance of an incident, train on its content, and further develop the operational concepts through standard operating procedures and guides.

Other Planning Resources

The STARRS Region has undertaken a variety of efforts leading up to the current ACS concept of operations. In earlier efforts, the foundational elements of regional coordination where defined and operationalized. The operation of an ACS will be dependent on these larger systems for guidance, resources, and coordination throughout the incident.

For the purposes of this document, the foundation on which a hospital-based medical surge will be facilitated is the *Hospital Mutual Aid Agreement, Memorandum of Understanding*. Similar coordination is accomplished in Illinois through the Region 4 Regional Hospital Coordination Center (RHCC) at Memorial Hospital Belleville in St. Clair County, Illinois.

It is assumed that each participating hospital will maintain its own emergency management plan that includes, at a minimum, provisions for the care of patients in an emergency or disaster situation, maintenance of disaster equipment, appropriate training of staff, and the implementation of an internal incident command system based on the principles of the Hospital Incident Command System (HICS). During a health and medical emergency, a hospital may convert from their current care capacity to surge capacity to handle the maximum patient load. The ACS guidance discussed in the following pages does not explicitly cover concepts in which hospitals can expand to accommodate increased patients within their normal parameters of delivering services; this is assumed to be addressed locally and in line with standard medical surge plans.

During an emergency, the St. Louis Medical Operations Center (SMOC) will serve as a center for collecting and disseminating current information about healthcare resources and needs (including equipment, bed capacity, personnel, supplies, etc.), developing priority allocations, tracking disbursement of resources, and other relevant healthcare response matters. As seen in Figure 1 (right), information exchange and the linkage to the community's broader response efforts will be facilitated through the SMOC. In consideration of the alternate care sites, the role of the SMOC cannot be overstated. It is the vital linkage required for the success of an ACS operation, involving many different community resources—from police, fire, medical providers, engineers, transportation, and housing experts.

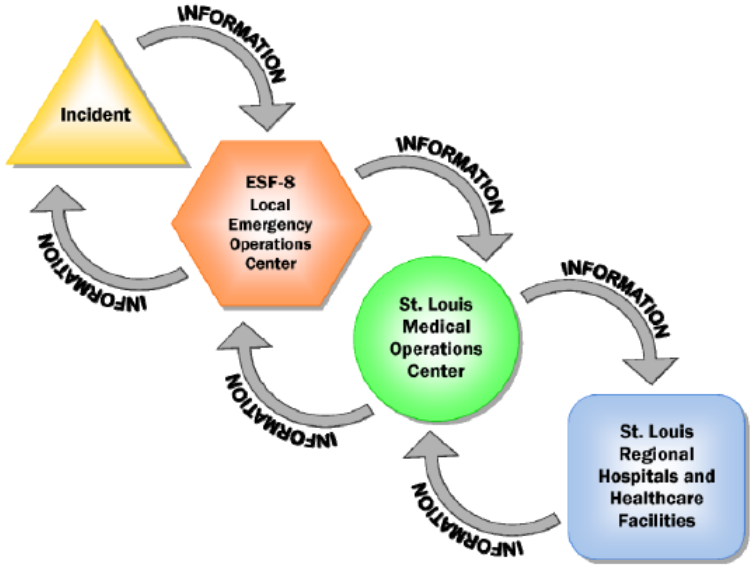


Figure 1

Among the planning and preparedness activities conducted throughout the STARRS Region, the following plans are essential to understanding the foundation on which ACS operations would be established and coordinated:

- Regional Emergency Resource Coordination Plan (RERC) – The St. Louis RERC Plan provides leaders of local government jurisdictions and their agencies, leaders of participating non-governmental organizations, and the private sector with the means to communicate, collaborate, and coordinate their actions while keeping abreast of the changing situation during a catastrophic region-wide threat or incident. Further, it provides an effective means to rapidly locate and acquire critical resources that the jurisdictions need in order to respond to a catastrophic threat or incident when traditional methods of acquiring resources through mutual aid arrangements may be overwhelmed.

- STARRS Regional Healthcare Coordination Plan (RHCP) – The RHCP establishes the organization and function of the St. Louis Medical Operations Center (SMOC). It is a coordination plan among participating entities that describes how medical (both acute care and non-acute care hospitals), emergency medical services (EMS), public health, emergency managers, and other first responders will coordinate and communicate during a disaster. Further, the plan describes how medical and healthcare resources will be coordinated, shared, and prioritized among healthcare facilities; it defines how patient allocation will be coordinated among participating hospitals during an emergency; and finally, the plan identifies how regional decisions affecting medical and healthcare issues will be made.

- SMOC Standard Operating Guidelines (SOG) – The SMOC has developed standard operating guidelines to outline the methods and actions the SMOC will utilize to interact with area hospitals and first response agencies to respond effectively during any disaster or emergency situation that may have significant impact on the healthcare infrastructure of the Greater St. Louis Area. These guidelines assign various emergency tasks and responsibilities that may need to be performed during any emergency or disaster situation.

- Hospital Mutual Aid Agreement Memorandum of Understanding (MOU) - The Hospital Mutual Aid Agreement establishes a coordinated system in which hospitals in the St. Louis Region, including hospitals owned and/or operated by agencies of the State of Missouri, will provide aid to each other as necessary to meet demand for

emergency medical care in a medical disaster. The hospitals that are parties to this agreement are collectively referred to as "participating hospitals."

- Regional ACS Medical Support Annex/Shelter Medical Support Group (SMSG) Plan – This plan describes the organizational structure, personnel, resources, responsibilities, types of activities, medical services and requirements of a shelter medical support group, and the conditions under which healthcare stakeholders in the region will provide medical support. This plan is not intended to describe how shelter managers will meet functional needs support services (other than non-acute medical services' needs) or how they will comply with the American Disabilities Act (ADA).

- STARRS Mass Fatality Operational Annex and Hospital Mass Fatality Template – This plan provides for the regional coordination of Mass Fatality Incident (MFI) response activities involving human remains collection, identification, and disposition. By statute, this responsibility lies with the local medical examiner or coroner's office. The plan focuses on the role of bi-state regional partners in supporting the mass fatality response activities of local jurisdictions within the region.

Limitations of the Document

This plan builds the foundation to a common operating picture as it pertains to the operation of an ACS in the St. Louis Region. This plan does not supersede any other state or local emergency plans. It is intended to work with and support individual local jurisdictional emergency operations plans to include the resources outlined in the above section.

The use of trade or manufacturer names in this plan does not constitute an official endorsement of any commercial products. The SMOC Stakeholder Group will manage and maintain this plan, as well as allow modifications and changes with the consent and approval of the SMOC Stakeholder Group.

Scope

The Regional ACS Plan seeks to provide guidance, definition, and delineation of organizational responsibilities pertaining to an ACS response. Further, this template provides operational considerations for the activation, operation, and demobilization of an ACS. An ACS will be executed according to one of three operational paradigms, listed below. Note that these operational approaches can occur independently of one another or be layered to encompass a multi-dimensional approach in response to a large, catastrophic incident.

- Operational Approach 1 - General Population Shelter Support Teams – In situations where a general population shelter is already activated but displaced persons present with advanced medical needs that require a level of care beyond that available within the Mass Care and Emergency Assistance (Emergency Support Function [ESF] #6) resource pool, individual or regional hospitals may deploy teams to support these facilities in meeting the individual needs present in the general population shelter. For additional context, consult the SMSG Plan.

- Operational Approach 2 - Hospital-based Alternate Care Site – In situations where traditional approaches to healthcare surge are insufficient to meet the needs of an incident, an existing healthcare facility may need to identify an area not used for patient care (but on or adjacent to their existing campus) that can be quickly converted to serve as a treatment area (e.g., physical therapy areas, adjacent medical buildings, affiliated professional office buildings, outpatient clinics, and/or waiting rooms).

  Procedures for accomplishing this expansion will be included in the hospital's emergency operations plan and driven at the local level. However, given the increased demand that operating such a facility would place on an individual hospital, the hospital may activate this location as a "Hospital-based Alternate Care Site" and activate the Hospital

Mutual Aid Agreement to facilitate the regional exchange of resources. The intensity of the incident and anticipated number of patients should be key factors to consider when identifying areas to host the hospital-based ACS.

- Operational Approach 3 – Regional Alternate Care Site – In large-scale incidents, a regional approach may be required to significantly increase the level of medical services available to the impacted community. This community-based ACS provides additional treatment area(s) with a minimum specific level of care.

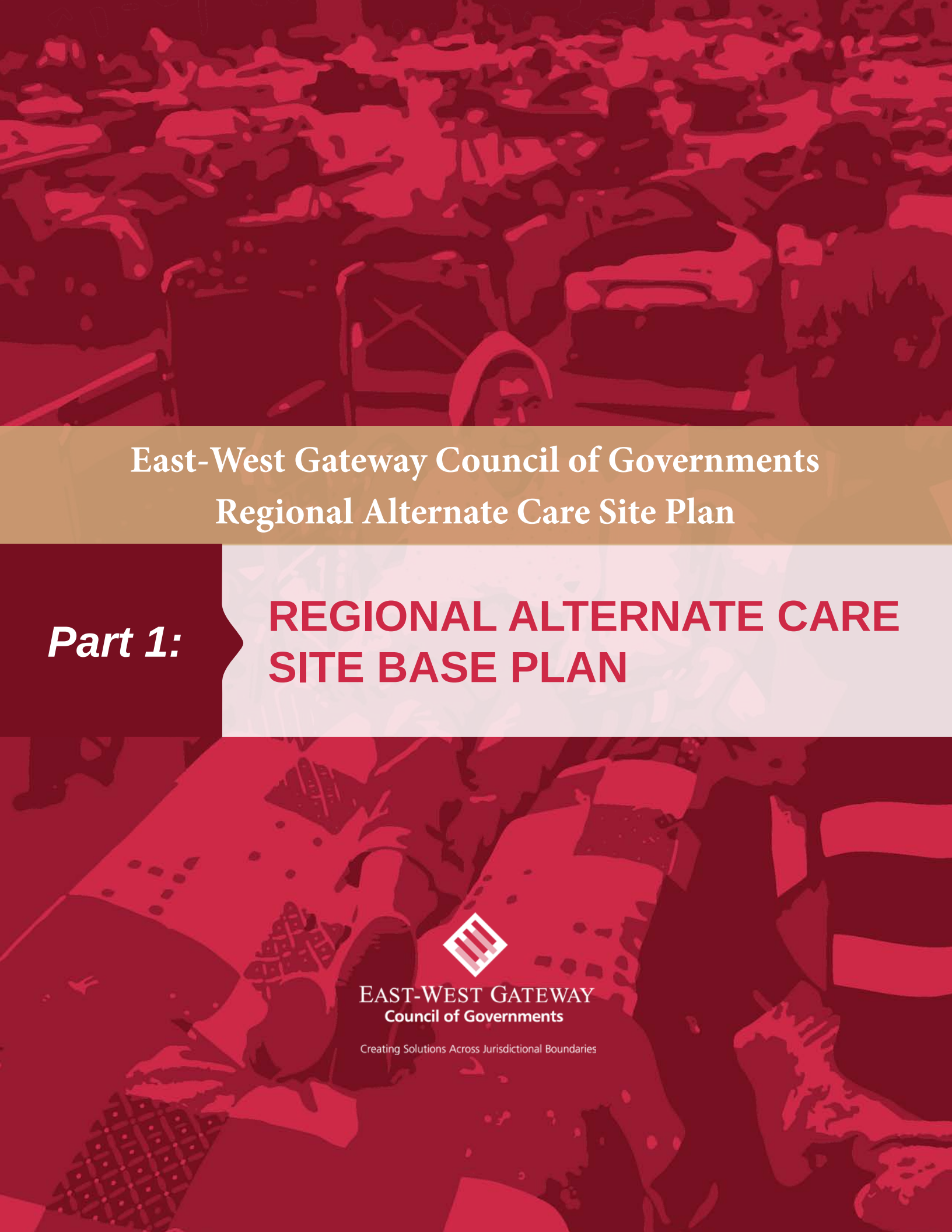
  Collaboration with local emergency operations centers, public health officials, and emergency medical services will provide hospitals with the necessary information to establish the appropriate type and number of outpatient/inpatient healthcare surge treatment areas. This site will typically be established where no medical care is usually provided or at a medical facility where the scope of services does not normally include large-scale urgent care or traditional inpatient services (e.g. nursing home or rehab facility). The ACS facility will be selected from an existing structure, although temporary structures may be erected and resourced from a variety of organizations, including local, state, and federal governments.

This Regional ACS Plan applies to the City of St. Louis, Missouri; the counties of Franklin, Jefferson, Lincoln, Perry, Pike, St. Charles, St. Francois, St. Genevieve, St. Louis, Warren, and Washington in Missouri; and the counties of Madison, Monroe, and St. Clair in Illinois.

Situation

The following situations should be considered as a baseline for planning the operation of an ACS:

- Large-scale health emergencies have the potential to overwhelm any local healthcare system. In situations where local hospitals are overwhelmed by an influx of individuals due to a significant incident, a hospital can opt to stand up an ACS to augment services.
- It is assumed that before activating an ACS, a hospital has already explored traditional healthcare surge practices, such as rapid discharge of the emergency department and other patients who can continue their care at home safely; canceling elective surgeries and procedures; reducing the usual use of imaging, laboratory testing, and other ancillary services; transferring patients to other institutions in the state, interstate region, or nationally; and other strategies that might alleviate the need to quickly convert an existing healthcare facility not used for patient care to serve as a treatment area.
- Depending on the severity of the incident and availability of resources in the community, regional partners may consider activating one or more ACSs to address incidents that result in inpatient and primarily outpatient hospital capacity that is insufficient to adequately care for those in need.
- Operations surrounding mass fatality emergencies should be addressed within localized hospital plans in accordance with hospital management policies, procedures, and plans.
- The foundation on which a hospital-based medical surge will be facilitated is the *Hospital Mutual Aid Agreement, Memorandum of Understanding*.
- Implementation of the Hospital Template depends on activation protocols, established level of care, ability to manage scarce resources, and pre-developed partnerships between primary and cooperating agencies. Operational considerations have been developed in the hospital template to allow flexibility to best meet the needs of the emergency or anticipated high-risk events (e.g., sports events, political conventions).



East-West Gateway Council of Governments
Regional Alternate Care Site Plan

Part 1: REGIONAL ALTERNATE CARE SITE BASE PLAN

EAST-WEST GATEWAY
Council of Governments

Creating Solutions Across Jurisdictional Boundaries

This plan is endorsed by the following regional committees:

(Name)
Co-Chair
XXXX Committee

(Name)
Co-Chair
XXXX Committee

(Name)
Co-Chair
XXXX Committee

(Name)
Co-Chair
XXXX Committee

(Name)
Co-Chair
XXXX Committee

(Name)
Co-Chair
XXXX Committee

(Name)
Co-Chair
XXXX Committee

(Name)
Co-Chair
XXXX Committee

(Name)
Co-Chair
XXXX Committee

(Name)
Co-Chair
XXXX Committee

(Name)
Co-Chair
XXXX Committee

(Name)
Co-Chair
XXXX Committee

Section 1
Introduction

1.1 Purpose

The St. Louis Regional Hospital Alternate Care Site (ACS) Plan is intended to enhance existing agency plans for managing a disaster that creates a surge of patients by providing additional facility care when regional hospitals are saturated and incapable of additional surge. The purpose of this plan is to provide operational concepts unique to ACS response, document coordination, and enhance response to regional healthcare demands. An ACS is a community-based location that may provide additional treatment area(s) with a minimum specific level of care for patients. An ACS may be established at sites where medical care is not usually provided or at medical facilities where the usual scope of medical services does not normally include large-scale urgent care or traditional inpatient services. The ACS facility will be selected from an existing structure, although temporary structures (if available) may be erected by responding partners.

During a large scale emergency, emergency departments, treatment centers, and other medical clinics across the community may see an influx of patients. By planning ACS operations, the community will be more prepared to provide effective care to the greatest number of victims. The goal is to advance planning towards a coordinated healthcare and public health response.

1.2 Scope

This plan recognizes the need to organize regional agencies and resources to plan for and respond to an incident that may require an ACS activation. This plan seeks to provide guidance, definition, and delineation of organizational responsibilities pertaining to ACS response, specifically the role of the Illinois Regional Hospital Coordination Center (RHCC) and Missouri healthcare systems. In addition, the intent is to incorporate regional organizations and resources into a coordinated response system to operate alternate medical treatment locations. The plan provides a possible outline for general activation, operation, and demobilization of an ACS, and applies to hospitals in the following counties:

1. Franklin County, Missouri
2. Jefferson County, Missouri
3. Lincoln County, Missouri
4. Madison County, Illinois
5. Monroe County, Illinois
6. Perry County, Missouri
7. Pike County, Missouri
8. St. Charles County, Missouri
9. St. Clair County, Illinois
10. St. Francois County, Missouri
11. St. Genevieve County, Missouri
12. St. Louis County, Missouri
13. Warren County, Missouri
14. Washington County, Missouri
15. City of St. Louis, Missouri

It is recognized that regional hospital resource coordination in Missouri is accomplished through the St. Louis Medical Operations Center (SMOC) and that similar coordination in Illinois is accomplished through the Region 4 RHCC at Memorial Hospital Belleville in St. Clair County, Illinois. This plan is focused on Missouri-based hospital coordination through the SMOC with the understanding that the SMOC will coordinate with the Illinois RHCC when appropriate.

Specific discussion of Scope of Care can be found in the Regional ACS Plan Summary Document.

1.3 Situation

Large-scale health emergencies have the potential to overwhelm any local healthcare system. In these situations, communities may need to expand their healthcare delivery system to one that includes an ACS. Depending on the severity of the incident and availability of resources in the community, activation of one or more ACSs may be considered by regional partners to address incidents that result in inpatient and primarily outpatient hospital capacity that hinders adequate care for those in need.

For mass fatality emergencies, jurisdictions and hospitals should reference their individual mass fatality plans.

1.4 ACS Objectives

Patient care objectives will likely be part of the discussion within an incident command system (ICS) employed locally by operators of an ACS. In the instance where the effort is coordinated with the local jurisdiction, the Unified Command System will be accessed through the SMOC to ensure a coordinated understanding of the intent of the facility, as well as its patient care objectives. Objectives may include, but are not limited to:

- Deliver sufficient medical care for a surge of patients who have disaster-related acute illnesses or injuries (non-immediate life-threatening) and who cannot be adequately cared for in a timely manner by the traditional healthcare system.
- Deliver urgent care for both disaster-related and unrelated medical conditions to offload emergency departments (ED) and ambulatory care clinics, so that these sectors can maximize care for other patient needs.
- Deliver sufficient non-complex care that is traditionally provided in inpatient settings to offload acute care hospitals and allow them to maximize care for more seriously injured or ill patients.
- Facilitate sufficient follow-up services so patients can be safely discharged to a non-medical site (e.g., home, ACS, or shelter).
- Triage and treat large numbers of exposed people (e.g., radiation, pathogen, toxic substance), and facilitate treatment and follow-up for recommended groups.

1.5 Level of Care

The ACS will provide treatment based on the operational approach selected, the availability of resources, and the objectives determined during activation and as the incident evolves. That said, for the purpose of uniformity and the establishment of a common operating picture, the following descriptions of capability are intended as guidelines for Operational Approach 3 – Regional Alternate Care Site. The operational approaches are fully outlined in Table 1 on the next page. No restrictions, limitations, or promises of care are implied.

Table 1: Operational Approach Definitions

Operational Approach	Definition	Details	Lead Agency/Responsibility
Operational Approach 1 - General Population Shelter Support Teams	In situations where a general population shelter is already activated, there may be general populations, including individuals with access and functional needs, requiring a level of care beyond that available from Mass Care and Emergency Assistance (Emergency Support Function #6) and individual or regional hospitals. At the request of the local emergency management agency, these stakeholders may be asked to deploy mission-typed teams to help meet individual needs present in the shelter environment.	General population shelters will be activated by local officials following an incident that displaces a large number of individuals. These shelters meet the needs of the general population, which includes individuals with access and functional needs. General population shelters cannot provide continuous medical supervision or life-sustaining or acute medical care.	Local government, in conjunction with Emergency Support Function #6 – Mass Care and Emergency Assistance stakeholders. The American Red Cross or other non-governmental organizations may be included. Mission-typed teams and other resources would be requested from the healthcare community through the SMOC by local emergency management agencies.
Operational Approach 2 - Hospital-based Alternate Care Site	In situations where traditional approaches to healthcare surge are insufficient to meet the needs of an incident, an existing healthcare facility may need to identify an area not used for patient care, but on or adjacent to their existing campus, which can be quickly converted to serve as a treatment area (e.g., physical therapy areas, adjacent medical buildings, affiliated professional office buildings, outpatient clinics, and/or waiting rooms).	Incident creates need for increased acute medical care capacity. May meet the needs of inpatient/outpatient care or critical care; however, every attempt should be made to keep critical care patients in a hospital.	Given the increased demand that operating such a facility would place on the hospital, the hospital may activate the Hospital Mutual Aid Agreement to facilitate the regional exchange of resources. Mission-typed teams and other resources would be requested from the healthcare community through the SMOC.
Operational Approach 3 – Regional Alternate Care Site	Following a major incident, outbreak, or declared emergency, a regional approach may be required to significantly increase the level of medical services available to the impacted community. A location not currently providing healthcare services and not part of the expansion of an existing healthcare facility will be identified through the SMOC, in conjunction with local emergency management. This location will likely be designated under the authority of the local government when existing healthcare facilities are unable to meet demand for services. This community-based location may provide additional treatment area(s) within an identified level of care.	Overall regional healthcare infrastructure has exhausted available resources through surge, with additional capacity still required. Likely heavily influenced, resourced, and overseen by the government in conjunction with the medical providers through a public-private partnership.	Typically activated by local government via a public-private partnership and can be supported by local public health, Emergency Medical Services, and medical providers. Mission-typed teams and other resources would be requested from the healthcare community through the SMOC. Governmental or non-governmental agencies or one or more participating hospitals may assume command and control of such a site. Other participating hospitals may be asked to transfer staff, equipment or supplies.

Defining the criteria for scope of care, based upon the mission and resources available, is critical to the success of an ACS mobilization. The scope of care provided in an ACS will likely be limited and generally will not include laboratory, radiology, surgical services, or mortuary service. Services may differ from that typically provided by fixed fully functional healthcare facilities because resources may be limited and the "surge" is situationally dependent. Furthermore, prolonged treatments requiring medical gas, vacuum, and certain types of isolation will present increased challenges in an ACS.

Note that the scope of care at the ACS may be based on many situations, patient needs, and resource availability.

Table 2: Operational Approach 2 - Alternate Care Site Recommended Scope of Care

Scope of Care	Objectives of ACS Implementation
1. Delivery of ambulatory / outpatient services	Decompression of emergency departments by providing nursing care for stabilized internal medicine, trauma, orthopedic, and obstetric patients. Provide medical workups and examinations. Provide care for a variety of acuity levels while providing treatment, transfer, and discharge, as appropriate.
2. Receiving site for inpatients (non-oxygen or power dependent)	Decompression of acute care hospital beds and the facilitation of the discharge and transfer (long-term acute care, nursing home, rehab) process.
3. Inpatient care for moderate acuity patients	Decompression of acute care hospital inpatient beds for specific patients, to be defined at the activation of the ACS. Generally will not provide care for patients who have need (or anticipated need) of laboratory, radiological, continuous oxygen therapy, or continuous power dependency.

The ACS will primarily activate for outpatient care surge capacity. Secondary activation criterion may be needed in moderate duration incidents where additional inpatient care surge is required. Long-term operational needs should consider state and federal resources (e.g., federal medical station [FMS], disaster medical assistance team [DMAT], etc.) allowing the local resources to progress into recovery.

The ACS is not designed to address the following; however, ACS personnel will triage and disseminate to the appropriate level of care:

- Advanced Cardiac Life Support (ACLS)
- Advance Trauma Life Support (ATLS)
- Long-term Airway Management (e.g., ventilator support)
- Neonatal Advance Life Support (NALS)
- Advanced Burn Life Support (ABLS)
- Respiratory Isolation Requirements
- Continuous Oxygen Dependency
- Durable Medical Equipment Provider
- Cold Storage of Remains/Decedents

1.6 Policies

The SMOC serves as the coordinating entity for all health and medical response, including but not limited to ACS activation. The SMOC shall be the ultimate authority of the ACS facility, responsible for administration and operations within its scope of services. This includes but is not limited to manners with respect to patient care, environmental safety, and institutional management.

The SMOC will work closely with cooperating agencies to coordinate the local level planning, response, and recovery. Agencies shall work with their legal department to review applicable codes, regulations, and licensures (e.g., medical care facility or general/special hospital) with respect to operations, liability, reimbursement, and other related issues. Health agencies will communicate with local board of health as necessary.

1.7 Planning Assumptions

Below is a list of operationally-specific planning assumptions. This is not meant to include redundant assumptions used to create the ACS Plan, but instead focuses on the assumptions that corroborate this Hospital Template.

- There are many different emergencies that can result in activation of this plan.
- If the entire medical system including pre-hospital response and medical specialty is stressed, ACS activation may be necessary.
- The region may have limited capability to treat specific patients (e.g., severe burn cases, severe trauma injuries, etc.).
- Local governments will continue to address and assess topics and issues related to coordinating trauma care and triage protocols within their own region and locally.
- Medical material and medical professionals will be scarce when health care systems are stressed.
- The jurisdiction has limited availability for additional resources (human and material) to support an ACS.
- ACS will be activated in a collaborative effort between health and medical partners within the St. Louis Area Regional Response System (STARRS) Region.
- Some resources may be available through mutual aid to help support sites.

Section 2
ACS Concept of Operations

2.1 Regional Coordination

Coordination will occur through the SMOC and be consistent with current operational guidelines. The SMOC will also execute the current Hospital Mutual Aid Agreement, Memorandum of Understanding (MOU) where applicable. Under these guidelines and subsequent addendums, responsibility for the activation of this ACS Plan will fall to the SMOC.

2.2 Operational Phases

In order to rapidly and effectively activate an ACS, operations have been broken out into four specific time phases, outlined below. For a specific breakout of tasks delineated with phase, consult the Execution Checklist.

Activation: The Activation Phase begins when a threat or hazard is identified that could lead to the standing up of an ACS. This phase focuses on the considerations for activating an ACS and necessary decisions and coordination elements for standing up an ACS. The actual movement of resources to stand up the ACS are covered in the next phase of operations. The Activation Phase includes the sub-phases of Initial Actions and Notification. Consult the Activation Protocols section within Triggers and Activation for more information.

Mobilization: The Mobilization Phase initiates the movement of resources, including staff, to the selected ACS. This phase begins the notification of people, systems, and resources to establish Incident Command and management structures, make coordinated decisions about priorities and resources, and to disseminate clear messaging to the public. For purposes of a hospital-specific ACS, mobilization of a site could take anywhere from 18-36 hours.

Site Operations: This phase includes all actions involved with actually running an ACS, including attending to patients, requesting additional resources, and maintaining situational awareness. Processes in this phase ensure that coordination is occurring where necessary.

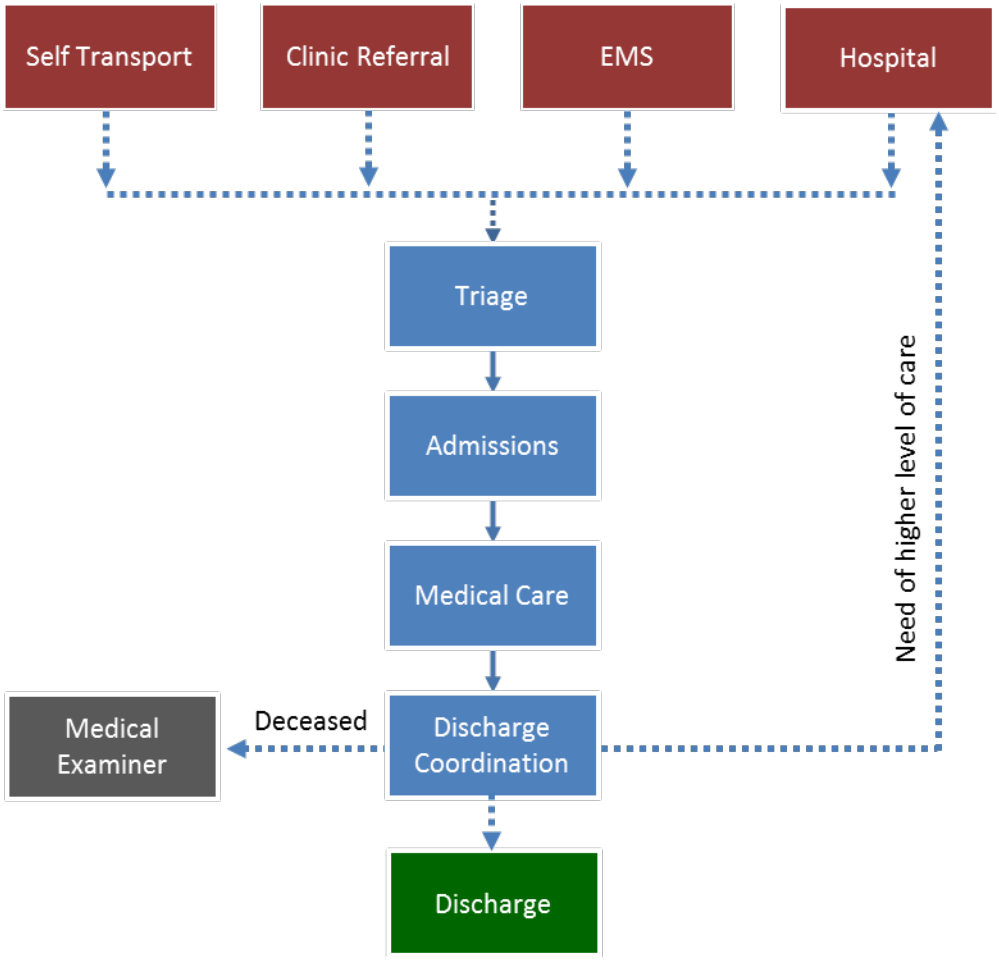
Demobilization: The Demobilization Phase initiates the deactivation of an ACS. This includes returning resources to their original state, documenting any necessary expenditures, and ramping down ACS operations.

2.3 Patient Flow

Patient Arrival

Patients can arrive to an ACS by:

- Transfer from a hospital.
- Referral from clinic.
- Ambulance.
- Self-transport.



Triage

- Evaluate (screen) all patients.
- Each patient must receive identification and triage tag. As appropriate, initial evaluations will be provided by triage unit director and discussed with the medical director. For field triage guidance, refer to guidelines for field triage of injured patients (available in resources). For triage procedures and protocols, refer to local procedures.
- Refill medication orders, as appropriate.
- Follow inclusion and exclusion criteria.

Admissions

- Collect required information on all patients and provide data to ACS administration. Any critical information that is not available from a qualified provider should be collected at the facility or prior to transfer.
- Maintain patient tracking.
- Provide family members with information about ACS care and procedures for discharge.
- The procedure will depend on the location from which the patient arrives. Hospitals, clinics, and emergency medical services (EMS) will need regular updates on the types of patients the facility can receive (e.g., severity of illness). Initial admission will allow space for more critical patients in the hospital. These admissions should meet the criteria for admissions to ACS, specific to the incident/event.

- Patients who do not meet ACS admittance criteria will receive transport to a hospital or mass care shelter, or be released as appropriate based on evaluation.

Medical Care

- Collect information on all patients and provide aggregated data to Hospital Command Centers and SMOC.
- Evaluate and provide sufficient care based on resources and scope of care.
- Identify patient condition deteriorates that warrant admission to hospital.
- Communicate about potential transfer.
- Provide additional services as applicable (e.g., patient and family support)
- If patient presents with a medical condition for which the facility cannot provide services, and failure to provide the service may result in severe illness or patient's death, the director will consult with the SMOC/EMS agencies for transfer.

Discharge Coordination

- The facility will discharge patients when the patient or assistive care is available and the patient no longer meets ACS criteria or transfer criteria.

When a patient is awaiting discharge to home, the facility will make contact with the family and attempt to assess the ability of caregivers to resume care of patient. Discharge will be delayed if persons are too weak to provide personal care and no caregiver is available. When discharged, written instructions on additional care and signs of secondary complication or reasons to bring the patient back to a medical facility will be provided to patient or caregiver. Depending on the exposure and illness, home care instructions may include recommendations for the use of appropriate barrier precautions, hand washing, waste management, and cleaning and disinfecting the environment and personal care items.

2.4 Estimating the Potential Impact of an Event

The following charts, based on data from the U.S. Department of Health and Human Services (HHS), estimate potential population effects following an influenza pandemic.

Figure 2: Potential Impact for a 30% Moderate Attack Rate Influenza Pandemic

Moderate attack rate of 30%

HHS estimates of Percent of Population Affected by next Pandemic	STARRS Region Total	Franklin County, MO	Jefferson County, MO	Lincoln County, MO	Madison County, IL	Monroe County, IL
2010 Population	**675,030**	**101,492**	**218,733**	**52,566**	**269,282**	**32,957**
Up to 30% of pop. will become ill with flu	202,509	30,448	65,620	15,770	80,785	9,888
Up to 15% of pop. will require out-patient visits	101,255	15,224	32,810	7,885	40,393	4,944
Up to 0.3% of pop. will require hospitalization	2,026	305	657	158	808	99
Up to 0.1% of pop. will die of flu related causes	676	102	219	53	270	33

HHS estimates of Percent of Population Affected by next Pandemic	Perry County, MO	Pike County, MO	St. Charles County, MO	St. Clair County, IL	St. Francois County, MO	St. Genevieve County, MO
2010 Population	**18,971**	**18,516**	**360,485**	**270,056**	**65,359**	**18,145**
Up to 30% of pop. will become ill with flu	5,692	5,555	108,146	81,017	19,608	5,444
Up to 15% of pop. will require out-patient visits	2,846	2,778	54,073	40,509	9,804	2,722
Up to 0.3% of pop. will require hospitalization	57	56	1,082	811	197	55
Up to 0.1% of pop. will die of flu related causes	19	19	361	271	66	19

HHS estimates of Percent of Population Affected by next Pandemic	St. Louis City, MO	St. Louis County, MO	Warren County, MO	Washington County, MO
2010 Population	**319,294**	**998,954**	**32,513**	**25,195**
Up to 30% of pop. will become ill with flu	95,789	299,687	9,754	7,559
Up to 15% of pop. will require out-patient visits	47,895	149,844	4,877	3,780
Up to 0.3% of pop. will require hospitalization	958	2,997	98	76
Up to 0.1% of pop. will die of flu related causes	320	999	33	26

Figure 3: Potential Impact for a 50% Severe Attack Rate Influenza Pandemic

Severe attack rate of 50%

HHS estimates of Percent of Population Affected by next Pandemic	STARRS Region Total	Franklin County, MO	Jefferson County, MO	Lincoln County, MO	Madison County, IL	Monroe County, IL
2010 Population	**675,030**	**101,492**	**218,733**	**52,566**	**269,282**	**32,957**
Up to 50% of pop. will become ill with flu	337,515	30,448	65,620	15,770	80,785	9,888
Up to 25% of pop. will require out-patient visits	168,758	15,224	32,810	7,885	40,393	4,944
Up to 3% of pop. will require hospitalization	20,251	305	657	158	808	99
Up to 2.5% of pop. will die of flu related causes	16,876	102	219	53	270	33

HHS estimates of Percent of Population Affected by next Pandemic	Perry County, MO	Pike County, MO	St. Charles County, MO	St. Clair County, IL	St. Francois County, MO	St. Genevieve County, MO
2010 Population	**18,971**	**18,516**	**360,485**	**270,056**	**65,359**	**18,145**
Up to 50% of pop. will become ill with flu	5,692	5,555	108,146	81,017	19,608	5,444
Up to 25% of pop. will require out-patient visits	2,846	2,778	54,073	40,509	9,804	2,722
Up to 3% of pop. will require hospitalization	57	56	1,082	811	197	55
Up to 2.5% of pop. will die of flu related causes	19	19	361	271	66	19

HHS estimates of Percent of Population Affected by next Pandemic	St. Louis City, MO	St. Louis County, MO	Warren County, MO	Washington County, MO
2010 Population	**319,294**	**998,954**	**32,513**	**25,195**
Up to 50% of pop. will become ill with flu	95,789	299,687	9,754	7,559
Up to 25% of pop. will require out-patient visits	47,895	149,844	4,877	3,780
Up to 3% of pop. will require hospitalization	958	2,997	98	76
Up to 2.5% of pop. will die of flu related causes	320	999	33	26

2.5 Triggers and Activation

ACS Triggers and Coordination Considerations

When traditional surge capacity exceeds or is expected to exceed and there is a need for an extended response, the SMOC, in coordination with local emergency management, may determine that an alternate care site is necessary. While there are no defined deployment time goals implied herein, the ACS should be an agile, rapid response force dedicated to the public health and safety of citizens.

Activation of an ACS should be considered during initial meetings of the SMOC duty officers and cooperating public health and emergency management agencies (EMAs). Before activating the ACS, those involved should consider the actual verses perceived need within the timeframe and alternatives through medical surge plans (e.g., canceling elective surgeries, discharging stable patients, relocating patients to other facilities, etc.). Medical care using acceptable treatment spaces in licensed medical facilities is always better than providing care in an alternate care facility.

Communication and coordination between the ACS, healthcare hospital command centers, and local emergency operations centers (EOCs) will be through the SMOC. The SMOC will coordinate with the most appropriate hospital for standing up an ACS. The SMOC will coordinate and request information from healthcare entities, shelters, and other response entities to ensure the activation and demobilization of the ACS is as efficient as possible for the overall regional healthcare infrastructure. For example, if a shelter is considering sending a large number of residents requiring acute medical intervention to a hospital or EMS has a large number of transport volume from a specific incident, the SMOC may consider using one or more ACSs, a single hospital destination for patients, or a rotation of patients to multiple hospitals. The EOC and SMOC should work together to identify the best care location for an ACS. In a situation where immediate medical care is needed, the shelter should call 911 and EMS will follow their standard protocols.

It is essential that all activated ACSs work in conjunction with the SMOC prior to and throughout the ACS operation. Prior to an ACS being established, the SMOC may coordinate with healthcare providers throughout the region to disperse patients throughout the medical community, providing healthcare in the most appropriate setting whenever possible.

ACS Activation Criteria

The intent of the following activation criteria is to provide general, guiding principles that are not restrictive to specific incidents and events. An ACS may be warranted if the SMOC predicts the following criteria may be met:

- Medical surge capacity in Missouri Region C hospitals has been, or has the potential to be, overwhelmed and/or exhausted during a health emergency and resources are available through internal or external sources to staff an ACS.
- Numbers of persons requiring care exceeds surge capacity of hospitals and other medical facilities.

Should specific hospitals require ACS support to augment a shortage of specialty services, the SMOC will convene to determine the appropriate course of action.

Immediate Notification

When the activation of an ACS is first being considered, the SMOC should notify key personnel, such as the ACS management staff and facility contacts, and implement initial activation activities, including notification of the hospitals and EMA. Initial activities should focus on appointing key personnel, according to the staffing plan, and enacting response efforts.

Determination of ownership and leadership of the ACS is an immediate action that will likely be dependent on the type of care administered at the site. Issues pertaining to lead should be decided at the EMA/SMOC level and must involve the identification of the individual(s) with the authority to decide whether, when, and where an ACS should be opened and the authority to operate the site. The most effective way to make such decisions is to use and build on the organizational and governance structure that is already functioning at the individual hospital.

Activation Protocols

<u>Phase 1 – Activation; Sub-Phase 1 – Initial Actions</u>
0-2 hours

Further initial actions include, but are not limited to:

- Activate the *Hospital Mutual Aid Agreement, Memorandum of Understanding.*
- Conduct outreach and engagement of the SMOC.
- Assure that the local government has requested a local emergency declaration, as outlined in local procedures.
- Assign an ACS administrator to initiate the hospital's plan and assume responsibility for operations. If multiple ACSs are required, an ACS administrator should be assigned to each site.
- Ensure key positions of the ACS command structure are staffed and supported to meet operational needs.
- Distribute job action sheets to assist in determining initial activation steps for each position.

Activities will simultaneously focus on the site of the ACS. Activities may include:

- Identify which physical locations will be activated for ACS operations and performing a site reassessment. The designated site representative should accompany the ACS administrator to complete the assessment of the area. This assessment should document the condition of the facility and any facility equipment that will be utilized.
- Secure the facility, controlling traffic flow of individuals and vehicles and identifying one primary and secondary entry point. Assign initial security personnel to the site. Personnel must secure areas not to be used during operation and secure exterior doors not being utilized as entrances from outdoor entry.
- Coordinate with EMS providers to triage and transport patients to the appropriate facility or locations within the facility.
- Establish a secure location to receive supplies, pharmaceuticals, and equipment.

Phase 1 – Activation; Sub-Phase 1 – Notification
0-4 hours

Secondary efforts will focus on organizing the ACS setup after the site has been assessed and properly secured. At this point key staff should prepare to receive supplies and make preparations for patient arrival. Activities at this stage include:

- Alert points of contact with stakeholder agencies of staffing needs; schedule and mobilize staff for security, environmental, administrative, clinical, pharmaceutical, and personal assistance services.
- Coordinate with team members, staff and volunteers to establish a reasonable time frame for the ACS to become operational.
- Alert and notify administrative and setup staff to prepare the site.
- Perform a complete cleaning of the site.
- Requesting, obtain, deliver and distribute resources according to ACS layout.
- Activate all applicable contracts for services, staff, supplies, pharmaceuticals and equipment.
- Take inventory of all delivered resources.
- Post all necessary interior and exterior signs.
- Set up the site according to the planned site layout.

Phase 3 – Mobilization
4-12 hours

During this phase, ACS staff should be reminded to make appropriate personal preparations based upon the anticipated number of hours away from home. This may be caused by an inability to leave the ACS because of the incident or other complicating factors. These preparations include:

- Making arrangements for family members and pets.
- Locating personal supplies.

- Providing current contact information to key points of contact.

As ACS staff arrive at the facility and begin their assigned role, they should be:

- Reviewing the plan and becoming familiar with roles and responsibilities.
- Ensuring a process for accommodating the arrival of the ACS staff and volunteers, establishing the registration and intake desk, issuing identification, credentialing, and establishing shift schedules.
- Performing a final health and safety facility walkthrough to ensure compliance and a safe ACS environment.
- Distributing supplies throughout the ACS, ensuring the availability of a secure area, and identifying procedures and policies for proper storage.
- Preparing feeding services, water, and storage of supplies.
- Addressing privacy issues, including communicating policies to ACS staff on maintaining privacy of patients and establishing visitation procedures (including those for the media and elected officials).

Phase 4 – Activation
8-24 hours

Finally, after the ACS has been activated and throughout the operation of the ACS, staff should:

- Communicate the discharge plan for patients, including the policies for self-discharge, transfer to higher care, record keeping, and other key administrative tasks needed for reimbursement, tracking, and future planning.
- Initiate planning for demobilization, returning resources to the place of origin, managing patient and staffing records, and transferring site management back to the facility owner.

2.6 Operational Considerations

Operational elements essential to the execution of the ACS are detailed in the operational tools attached to this plan. These tools represent the following operational elements:

- ACS operations and coordination
- Site considerations
- Staffing
- Supplies, pharmaceuticals, and equipment
- Intake and triage
- Medical operations
- Administration
- Demobilization

2.7 Coordination with External Agencies

- St. Louis Medical Operations Center
  The SMOC will serve as a center for collecting and disseminating current information about healthcare resources and needs (including equipment, bed capacity, personnel, supplies, etc.), developing priority allocations, tracking disbursement of resources, and other relevant healthcare response matters. The SMOC is the vital linkage required for the success of an ACS operation, involving many different community resources—from police, fire, medical providers, engineers, transportation, and housing experts.

The SMOC should be engaged through the hospital command center. The hospital command center should request support from the SMOC according to the procedures outlined in the SMOC Standard Operating Guidelines (SOG). During a regional operation, the SMOC may assume a much larger role in the management and operation of the ACS. If a regional approach is undertaken, it will likely involve resources from a variety of organizations and agencies. The SMOC, working with the local government, will determine the allocation of those resources and the best method for establishing and sustaining the regional ACS.

- Public Health

  Public health departments have a role in all aspects of an ACS, including:
  - Coordination of planning, response, and recovery.
  - Coordination of ACS activation.
  - Coordination of deployment of staffing and other resources to support ACS operations.
  - Provision of basic medical care.

  One of the biggest challenges to ACS operations is the ability of public health and medical entities to access available resources. Each public health agency should understand the processes used to request health and medical resources and support local hospitals in this task.

  In most cases the hospitals have a working relationship with the local public health department and would engage their representatives in the SMOC for assistance with a regional ACS. Public health should be engaged in conversations pertaining to resource needs through regular conference calls and through identifying a public health liaison to sit in the SMOC and, potentially, at the regional ACS. This liaison would work with the ACS Administrator to determine the likely needs present within the ACS and any modifications to scope of care.

- Emergency Medical Service Providers

  EMS providers play an essential role by triaging, treating and transporting patients to an appropriate ACS. Once a regional ACS is established, triage protocols should be communicated to the providers to assist them in effectively triaging appropriate individuals to the ACS. EMS providers may also be able to provide paramedics and emergency medical technicians to assist in staffing the ACS.

  Working through the SMOC, the ACS should include a medical plan that includes a standby ambulance at or near the ACS. If the ACS is located in very close proximity to another hospital, then this staging may not be necessary. The intent is to provide emergency transportation as needed for clients with decompensating medical conditions.

  EMS should be given instruction as to the means of transporting patients directly to the ACS, if direct transfer is allowed under the operational configuration. If this does occur, appropriate messaging should be undertaken with EMS authorities to ensure responding units are aware of any modification to normal operation.

- Emergency Management

  Emergency management (Emergency Support Function [ESF] #5) agencies typically support the local lead agency for mass care (ESF #6), including general population sheltering. In the case of a regional ACS, emergency management is assumed to have a large role in identifying the facility, obtaining resources to support the mission, and ensuring that the appropriate protection, proclamations, and declarations are in place.

  Activities often occur through the jurisdiction's emergency operations center in conjunction with the SMOC. Generally, the ACS will engage local emergency management through the SMOC, with the SMOC being engaged through the hospital command center. This creates an established chain of command between the ACS administrator, the hospital

command staff, and the local jurisdiction. In some cases, the local hospital may coordinate directly with the local emergency manager through use of WebEOC, phone, email, or other relevant communications system.

In addition to providing situational awareness, the SMOC may convey the overall status of the ACS operation and the ability to continue operations given any impacts on the infrastructure of the facility. It is likely that as the incident advances, if cascading events occur, emergency management would have an increased role in any long term sustainment of the ACS operation.

- Social Services

  Social services agencies are often designated as the local mass care lead agency. Social services agencies may coordinate with emergency management and non-governmental organizations to plan, staff, equip, and operate general population shelters. However, jurisdictions vary greatly regarding the ability of social services agencies to support sheltering activities.

  Social services agencies will be contacted according to the established protocol for outreach to the local emergency management and public health offices. The exception for social services would be the existing engagement in the EOC because of their ESF-6 mission; this may cause coordination to be driven at the jurisdiction level in a larger scale, regional ACS operation.

- Mental Health

  Mental health providers not only play a significant role in general population shelters, but also in the treatment and housing for clients within the behavioral health system at the ACS. They may be involved in assessing and activating the response to behavioral health issues at an ACS. There may also be a role for mental health support in treating the staff who work within an ACS, under austere conditions, in a situation that is not familiar to them.

  In some jurisdictions, mental health may formulate plans to ensure medical health professionals are available to provide behavioral health services at the ACS. These services should include support for both clients with pre-existing conditions and clients needing new support. Typically, mental health services are engaged through established relationships with the local public health department or through contract with private services or non-governmental organizations.

- State Level Government Agencies

  As the complexity of ACS operations increases, the involvement of the state may be requested. The state EMA and Missouri Hospital Association both may be in a position to provide resources and expertise to augment the ongoing operations.

  In most instances, the state's involvement will be facilitated through the local emergency management office. It is likely to require a local declaration of emergency for significant state-level assistance to become available. With the state's involvement, the local hospital may be able to access greater levels of resources from surrounding jurisdictions and states. In a declared emergency, the resources of other states may become available through the Emergency Management Assistance Compact (EMAC).

  The state will have a key role in a larger scale incident. In a presidentially declared disaster, the state will work with the local jurisdiction and support requests for assistance. This assistance might include the deployment of staff, commodities, or other assets that would greatly assist the local hospital in the execution of the ACS mission. This activity would be facilitated through requests coming from the individual hospital's command center, through the SMOC, and then to local emergency management.

One resource that may greatly assist ACS operations is the 501(c) 3 Missouri – 1 DMAT, Inc. (MO-1 DMAT, Inc.). MO-1 DMAT, Inc. maintains several hundred members representing medical and other professional disciplines coupled with an extensive logistical support system and equipment fleet, housed in three strategically located warehouses throughout the state.

- Federal Agencies
  Federal assistance may be requested, consistent with existing plans and procedures regarding requests for assistance. Local jurisdictions should utilize the standardized process. FMS, DMAT, the National Disaster Medical System, and Veterans Health Administration may be viable federal resources to assist with ACS operations.

- Volunteers
  - Volunteer Organizations Active in Disaster
    Voluntary Organizations Active in Disaster (VOAD) is a nonprofit, nonpartisan membership organization that serves as the forum where organizations share knowledge and resources throughout the disaster cycle—preparation, response, recovery, and mitigation—to help communities prepare for and recover from disasters. The national VOAD coalition includes over 50 of the country's most reputable national organizations (faith-based, community-based, and other non-governmental organizations) and 55 state/territory VOADs, which represent local/regional VOADs and hundreds of other member organizations throughout the country. For the purposes of a large ACS operation, VOAD may be sought to coordinate support from volunteer and other community-based organizations.

    VOAD and other volunteer support will be coordinated through the SMOC in conjunction with local emergency management and/or public health. In advance of the incident, each hospital should determine a role for volunteers in the establishment and operation of their ACS. It is assumed that volunteers could have a meaningful role in both clinical and non-clinical functions critical to ACS operations.

  - American Red Cross
    In most local jurisdictions, the American Red Cross is designated as the primary community-based organization responsible for shelter, feeding, and other disaster relief services, such as nursing, mental health, and client casework. The American Red Cross may have the responsibility to establish shelters for the general population during a disaster. It is also responsible for compiling and reporting information on shelter-seeking populations. The information includes the number of displaced individuals, the number of individuals residing within the shelter, and any unmet needs. The American Red Cross recently revised their concept of operations for nursing. The concept allows registered nurses and licensed vocational nurses (RN and LVN), and those they supervise, to practice nursing at the community level scope of practice.

  - Medical Reserve Corps
    The Medical Reserve Corps are units of volunteers registered through the Federal Office of the Surgeon General. Each Medical Reserve Corps Unit comprises local volunteer medical and public health professionals such as physicians, nurses, pharmacists, dentists, veterinarians, and epidemiologists, as well as auxiliary support staff. Medical Reserve Corps members may provide staffing and support for ACS.

  - Community Emergency Response Teams
    Community Emergency Response Teams, organized by local law enforcement, fire, or emergency management agencies, are provided training in basic disaster response skills such as fire safety, light search and rescue, team organization, and disaster medical operations. The trained response teams also educate volunteers within the community to prepare for hazards that may impact their area.

- Spontaneous Unaffiliated Volunteers
  Spontaneous unaffiliated volunteers often arrive at shelters ready to help. Clients may arrive with family members who could also be incorporated into shelter operations as volunteers. These volunteers may be skilled and capable of meeting significant needs within an ACS. In order to leverage this potentially valuable workforce, planning efforts should anticipate and manage them in supportive (e.g., personal assistance services) and administrative capacities (e.g. personnel timekeeping).

- Emergency System for Advance Registration of Volunteer Health Professionals
  Volunteers may provide support to a variety of emergency response activities within the ACS. Close coordination should occur with sources of anticipated volunteers to ensure capability to meet projected needs. The St. Louis Region will rely on Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) system for credentialing of clinical staff, including: Missouri Show-Me Response (https://www.showmeresponse.org/) and Illinois HELPS (https://www.illinoishelps.net/).

  Each hospital will determine the extent of use of ESAR-VHP as well as how this system will be integrated into the staffing of an ACS. ESAR-VHP may provide an expedited response to credential key staff and volunteers following a disaster.

- Other Participants and Programs
  - Healthcare, Skilled Nursing, and Long-Term Care
    Each healthcare facility must have a detailed written plan and procedures to address potential emergencies and disasters. These plans include the identification of "like-facilities" to accommodate residents if evacuation is required. If evacuated, the healthcare facility may be a source of skilled staff, pharmaceuticals, and portable equipment needed to sustain care at the ACS.

    In planning for staffing prior to an event, each hospital should determine if relationships exist with other healthcare, skilled nursing, and long-term care facilities that would assist with surge staffing or resource gaps. Medical schools, nursing schools, or other specialty programs might be considered for assistance in carrying out the ACS mission.

    For resources outside the immediate vicinity or network of the individual hospital, the SMOC should be seen as the central point for regional coordination and resource sharing. The SMOC should serve as the central body for resource allocation decisions if the need exceeds the availability of total resources.

  - Private Sector
    The private sector includes private health care facilities, pharmacies, contractors, facility owners, and other stakeholders. The private sector is often the primary provider of critical services to the public and possesses knowledge and resources to supplement and enhance public efforts.

    One specific area of interest are private pharmacies and clinics (e.g., Walgreens), that operate in or around the regional hospitals. It is recommended that hospitals pursue agreements with these organizations as a means of building the just-in-time capacity of the organization to meet increased needs and to lessen any impact the incident may have on an individual supply chain.

    It is generally understood that Memoranda of Understanding (MOUs) and Memoranda of Agreement (MOAs) can be developed with certain private sector organizations so an increased number of certain items are always retained and available for the region. This vendor-managed inventory concept is a viable option for items that must be available in quantity, but are unrealistic to be stored in a cache for prolonged periods.

The private sector will likely be engaged by the hospital command center at the local hospital level. However, in larger events, it is possible that this coordination occurs through the SMOC, with emergency management, or in coordination with public health.

2.8 Demobilization

Demobilization is the process by which an ACS is closed and ceases operation. Demobilization includes scaling back or shutting down the ACS operations and transitioning patients back to the hospital or discharging them from the medical system.

Trigger for Demobilization

This decision will be strongly influenced by the needs of the incident and resources available. In the case of an ACS, this decision will likely be led by the SMOC in coordination with hospital command centers and influenced by many stakeholders working through ESF-8 (Public Health and Medical), EMAs, and other authorities outside the hospital. However, it is assumed that the SMOC will have ultimate authority for the decision to deactivate. If a decision is made to demobilize an ACS, coordination with various response partners will be required to return patients to pre-incident conditions and properly restore the ACS site.

The decision on when to close the ACS should incorporate the following factors:

- Impact of the incident on the community.
- Urgency of need to return the site to normal conditions.
- Time of day.
- Political impact.
- Medical impact.
- Availability of transportation resources.

Patients should be transitioned to the most appropriate facility, according to medical status. It is important to allow a reasonable amount of time and assistance to find suitable locations for the sustainment of care.

Procedures for Closure

- Coordinate with the SMOC for a demobilization timeline.
- Transfer/discharge all patients.
- Arrange for the transfer of medical records and/or establish storage procedures and location to ensure future availability of records and documentation.
- Terminate ongoing contracts or arrangements.
- Identify resources and equipment that are no longer needed.
- Coordinate pickup and transportation of supplies.
- Ensure that all areas of the site are restored to pre-ACS conditions.
- Prepare an after-action report and conduct an assessment of efforts, resources, actions, leadership, coordination, and communication in order to improve future operations.

Financial Considerations and Reporting

Accounting for the costs associated with the operation of an ACS may occur away from the site and should be coordinated with the local jurisdiction and according to any activated MOUs/MOAs. The cost accounting system utilized must separate all disaster-related costs from other activities and capture the information necessary to justify disaster-related costs. The accounting system should identify and document separate costs in each of the following categories:

Labor Costs

- Force account labor hours by individual, rates of pay, duty assignment, and work locations.
    - The Federal Emergency Management Agency (FEMA) uses the term "force account" to refer to local government personnel and equipment.
- Temporary hires by individual, hours of work, and rates of pay.
- Breakdown of fringe benefits for regular employees and emergency hires, including both regular and overtime rates.

Equipment and Contract Costs

- Equipment used for eligible disaster recovery work, hours of use, applicable equipment rates charged (local rates or government cost code), location of work, and name of employee operator.
- Services contracted for and/or purchased for use on eligible work, location of work purchase orders, costs, and invoices to support the costs.
- Listing of equipment damaged and cost to repair or replace.

Other Supporting Records

- Labor policies in effect at the time of disaster.
- Insurance adjustments, settlements, and other documents and records related to project worksheets.
- Volunteer labor and equipment records to include, for each volunteer, a record of hours, location, description of work performed, and equivalent information for equipment and materials.
    - FEMA recommends that each volunteer's time in and time out be recorded as a means to capture the total hours worked per day.
- Photographs of work sites before and after, labeled with location and date.
- Mutual aid and assistance agreements in effect.
- All other documents or costs associated with the disaster.

Accounting records must be supported by source documentation such as cancelled checks, copies of paid bills, payroll sheets, time and attendance records, etc.

Charge capture is the process of collecting charges for services, supplies, and pharmaceuticals provided to patients during a healthcare encounter. The suggested minimum data list for charge capture consists of the following:

- Patient name.
- Medical record number.
- Date of service.
- Medication units/dose/quantity.
- Department in which services were provided.
- Service description.

The tracking and monitoring of potentially eligible expenses is critical so that when and if funding becomes available, the applicant is in a position to maximize reimbursement and other forms of assistance as part of the recovery process. Jurisdictions also need to consider if they will be seeking reimbursement of costs through long-term care facilities and if Medicare/Medicaid will be sought for reimbursement for services provided.

- Federal funds may not be available until a disaster is federally declared by the president. Although FEMA has traditionally focused mainly on property losses due to a disaster, some funds have been appropriated for payment of medical services when temporary but substantial population displacement has occurred.
- Procedures for reimbursement are managed by the emergency management agency of the state in which the participating hospital is located.
- Participating hospitals may enter into other mutual aid agreements with governmental or non-governmental agencies, including other hospitals and health systems that provide reimbursement during medical disasters. Participating hospitals may be eligible for reimbursement under laws other than the Stafford Act that may be in effect at the time of a medical disaster.
- When a participating hospital is reimbursed for part or all of its expenses under another mutual aid agreement or law, it is not entitled to duplicate reimbursement from another participating hospital. If a participating hospital receives reimbursement under the Stafford Act and has not reimbursed a transferring hospital, the participating hospital will reimburse the transferring hospital within sixty (60) days of receiving the Stafford Act funds.

Section 3
Concept of Logistical Operations

3.1 Resource Management

The SMOC will make decisions on whether or not to set up an ACS and the level of care it is to provide if established. As such, each ACS will follow the activating hospital's incident command processes. Each role within the ACS should have pre-established or just-in-time job action criteria and organizational charts. Each healthcare facility is required to have an incident command structure and resource management procedures, which should include ACS integration.

The hospital incident command structure will be used to direct movement of patients along with staff, medical equipment, and supplies for their ACS. The SMOC will be responsible for the resource management at the ACS and will work with the SMOC to provide timely situational awareness, as appropriate. Through the standard operating guidelines of the SMOC, the hospital's ACS will be made aware of available resources, including transportation, fixed facility ED capacity, and inpatient bed availability throughout the region.

While the Hospital Template is primarily focused on Operational Approach 2, it should be noted that there are two other Operational Approaches that may be considered in meeting the medical needs on the impacted population. Each Operational Approach will have its own unique response requirements and resource needs. The Operational Approaches (outlined in detail in the Summary Document) are:

- Operational Approach 1 - General Population Shelter Support Teams
- Operational Approach 2 - Hospital-Based Alternate Care Site
- Operational Approach 3 – Regional Alternate Care Site

Where feasible, hospitals should coordinate with private sector partners to supplement or augment ACS resource needs. Establishing MOUs/MOAs in advance of a disaster ensures that these mechanisms for resource sharing are viable when needed. Partnering with private sector entities provides an additional layer of resources that could sustain an ACS operation.

3.2 Regional Resource Coordination

The entire operations of the ACS will be conducted in alignment with the National Incident Management Systems (NIMS) standards using an ICS structure. All operations should be documented on appropriate ICS forms, either electronically or in written form. A 214 (unit log) should be completed by each unit for each operational period and provided to the SMOC. Various levels of command may be inserted, as incident scope affects the span of control and will be highly dependent upon the size and scope of the ACS.

The ACS will face unique challenges related to its deployment and operation. Specifically, given the large and complex scope of most foreseeable mission profiles, the ACS may require an extensive level of organizational support during the incident. Consistent with the ICS, each staff position should receive a Job Action Sheet (JAS), which is a simple checklist that describes the role, responsibility, and reporting structure of each position within the ICS structure. These job action sheets compose the larger Staffing Plan, outlined in the next section. These forms should be prepared in advance of the incident for rapid distribution to participating staff upon their arrival to the ACS.

Operationally, all medical supplies should be stored in a secure, climate-controlled area in close proximity to the patient treatment area. Consideration for this guideline should be made when selecting the physical make-up of the ACS.

The ACS is designed to rapidly surge healthcare capacity into an affected region. To align to that mission, this plan recommends that supply caches be configured based on interventions to be performed, rather than in bulk caches. This will limit the set up time required for the stocking of treatment areas in the ACS, thus shortening the deployment to open time as well as aid in demobilization and restocking.

ACS supplies may be broken out into categories of care, both to aid in par stocking levels (related to expected patient loads) and cache configuration. The recommended categories are as follows:

- General ACS supplies related to all patient care areas (sheets, personal hygiene, gowns, isolation, etc.)
- Emergency room (ER)
- Skilled nursing facility (SNF)
- Orthopedics
- Obstetrics (OB)
- Pediatrics
- Infection control (IC)
- Mental health

Of these categories, historically the SNF unit supplies have represented the highest demand for disposable supplies.

3.3 Patient Record Keeping

Personnel should establish a medical record for every individual treated at the ACS, containing information that includes, but is not limited to, patient demographics, assessment, medical history, medications, allergies, and all treatments and interventions conducted. All care providers (vocational, technical, and professional) should document patient activities within the medical record. The medical record should also include related admission, discharge, and transfer details. A medical record should accompany each patient throughout care at the ACS. Any patient transferred out of the ACS should be sent with a copy of the medical record and the original medical record should remain within the ACS. All records must be complete, legible, and thorough, and should exclude abbreviations whenever possible. Consult the Operational Tools and Support Template for a myriad of example patient forms.

3.4 Patient Tracking

It is imperative to track individuals from first medical contact to final release from a medical facility. Proper patient tracking will help promote accountability of patients for providers, enhance information sharing to patients' family members, and provide accurate incident casualty numbers and status to incident management staff. Accurate patient tracking is a critical function of the ACS, as relatives, media, and incident investigators will be trying to locate individuals. Patient tracking is the responsibility of all medical responders.

Patients are tracked throughout the ACS operation process and should be followed by case management whenever possible. All patients will be tracked consistent with the regional patient tracking guidelines and procedures, and include at a minimum the dates/times of reception, discharge, and transfer in or out of the ACS. Case management personnel will be an integral part of transitions from outpatient to inpatient status, discharge, and transfer to a fixed facility. Note that general population shelters do not have patients, but rather clients who are not typically tracked. Whoever leads the operations of an ACS is responsible for maintaining situational awareness of all patients within their care responsibility. This will be extremely important for reimbursement, patient safety, and continuity of care.

In instances where patients are transferred, operators should track all patients and coordinate follow-up services when needed. All traditional patient transfer procedures should be followed and communicated with EMS and hospitals. Before transfer is allowed, confirmation is required by receiving facility, with all transfers being accepted on the condition of available space and staffing. For more information, the patient tracking form can be found in the appendices within the Operational Toolkit. In addition, the use of sample medical forms within the appropriate appendices can ease the transfer of patient medical records.

Section 4
Staffing Plan

4.1 General Staffing Management Strategy

An emergency requiring the activation of an ACS will stress current routing staffing levels and require agencies to fully engage all their available staff. Planners should consider out of region staffing needs for an ACS activation. However, activation of an ACS will only be successful if necessary medical and ancillary personnel can be identified. The SMOC duty officer will determine which agency (or agencies) will initially staff the ACS.

All licensed temporary staff and volunteers will be required to provide proof of license and certifications. Verification of credentials will be in accordance with appropriate emergency credentialing policy. The records/planning section will maintain copies of all licensures, certifications, and proof of competency for disaster recovery records.

Providing effective care to children poses unique challenges, especially in a disaster situation. Children have special needs, both physically and psychologically. The region will make every effort to ensure children receive appropriate outpatient care in the ACS and that all moderate and continued care needs are provided at a fixed facility by expediting patient transfer as quickly as possible.

The ACS Staffing Plan encompasses both clinical roles and nonclinical staff. This includes site set-up, site administration, clinical operations, support functions, and command staff. It is important that ACS staff understand the incident may require them to fill various positions and take on new responsibilities over time.

Staff Planning

If activated, it is assumed that staff planning should project out a minimum of seven days of operation. In the initial stages of response, ACS hours are generally assigned as two 12-hour shifts per day. The benefit of a longer shift is that it provides consistency for ACS management and patients and is generally more efficient coordination because of comfort with operations. Staff should remain assigned to the same site for the duration of the operation or until their skills are no longer required. ACS management should also enforce a system for mandatory breaks to prevent overwork.

Staff should ensure that they arrive at the ACS for their shift in sufficient time to overlap with outgoing staff for the shift debrief or as dictated by the hospital. Upon arrival, staff should sign in and record their time worked on a timesheet in addition to using whatever system is currently operationalized by the host hospital. Detailed record keeping is essential to tracking associated costs for the potential reimbursement of expenses.

Staff-to-patient ratios are an important consideration for clinical operations. Where applicable, this ratio can be guided by union contract parameters. The staffing pattern should be adjusted based on the site layout, as well as the actual number and needs of individuals and availability of resources. Levels of care and specific operational care categories within the ACS influence the number and type of staff present; thus, continual assessment is required to ensure adequate support. It is important to note that although a baseline ACS layout encompasses a 25 bed subunit, this approach can be scaled up or down based on incident needs in accordance with the appropriate operational approach. To scale staffing needs up as the ACS capacity grows, multiply each staffing allocation by the number of 25 bed increases.

The table below outlines the suggested minimum staffing for an Alternate Care Site, to include additional surge staffing considerations for the following specialized areas:

- Emergency room (ER)
- Skilled nursing facility (SNF)
- Orthopedics (Ortho)
- Obstetrics (OB)
- Pediatrics (Pedi)
- Infection control (IC)
- Mental health (MH)

Table 3: Suggested Minimum Staffing Considerations per 12-hour Shift for a 25 bed subunit for ACS and ACS+Specialty Area

Assignment	Priority	ACS	+ER	+SNF	+Ortho	+OB	+Pedi	+IC	+MH
Physician	High	1	1	1	1	1	2	1	1
Physician extender (PA/NP)[1]	High	1	1	1	2	2	2	1	1
RNs or RNs/LPNs	High	3	5	3	5	5	5	5	5
Health technicians	High	2	2	2	1	1	1	2	2
Unit secretaries	Medium	1	1	1	1	1	1	1	1
Respiratory therapist	Medium	1	1	1	0	0	1	2	0
Case manager	Medium	1	1	1	1	1	1	1	2
Social worker	Medium	1	1	1	0	0	0	0	2
Housekeepers	Medium	1	1	1	1	1	1	1	1
Lab personnel	Low	1	1	1	0	1	1	1	1
Medical assistant/phlebotomy	Low	1	1	1	0	0	0	1	1
Food service	Low	1	1	2	0	0	1	1	1
Chaplain/pastoral	Low	1	1	1	0	1	1	1	1
Volunteers/care assistants	Medium	2	2	2	1	1	1	1	1
Engineering/maintenance	Medium	1	1	1	1	1	1	1	1
Biomed-to set up equipment	High	1	1	1	1	1	1	2	1
Security	Medium	1	1	1	1	1	1	1	1
Patient transporters	Medium	1	1	1	1	1	1	1	1
Total ACS staff / 12-hour shift:	-	22	24	23	17	19	22	24	24

[1] Physician's Assistant/Nurse Practitioner (PA/NP)

Coordination between ESF #6 and ESF #8

Continual coordination with emergency management, specifically Emergency Support Function #6 – Mass Care and ESF #8 – Health and Medical will enhance overall ACS operations. ESF #6 and #8 can, in some cases, provide emergency staffing support to supplement hospital ACSs and can also ensure coordination is happening across the region in a significant catastrophic incident.

In addition, it is recommended that hospitals establish an EMS field liaison to coordinate emergency response in the field with incoming client flow for a hospital ACS. Coordination between field operations and ACS operations ensures that capability and capacity of an ACS is managed in real-time and can inform decisions of whether or not to open up additional ACSs or reroute clients to different area hospitals.

Sources for Surge Staffing

A hospital's first option to address staffing demands is to depend on their existing staff (e.g., increasing the number of hours per work shift, calling back staff who have been on leave, etc.) and reassign non-essential roles (e.g. educators, public outreach, etc.). When hospitals have maximized the productivity of their existing staff the next option would be to call upon external sources for temporary staff, as they normally would when there is a staff shortage. Hospital human resources and medical staff departments should use existing processes for contacting these sources. Additional sources of temporary staff may include nurse agencies and locum tenens registries. Once these sources are exhausted, additional staffing resources will be requested through the SMOC structure under the mechanisms outlined in the *Hospital Mutual Aid Agreement, Memorandum of Understanding*.

Staff Training

Just-in-time training refers to rapid training courses designed to familiarize staff with processes and operations. This training must occur prior to staff engaging in operational activities, and should cover the operations and administration of the ACS as well as instructions on using equipment, medical supplies, and other materials. In addition, jurisdictions should consider their just-in-time training needs and develop the appropriate courses prior to the incident. On-site and/or just-in-time training courses may include:

- Site operations and procedures.
- Patient tracking and patient valuables tracking.
- Report procedures, check-in procedures, and credentialing.
- Personal protective equipment, medical evaluation and testing, infection control, and fit testing.
- Medical records keeping, storage, and chain of command.
- Communication procedures.
- Procedures for obtaining prescriptions.
- 911 protocols.
- Logistics.

Credentialing and Personnel Verification for Clinical Staff

The St. Louis Region will rely on ESAR-VHP system for credentialing of clinical staff, including: Missouri Show-Me Response (https://www.showmeresponse.org/) and Illinois Helps (https://www.illinoishelps.net/). Coordination with state and local administrators for appropriate credential validation and personnel deployment prior to arriving is highly recommended. It is recommended that this occur away from the ACS site at a location focused on the administrative processing of incident-related volunteers or with the host hospitals Human Resources department. At the ACS, the ACS administrator will verify that all licensed professionals arriving to work at the ACS have the required credentials according to local policy and procedures. On-site accreditation and credentialing is not recommended.

Medical Director

The host hospital should identify the medical director for the ACS. This role, which should be filled by a licensed physician, is essential to the medical direction and medical authority for clinical staff operations within the ACS. The medical director should be available for the duration of the ACS operation for medical consultation, which can occur virtually or in person. This individual should be prepared to serve in an advisory role for all clinical staff and it is recommended he/she be board certified in the ACS category deployed (e.g. ED, Ortho, OB, etc.). Guidance from the medical director may be sought whenever clinical staff needs physician consultation.

ACS Management

All management activities within an ACS should be facilitated through the staffing plan command structure outlined in the ACS organizational chart. Utilization of this structure will facilitate the integration of all ACS staff into a single incident action plan. This coordination of effort will result in optimum medical care.

Setup Staff

The number of staff required to set up the ACS is included the staffing projections above. Factors to consider in setting up an ACS include, but are not limited to: site conditions, ease of cleaning, accessibility, Americans with Disabilities (ADA) compliance, availability of storage, and ability to lock valuables and medications. Resources from non-clinical sources may be sought to assist with setting up the ACS. In some instances, jurisdictions may wish to pursue memorandum of understanding agreements and vendor agreements to support ACS activities. Setup staff should be given detailed instruction on how to appropriately establish the site. Layout schematics may help; a sample is available in this plan. Setup is generally overseen by the ACS administrator, who is ultimately responsible for ensuring that the site is prepared to receive patients.

Support Staff

An ACS will require the participation of numerous support staff. The services such staff may need to provide include, but are not limited to, administrative, food service, child care, laundry, traffic control, security, engineering, housekeeping, transportation, and facility maintenance.

4.2 ACS Staffing Communications Protocols

Within the regional ACS, a strong communication infrastructure must be present for adequate and timely notifications to outside agencies and personnel.

During active operational periods, the ACS will maintain communication with the agencies listed below. For more information, consult the Coordination with External Agencies section.

- SMOC
- ESF-8
- Local EMAs
- Supporting hospitals
- Supporting patient transportation agencies

Types of communication methods used within the ACS include:

- Telephones (land line).
- Cell phones.
- Email.
- Fax.

- Radios.
- Satellite phones.
- Pagers.
- Amateur radio.

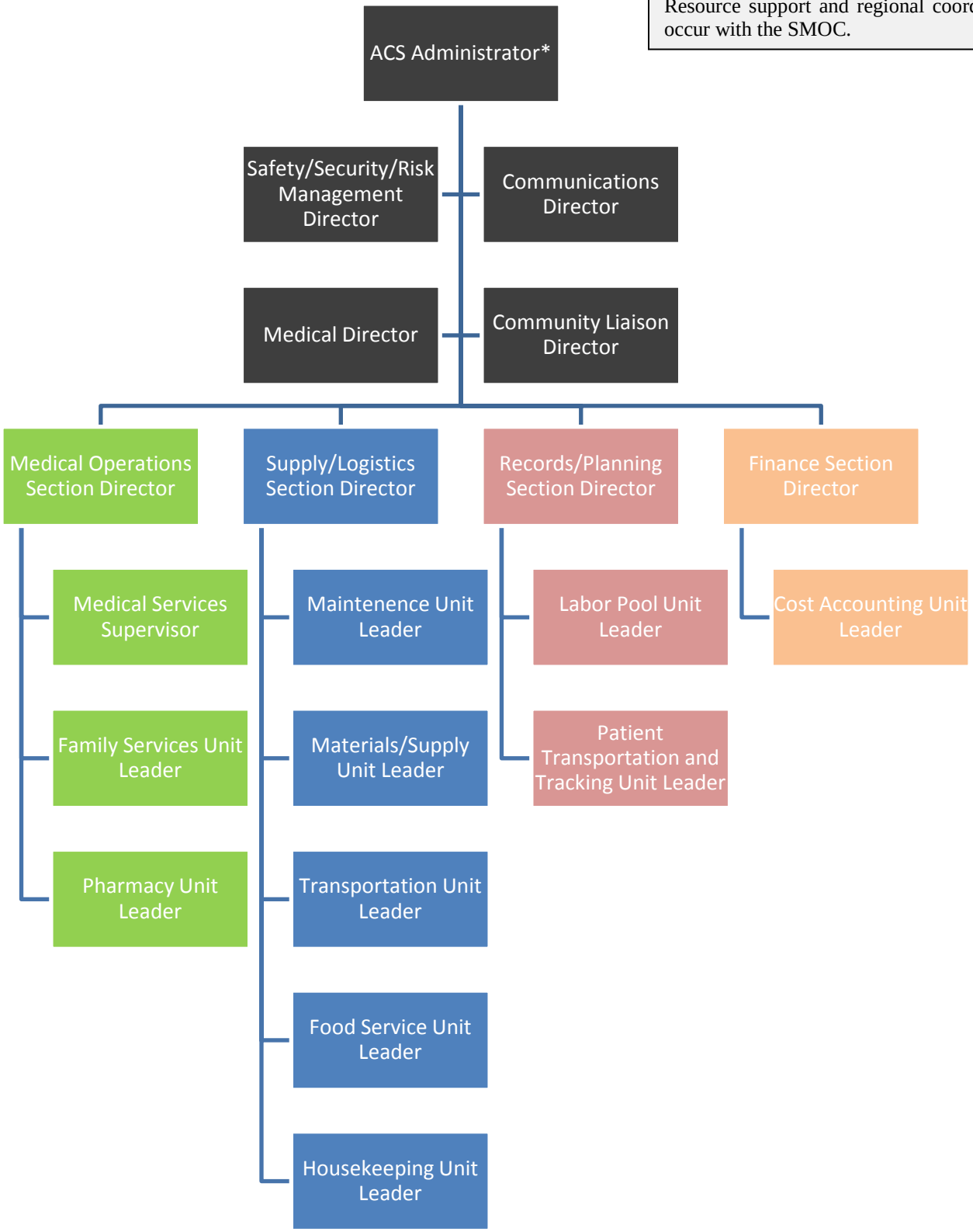
The communications director will issue two-way radios and/or cell phones and announce the radio channel to be used at the beginning of each shift. Radio messages will be short, concise, and begin with a sector identifier. The ICS 205 form can be utilized to document incident radio channels.

In the absence of radios or cell phones, face-to-face communication, runners, and written communication using the ICS 213 form shall be used. Voice amplification systems (bullhorn, public address system) should be appropriately used, if available.

4.3 ACS Organizational Structure

The organizational chart displayed below highlights the essential functions needed to carry out ACS operations. The chart is based on ICS principles, and therefore the number of actual positions that are individually staffed is scalable based on operational needs, span of control, and resources available. In many cases, the situation will not require individual staffing for each function listed in the functional chart. In keeping with ICS principles, any function not staffed is rolled up into the responsibility of the next higher level of management. Appendix 1 in the Operational Toolkit provides job action sheets for each of the positions within the ACS organizational structure (found on the next page).

* ACS Administrator will report to and coordinate with the established hospital command center. Resource support and regional coordination will occur with the SMOC.



Section 5
Plan Administration

5.1 Plan Review

The STARRS Hospital Preparedness Committee has the overall responsibility for the review and revision of this plan. Reviews will occur annually and revisions will occur as needed. The revision process will incorporate input from training and exercises, improved practices, and lessons learned.

5.2 Training and Exercise

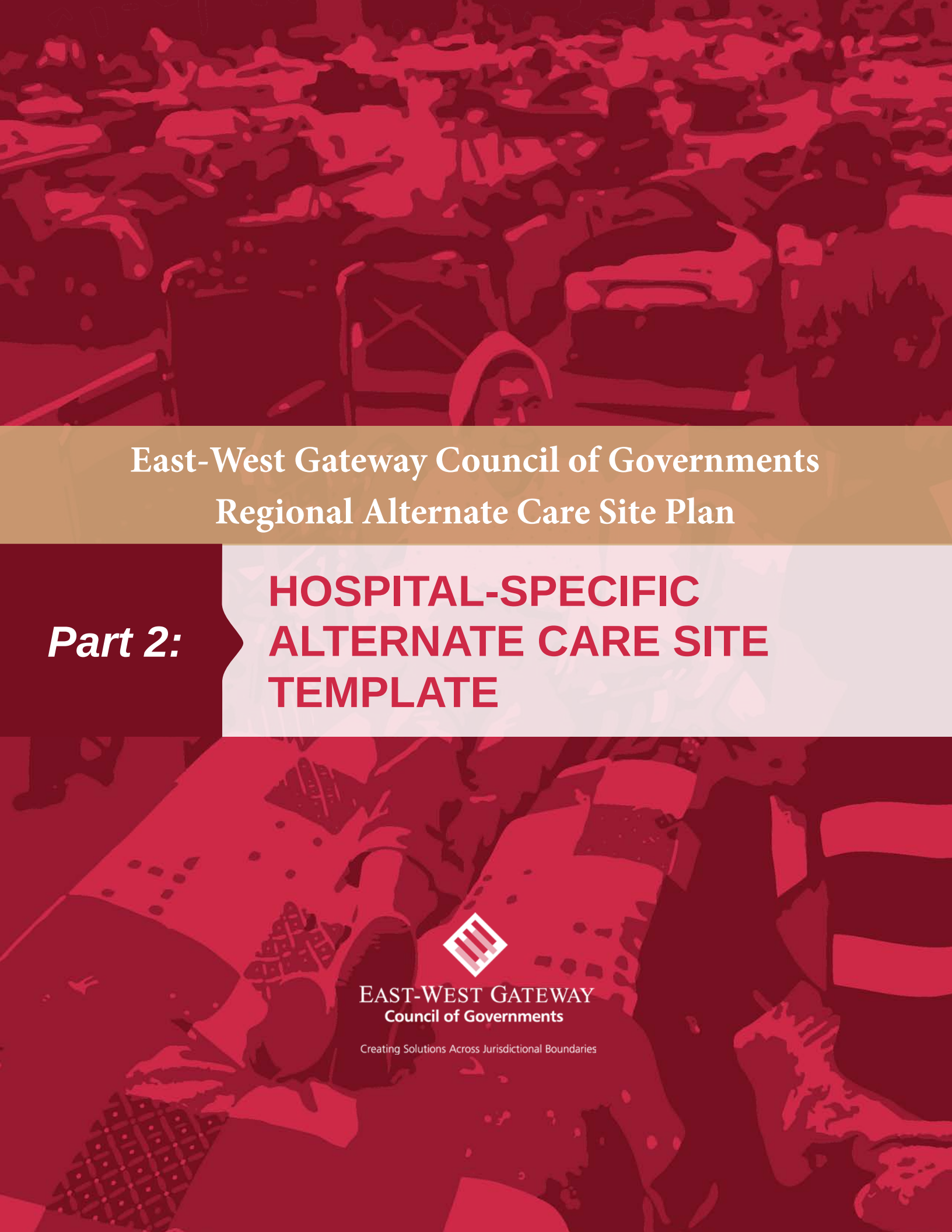
The purpose of training and exercise is to ensure that individuals know how to effectively perform their jobs, how to work with others in their functional group, and that functional groups know how to work together. Training and exercise for ACS concept of operations will be an ongoing activity. Ensure exercise design is consistent with Homeland Security Exercise and Evaluation Program (HSEEP) and that After-Action Reports/Improvement Plans (AAR/IP) are completed for each exercise conducted.

Suggested Training Objectives

- Understanding ACS concepts – mission, scope, situation, contents, responsibilities, and concepts of operation.
- Provide orientation and background information necessary for staff to effectively operate an ACS.
- Provide staff with the knowledge and skills needed to perform their ACS tasks effectively.
- Cross-train staff to work in other functional areas where they may be assigned.
- Understand the legal standards and measures for successfully activating and operating all ACS functions.
- Demonstrate competency in completing ACS-related tasks.

NIMS defines the preparedness cycle as “planning, training, equipping, exercising, evaluating, and taking action to correct and mitigate.” Exercises play an important role in this broad preparedness cycle and the implementation of corrective actions is the mechanism by which exercises can inform and improve other preparedness cycle components.

The STARRS Regional ACS Workshop is a key initial step for training stakeholder groups on plan content and holding scenario-based discussion surrounding ACS operations in a no-fault environment.



East-West Gateway Council of Governments
Regional Alternate Care Site Plan

Part 2: HOSPITAL-SPECIFIC ALTERNATE CARE SITE TEMPLATE

EAST-WEST GATEWAY
Council of Governments

Creating Solutions Across Jurisdictional Boundaries

Section 6
General ACS Operations and Foundational Information

6.1 Purpose of Hospital Template

The St. Louis Regional ACS Hospital Specific Template, hereafter "Hospital Template," outlines operational and logistical considerations for hospitals activating an Alternate Care Site (ACS) after a significant emergency or circumstances in which the healthcare delivery system has been substantially impacted, resulting in demand beyond capacity. As a result, the individual hospital or community at large concludes that it is necessary to identify and activate locations not currently providing healthcare services to be converted in order to provide needed care.

This template outlines specific tactics for hospitals to operationally manage an ACS response, to include resource validation, prioritization, allocation, and sourcing; staffing coordination; and strategic implementation of concepts outlined in the St. Louis Regional Hospital ACS Plan and Operational Guide.

This document outlines specific operational considerations for hospitals in standing up an ACS, including relevant processes for operational communications and ensuring a common operating picture across the region. The intent is to identify common operational considerations for an individual hospital that decides to use a pre-identified site (e.g., an adjacent medical building or professional office building) to operate an ACS that may or may not have government authorization.

6.2 Background

A major disaster could significantly affect the ability of a community to meet the health and medical needs of the impacted population or result in an increased number of persons requiring medical care. In these situations, it may be necessary to identify and activate a location not currently providing healthcare services to be converted to provide such services. For the purposes of the Hospital Template, concepts of an ACS will be explored as a means of alleviating the burden caused by a surge of patients entering the healthcare system.

Pertaining to ACS, the precise roles of healthcare providers, local communities, and government during a health and medical emergency cannot fully be predicted, as they will largely depend on the unique situation at the time of the incident. However, what is known is that planning and coordination between various members of the community will be essential to maintain business continuity and operations. For the purposes of this document, the foundation on which a hospital-based medical surge will be facilitated is the *Hospital Mutual Aid Agreement, Memorandum of Understanding*. It is recognized that similar coordination in Illinois is accomplished through the Region 4 Regional Hospital Coordination Center (RHCC) at Memorial Hospital Belleville in St. Clair County, Illinois. Additionally, it is assumed that each participating hospital will maintain its own emergency management plan that includes, at a minimum, provisions for the care of patients in an emergency or disaster situation, maintenance of disaster equipment, appropriate training of staff, and the implementation of an internal incident command system based on the principles of the Hospital Incident Command System (HICS).

During an emergency, the St. Louis Medical Operations Center (SMOC) will serve as a center for collecting and disseminating current information about healthcare resources and needs (including equipment, bed capacity, personnel, supplies, etc.), developing priority allocations, tracking disbursement of resources, and other relevant healthcare response matters. As shown in Figure 1 (right), information exchange and the linkage to the community's broader response efforts will all be facilitated through the SMOC. The importance of the SMOC's role related to alternate care sites cannot be overstated. It is the vital linkage required for the success of an ACS operation involving many different community resources—such as police, fire, medical providers, engineers, transportation, and housing experts. This template is focused on Missouri-based hospital coordination through the SMOC with the understanding the SMOC will coordinate with the Illinois Region 4 RHCC when appropriate.

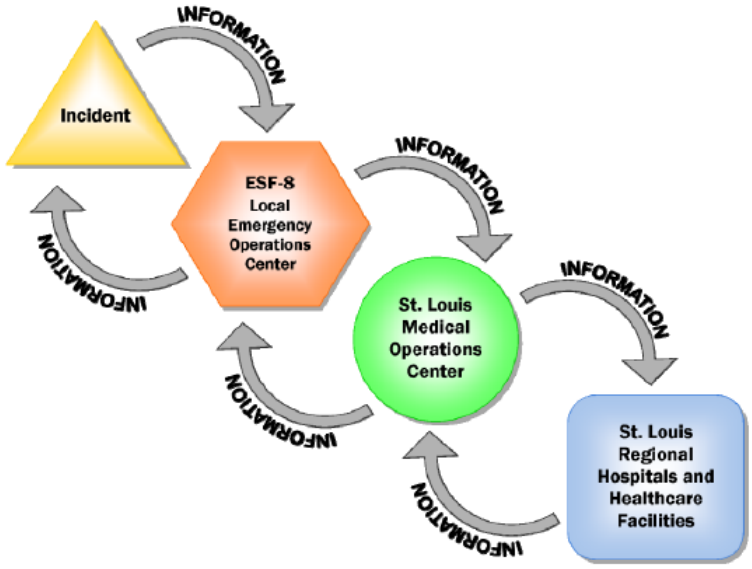


Figure 4

The hospital plays a crucial role. It is the epicenter of medical care delivered to those who are injured or ill. During a health and medical emergency, a hospital may convert from their current care capacity to surge capacity to handle the maximum patient load. The Hospital Template does not explicitly cover concepts in which hospitals can expand to accommodate increased patients within their normal parameters of delivering services. However, if a healthcare facility determines it is experiencing a healthcare surge, it could use the following guidelines to assess, prepare, and mobilize to meet the need for increased patient care:

- Rapid discharge of Emergency Department (ED) and other outpatients who can continue their care safely at home.
- Facilitated "early" discharge of inpatients no longer requiring inpatient care.
- Cancel elective surgeries and procedures.
- Reduce usual utilization of imaging, laboratory testing, and other ancillary services.
- Transfer patients to other institutions in the region, state, or other states.
- Group like-patient types together to maximize efficient delivery of patient care.
- Expand critical care capacity by placing select ventilated patients on monitored or stepdown beds, using pulse oximetry (with high/low rate alarms) in lieu of cardiac monitors, or relying on ventilator alarms (that alert for disconnect, high pressure, and apnea).
- Convert single rooms to double rooms or double rooms to triple rooms if possible.
- Designate wards or areas of the facility that can be converted to negative pressure or isolated from the rest of the ventilation system for cohorting contagious patients or use these areas for healthcare providers caring for contagious patients to minimize disease transmission to uninfected patients.
- Use cots and beds in flat space areas (e.g., classrooms, lobbies) within the hospital for noncritical patient care.
- Avert elective admissions at hospitals and discharge patients to a rehabilitation or long-term care facility or to home-based care.
- Convert non-traditional care areas to inpatient services (e.g., gastrointestinal lab, day surgery, diagnostic imaging, etc.).

- As a last resort, fill obstetrics, considered a “clean” unit (no infectious patients should be placed in obstetrics), with other noninfectious patients.
- Use any unit for immuno-suppressed patients so that these patients are not counted as inpatient healthcare surge capacity beds.

As a general assumption, healthcare surge will depend on how the hospital is configured and the availability of resources and infrastructure. Ideally, hospitals will surge within their own facility first, to their organizational assets next (e.g., affiliated hospitals, long-term care facilities, or clinics), then to other hospitals and healthcare facilities inside and outside of their system, and lastly, to an ACS.

6.3 ACS Objectives

Patient care objectives will likely be determined as part of the discussion within an incident command system employed locally by the hospital hosting the ACS. In the instance where the effort is coordinated with the local jurisdiction, the Unified Command System will be accessed through the SMOC to ensure a coordinated understanding of the intent of the facility, as well as its patient care objectives. Objectives may include, but are not limited to:

- Deliver sufficient medical care for a surge of patients who have disaster-related acute illnesses or injuries (non-immediate life-threatening) and who cannot be adequately cared for in a timely manner by the traditional healthcare system.
- Deliver urgent care for both disaster-related and unrelated medical conditions to offload EDs and ambulatory care clinics, so that these sectors can maximize care for other patient needs.
- Deliver sufficient non-complex care that is traditionally provided in inpatient settings to offload acute care hospitals to maximize care for more seriously injured or ill patients.
- Facilitate sufficient follow-up services so patients can be safely discharged to a non-medical site (e.g. home, ACS, or shelter).
- Triage and treat large numbers of exposed people (e.g., radiation, pathogen, toxic substance) and facilitate treatment and follow-up for recommended groups.

6.4 Level of Care

The ACS will provide treatment based on the operational approach selected, the availability of resources, and the objectives determined during activation and as the incident evolves. That said, for the purpose of uniformity and the establishment of a common operating picture, the following descriptions of capability are intended as guidelines for Operational Approach 2 - Hospital-based Alternate Care Site. The Operational Approaches are outlined in Table 1 on the next page. No restrictions, limitations, or promises of care are implied.

Table 3: Operational Approach Definitions

Operational Approach	Definition	Details	Lead Agency/Responsibility
Operational Approach 1 - General Population Shelter Support Teams	In situations where a general population shelter is already activated, there may be general populations, including individuals with access and functional needs, requiring a level of care beyond that available from Mass Care and Emergency Assistance (Emergency Support Function #6) and individual or regional hospitals. At the request of the local emergency management agency, these stakeholders may be asked to deploy mission-typed teams to help meet individual needs present in the shelter environment.	General population shelters will be activated by local officials following an incident that displaces a large number of individuals. These shelters meet the needs of general population, which includes those individuals with access and functional needs. General population shelters cannot provide continuous medical supervision or life-sustaining or acute medical care.	Local government, in conjunction with Emergency Support Function #6 – Mass Care and Emergency Assistance stakeholders. This may include the American Red Cross or other non-governmental organizations. Mission-typed teams and other resources would be requested from the healthcare community through the SMOC by local emergency management agencies.
Operational Approach 2 - Hospital-based Alternate Care Site	In situations where traditional approaches to healthcare surge are insufficient to meet the needs of an incident, an existing healthcare facility may need to identify an area not used for patient care, but on or adjacent to their existing campus, which can be quickly converted to serve as a treatment area (e.g. physical therapy areas, adjacent medical buildings, affiliated professional office buildings, outpatient clinics, and/or waiting rooms).	Incident creates need for increased acute medical care capacity. May meet the needs of inpatient/outpatient care or critical care; however, every attempt should be made to keep critical care patients in a hospital.	Given the increased demand that operating such a facility would place on the hospital, the hospital may activate the Hospital Mutual Aid Agreement to facilitate the regional exchange of resources. Mission-typed teams and other resources would be requested from the healthcare community through the SMOC.
Operational Approach 3 – Regional Alternate Care Site	Following a major incident, outbreak, or declared emergency, a regional approach may be required to significantly increase the level of medical services available to the impacted community. A location not currently providing healthcare services and not part of the expansion of an existing healthcare facility will be identified through the SMOC, in conjunction with local emergency management. This location will likely be designated under the authority of the local government when existing healthcare facilities are unable to meet demand for services. This community-based location may provide additional treatment area(s) within an identified level of care.	Overall regional healthcare infrastructure has exhausted available resources through surge, with additional capacity still required. Likely heavily influenced, resourced, and overseen by the government in conjunction with the medical providers through a public-private partnership.	Typically activated by local government via a public-private partnership and can be supported by local public health, emergency medical services and medical providers. Mission-typed teams and other resources would be requested from the healthcare community through the SMOC. Governmental or non-governmental agencies or one or more participating hospitals may assume command and control of such a site. Other participating hospitals may be asked to transfer staff, equipment, or supplies.

Defining the criteria for scope of care, based on the mission and resources available, is critical to the success of a hospital-based ACS mobilization. The scope of care provided in a hospital-based ACS will likely be limited and generally will not include laboratory, radiology, surgical services, or mortuary service. Services may differ from those typically provided by fixed fully functional healthcare facilities because resource availability may be limited and the "surge" is situationally dependent. Furthermore, prolonged treatments requiring medical gas, vacuum, and certain types of isolation will present increased challenges in a hospital-based ACS.

Note that the scope of care at the hospital-based ACS may be based on many situations, patient needs, and resource availability.

Table 4: Operational Approach 2 - Hospital-based Alternate Care Site Recommended Scope of Care

Scope of Care	Objectives of ACS Implementation
1. Delivery of ambulatory / outpatient services	Decompression of emergency departments by providing nursing care for stabilized internal medicine, trauma, orthopedic, and obstetric patients. Provide medical workups and examinations. Provide care for a variety of acuity levels while providing treatment, transfer and discharge, as appropriate.
2. Receiving site for in-patients (non-oxygen or power dependent)	Decompression of acute care hospital beds and the facilitation of the discharge and transfer (long term acute care, nursing home, rehab) process.
3. Inpatient care for moderate acuity patients	Decompression of acute care hospital inpatient beds for specific patients, to be defined at the activation of the ACS. Generally will not provide care for patients who have or anticipated need for laboratory, radiological, continuous oxygen therapy, or continuous power dependency.

The Hospital-based ACS will primarily activate for outpatient care surge capacity. Secondary activation criterion may be needed in moderate duration incidents where additional inpatient care surge is required. Long-term operational needs should consider state and federal resources (e.g. federal medical station [FMS], disaster medical assistance team [DMAT], etc.) allowing the local resources to progress into recovery.

The ACS is not designed to address the following; however, ACS personnel will triage and disseminate to the appropriate level of care:

- Advanced Cardiac Life Support (ACLS)
- Advance Trauma Life Support (ATLS)
- Long-term Airway Management (e.g. ventilator support)
- Neonatal Advance Life Support (NALS)
- Advanced Burn Life Support (ABLS)
- Respiratory Isolation Requirements
- Continuous Oxygen Dependency
- Durable Medical Equipment Provider
- Cold Storage of Remains/Decedents

6.5 Operational Planning Assumptions

Below is a list of operationally-specific planning assumptions. This is not meant to include redundant assumptions used to create the ACS Plan, but instead focuses on the assumptions that corroborate this Hospital Template.

- Considerations for access and functional needs populations and the concept of the "Whole Community" will be included in all planning.
- Most displaced individuals with medical needs that existed prior to the incident can be accommodated through the medical support provided at general population shelters. Typically, those with significant injuries and medical conditions resulting from the incident will require medical care from the existing healthcare system such as a hospital or clinic. This may also be true of individuals with pre-existing conditions that have decompensated.
- Where possible, agreements have been established with outside agencies to support the functionality of an ACS. Agreements should clearly describe the strategy and processes for preparing for and responding to an incident and should delineate roles, responsibilities, and liability.
- As needed, hospitals can identify resource-typed teams to deploy to support general population shelters in accordance with Operational Approach 1. It is assumed that this effort will be coordinated through the SMOC with the individual hospital in accordance with the Shelter Medical Support Group (SMSG) Plan.
- This template is focused on Missouri-based hospital coordination through the SMOC with the understanding the SMOC will coordinate with the Illinois Region 4 RHCC when appropriate. For more information about coordination with the SMOC, see the discussion in the Triggers and Activation section.

6.6 Limitations of an ACS

To respond effectively, advanced planning is critical. Public safety, public health, and emergency management as well as representatives from local health care organizations or institutions must have a common understanding of both the capabilities and limitations of an ACS. Stakeholders must delineate the specific medical functions and treatment objectives that the ACS facility will accomplish.

The biggest limitation is the fact that most hospitals will find it difficult to procure the amount and complexity of resources or the level of staffing required to extend hospital facilities into designated ACSs. It is imperative for planners to establish clear operational definitions of what can and cannot be accomplished in the setting of an ACS and coordinate with the appropriate entities to establish agreements such as memoranda of understanding for the acquisition of a site, resources (supplies and equipment), and staff. Agreements should be established with emergency management, healthcare organizations, volunteer organizations, coalitions, planned ACS sites, and other stakeholders prior to an incident. Agreements should clearly describe the strategy and processes for preparing for and responding to an incident. In addition, agreements should clearly delineate roles, responsibilities, and liability.

Limitations will be communicated operationally through an organized mechanism, including the SMOC. This is essential so that patient needs are matched with available medical resources. As a means of determining this in terms clearly communicated throughout the medical system, hospitals might consider the development and distribution of a triage aid. Please see Appendix 2: Triage Planning Aid Table for a specific breakdown of triaging patients across general population shelters, alternate care site(s), and acute healthcare facilities.

6.7 Operational Phases

In order to rapidly and effectively activate an ACS, operations have been broken out into four specific time phases, outlined below. For a specific breakout of tasks delineated with phase, consult the Execution Checklist.

Activation: 0 to 4 hours following the incident. The Activation Phase begins when a threat or hazard is identified that could lead to a hospital standing up a hospital-based ACS. This phase focuses on the considerations for activating an ACS and necessary decisions and coordination elements for standing up an ACS. The actual movement of resources to stand up the ACS are covered in the next phase of operations. The Activation Phase includes the sub-phases of Initial Actions and Notification. Consult the Activation Protocols section within Triggers and Activation for more information.

Mobilization: 4 to 12 hours following the incident. The Mobilization Phase initiates the movement of resources, including staff, to the selected ACS. This phase involves the process of notifying people, systems, and resources to establish Incident Command and management structures, making coordinated decisions about priorities and resources, and disseminating clear messaging to the public. For purposes of a hospital-specific ACS, mobilization of a site could take anywhere from 18-36 hours.

Site Operations: 8 to 24 hours following the incident. This phase includes all actions involved with actually running a hospital-based ACS, including attending to patients, requesting additional resources, and maintaining situational awareness. Processes in this phase ensure that coordination is occurring where necessary.

Demobilization: The Demobilization Phase initiates the deactivation of a hospital-based ACS. This includes the return of resources to their original state, documenting any necessary expenditure, and ramping down ACS operations.

6.8 Triggers and Activation

ACS Triggers and Coordination Considerations

When surge exceeds or is expected to exceed capacity, and an extended response is required related to the incident, the SMOC, in coordination with local emergency management, may affirm a need for an alternate care site. While there are no defined deployment time goals implied herein, the goal of the ACS is to be an agile, rapid response force dedicated to the public health and safety of the citizens.

Activation of an ACS should be considered during initial meetings of the SMOC duty officers, affected hospitals, and cooperating public health and emergency management agencies (EMAs). Before activating the ACS, those involved should consider the actual versus perceived need within the timeframe and also explore alternatives through medical surge plans (e.g., canceling elective surgeries, discharge stable patients, relocate patients to other facilities, etc.). Medical care using acceptable treatment spaces in licensed medical facilities is always better than providing care in an alternate care facility.

Communication and coordination between ACS, healthcare organizations, and emergency operations centers (EOCs) will be through the SMOC. The SMOC will coordinate with the most appropriate hospital for standing up an ACS. The SMOC will coordinate and request information from healthcare entities, shelters, and other response entities to ensure the activation and demobilization of the ACS is as efficient as possible for the overall regional healthcare infrastructure. For example, if a shelter is considering sending a large number of residents requiring acute medical intervention to a hospital or EMS has a large number of transport volume from a specific incident, the SMOC may consider using one or more ACSs, a single hospital destination for patients, or a rotation of patients to multiple hospitals. The EOC and SMOC should work together to identify the best care location for the individuals. In a situation where immediate medical care is needed, the shelter should call 911 and emergency medical services (EMS) will follow their standard protocols.

It is essential that all hospital-based ACSs work in conjunction with the SMOC, prior to and throughout the ACS operation. The SMOC may coordinate with healthcare providers throughout the region to disperse patients throughout the medical community prior to the establishment of an ACS, providing healthcare in the most appropriate setting whenever possible.

ACS Activation Criteria

The intent of the following activation criteria is to provide general, guiding principles that are not restrictive to specific incidents and events. It may be warranted to open an ACS if the SMOC predicts the following criteria may be met:

- Medical surge capacity in Missouri Region C hospitals has been, or has the potential to be, overwhelmed and/or exhausted during a health emergency and resources are available through internal or external sources to staff an ACS.
- Numbers of persons requiring inpatient care exceeds surge capacity of hospitals and other medical facilities.

Should specific hospitals require ACS support to augment a shortage of specialty services; the SMOC will convene to determine the appropriate course of action.

Initial Site Selection

It is assumed that the individual healthcare facility has identified potential locations for a hospital-based ACS in advance of the incident. Healthcare facilities may identify wings, areas, and spaces that could serve as alternate care sites such as:

- Physical therapy areas.
- Outpatient clinics.
- Waiting rooms.
- Wings previously used as inpatient areas that can be reopened.
- Conference rooms.
- Medical office buildings.
- Areas of the facility no longer in use.
- Temporary ACSs on facility premises (cots in tents).

Immediate Notification

When the activation of an ACS is first being considered, the hospital should notify key personnel, such as the ACS management staff and facility contacts, and implement initial activation activities, including notification of the SMOC and EMA. Initial activities should focus on appointing key personnel, according to the staffing plan, and enacting response efforts.

Determination of ownership and leadership of the ACS is an immediate action that will likely be dependent on the type of care administered at the site. If pursued under Operational Approach 2 - Hospital-Based Alternate Care Site, issues pertaining to lead should be decided at the hospital level and must involve identifying individual(s) to decide whether, when, and where an ACS should be opened and granting the individual(s) the authority to operate the site. The most effective way to make such decisions is to use and build on the organizational and governance structure that is already functioning at the individual hospital.

Activation Protocols

Phase 1 – Activation; Sub-Phase 1 – Initial Actions

0-2 hours

Further initial actions include, but are not limited to:

- Activate the *Hospital Mutual Aid Agreement, Memorandum of Understanding*.
- Conduct outreach and engagement of the SMOC.
- Assure that the local government has requested a local emergency declaration, as outlined in local procedures.
- Assign an ACS administrator to initiate the hospital's plan and assume responsibility for operations. If multiple ACSs are required, ACS administrators should be assigned to each site.
- Ensure key positions of the ACS command structure are staffed and supported to meet operational needs.
- Distribute job action sheets to assist in determining initial activation steps for each position.

Activities will simultaneously focus on the site of the ACS. Activities may include:

- Identify which physical locations will be activated for ACS operations and perform a site reassessment. The designated site representative should accompany the ACS administrator to complete the assessment of the area. This assessment should document the condition of the facility and any facility equipment that will be utilized.
- Secure the facility, including controlling traffic flow of individuals and vehicles and identifying a primary and secondary entry point. Assign initial security personnel to the site. Personnel must secure areas not to be used during operation and secure exterior doors not being utilized as entrances from outdoor entry.
- Coordinate with EMS providers to triage and transport patients to the appropriate facility or locations within the facility.
- Establish a secure location to receive supplies, pharmaceuticals, and equipment.

Phase 1 – Activation; Sub-Phase 1 – Notification
0-4 hours

Secondary efforts will focus on organizing the ACS setup after the site has been assessed and properly secured. At this point key staff should prepare to receive supplies and make arrangements for patient arrival. Activities at this stage include:

- Alert points of contact within stakeholder agencies of staffing needs; schedule and mobilize staff for security, environmental, administrative, clinical, pharmaceutical and personal assistance services.
- Coordinate with team members, staff, and volunteers to establish a reasonable time frame for the ACS to become operational.
- Alert and notify administrative and setup staff to prepare the site.
- Perform a complete cleaning of the site.
- Request, obtain, deliver, and distribute resources according to ACS layout.
- Activate all applicable contracts for services, staff, supplies, pharmaceuticals, and equipment.
- Take inventory of all delivered resources.
- Post all necessary interior and exterior signs.
- Set up the site according to the planned site layout.

Phase 2 – Mobilization
4-12 hours

During this phase, ACS staff should be reminded to make appropriate personal preparations based on the anticipated number of hours away from home. This may be caused by an inability to leave the ACS because of the incident or other complicating factors. Preparations include:

- Making arrangements for family members and pets.
- Locating personal supplies.
- Providing current contact information to key points of contact.

As ACS staff arrive at the facility and begin their assigned role, they should:

- Review the plan and becoming familiar with roles and responsibilities.
- Ensure a process for accommodating the arrival of the ACS staff and volunteers, establish the registration and intake desk, issue identification, handle credentialing, and establish shift schedules.
- Perform a final health and safety facility walkthrough to ensure compliance and a safe ACS environment.

- Distribute supplies throughout the ACS, ensuring the availability of a secure area, and identify procedures and policies for proper storage.
- Prepare feeding services, water, and storage of supplies.
- Address privacy issues, including communicating policies, to ACS staff on maintaining privacy of patients and establishing visitation procedures (including those for the media and elected officials).

Phase 3 – Site Operations
8-24 hours

Finally, after the ACS has been activated and throughout its operations, staff should:

- Communicate the discharge plan for patients, including policies for self-discharge, transfer to higher care, record keeping, and other key administrative tasks needed for reimbursement, tracking, and future planning.
- Initiate planning for demobilization, returning resources to the place of origin, managing patient and staffing records, and transferring site management back to the facility owner.

6.9 Operational Considerations

Operational elements essential to the execution of the ACS are detailed in the operational tools attached to this plan. These tools represent the following operational elements:

- ACS operations and coordination
- Site considerations
- Staffing
- Supplies, pharmaceuticals, and equipment
- Intake and triage
- Medical operations
- Administration
- Demobilization

6.10 Coordination with External Agencies

- St. Louis Medical Operations Center
  SMOC will serve as a center for collecting and disseminating current information about healthcare resources and needs (including equipment, bed capacity, personnel, supplies, etc.), developing priority allocations, tracking disbursement of resources, and other relevant healthcare response matters. The SMOC is the vital linkage required for the success of an ACS operation, involving many different community resources—such as police, fire, medical providers, engineers, transportation, and housing experts.

  The SMOC should be engaged in the ACS operation through the hospital command center. The hospital command center should request support from the SMOC according to the procedures outlined in the SMOC Standard Operating Guidelines (SOG).

- Public Health
  Public health departments have a role in all aspects of an ACS, including:

  - Coordination of planning, response, and recovery.

- Coordination of ACS activation.
- Coordination of deployment of staffing and other resources to support ACS operations.
- Provision of basic medical care.

One of the biggest challenges to ACS operations is the ability of public health and medical entities to access available resources. Each of the public health agencies should understand the processes used to request health and medical resources and support local hospitals in this task.

In most cases the hospital will have a working relationship with the local public health department. The public health department may also be engaged through the SMOC or directly through the local emergency management agency. Public health should be engaged in conversations pertaining to resource needs through regular conference calls and, potentially through identifying a public health liaison to sit in the hospital command center. This liaison would work with the ACS administrator to determine the needs present within the ACS and any modifications to scope of care.

- Emergency Medical Service Providers

  EMS providers play an essential role by triaging, treating and transporting patients to an appropriate healthcare facility. Once an ACS is established, triage protocols should be communicated to the providers to assist them in effectively triaging appropriate individuals to the ACS. EMS providers may also be able to provide paramedics and emergency medical technicians to assist in staffing the ACS.

  Working through the hospital command center and in coordination with the greater hospital operational approach, the ACS should include a medical plan that includes a standby ambulance at or near the ACS. If the ACS is located in very close proximity this staging may not be necessary. The intent is to provide emergency transportation as needed for clients with decompensating medical conditions.

  EMS should be given instruction as to the means of transporting patients directly to the ACS, if direct transfer is allowed under the operational configuration. If this does occur, appropriate messaging should be undertaken with EMS authorities to ensure responding units are aware of any modification to normal operation.

- Emergency Management

  Emergency management (Emergency Support Function [ESF] #5) agencies typically support the local lead agency for mass care (ESF #6), including general population sheltering. Emergency management may initiate the activation of an ACS once a need has been identified and will often coordinate logistics for ACS. These activities often occur through the jurisdiction's emergency operations center in conjunction with the SMOC.

  Generally, the ACS will engage local emergency management through the SMOC, with the SMOC being engaged through the hospital command center. This creates an established chain of command between the ACS Administrator, the Hospital Command Staff, and the local jurisdiction. In some cases, the local hospital may coordinate directly with the local emergency manager through use of WebEOC, phone, email or other communications system.

  In addition to providing situational awareness, hospitals may convey the overall status of their facility and their ability to continue operations given any impacts on the infrastructure of the facility. It is likely that as the incident advances, if cascading events occurs, emergency management would have an increased role in any consideration of a regional alternate care site.

- Social Services

  Social services agencies are often designated as the local mass care lead agency. Social services agencies may coordinate with emergency management and non-governmental organizations to plan, staff, equip and operate

general population shelters. However, social services agencies vary greatly across jurisdictions in their ability to support sheltering activities.

Social services agencies will be contacted in conjunction with the established protocol for outreach to the local emergency management and public health offices. The exception for social services would be if a facility has ongoing coordination due to their typical patient population.

- Mental Health
  Mental health providers not only play a significant role in general population shelters, but also in the treatment and housing for clients within the behavioral health system at the ACS. They may be involved in assessing and activating the response to behavioral health issues at an ACS. There may also be a role for mental health support in treating the staff who works within an ACS, under austere conditions, in a situation that is not familiar to them.

  In some jurisdictions mental health may formulate plans to ensure medical health professionals are available to provide behavioral health services at the ACS. These services should include support for both clients with pre-existing conditions and clients needing new support. Typically, mental health services are engaged through established relationships with the local public health department or through contract with private services or non-governmental organizations.

- State Level Government Agencies
  As the complexity of ACS operations increases, the involvement of the state may be requested. The State Emergency Management Agency, Missouri Hospital Association, and Missouri – 1 DMAT, Inc. or MO-1 DMAT, Inc. may be in a position to provide resources and expertise to augment the ongoing operations.

  In most instances, the state's involvement will be facilitated through the local emergency management office. It is likely that a local declaration of emergency will be required for significant state-level assistance to become available. With the state's involvement, the local hospital may be able to access greater levels of resources from surrounding jurisdictions and states. In a Declared Emergency, the resources of other states may become available through the Emergency Management Assistance Compact (EMAC).

  The state will have a key role in a larger scale incident. In a presidentially declared disaster, the state will work with the local jurisdiction and support requests of assistance. This assistance might include the deployment or staff, commodities, or other assets that would greatly assist the local hospital in the execution of the ACS mission. This activity would be facilitated through request coming from the individual hospital's command center, through the SMOC, and then to local emergency management.

  One resource that may greatly assist ACS operations is the 501(c) 3 Missouri – 1 DMAT, Inc. (MO-1 DMAT, Inc.). MO-1 DMAT, Inc. maintains several hundred members representing medical and other professional disciplines coupled with an extensive logistical support system and equipment fleet housed in three strategically located warehouses throughout the state.

- Federal Agencies
  Federal assistance may be requested, consistent with existing plans and procedures regarding requests for assistance. Local jurisdictions should utilize the standardized process. FMS, DMAT, the National Disaster Medical System, and Veterans Health Administration may be viable federal resources to assist with ACS operations.

- Volunteers
  - Voluntary Organizations Active in Disaster

    Voluntary Organizations Active in Disaster (VOAD) is a nonprofit, nonpartisan membership organization that serves as the forum where organizations share knowledge and resources throughout the disaster cycle—preparation, response, recovery and mitigation—to help communities prepare for and recover from disasters. The National VOAD coalition includes over 50 of the country's most reputable national organizations (faith-based, community-based and other non-governmental organizations) and 55 state/territory VOADs, which represent local/regional VOADs and hundreds of other member organizations throughout the country. For the purposes of a large ACS operation, VOAD may be sought to coordinate support from volunteer and other community-based organizations.

    VOAD and other volunteer support will be coordinated through the SMOC in conjunction with local emergency management and/or public health. In advance of the incident, each hospital should determine a role for volunteers in the establishment and operation of their ACS. It is assumed that volunteers could have a meaningful role in both clinical and non-clinical functions critical to ACS operations.

  - American Red Cross

    In most local jurisdictions, the American Red Cross is designated as the primary community-based organization responsible for shelter, feeding, and other disaster relief services, such as, nursing, mental health, and client casework. The American Red Cross may have the responsibility to establish shelters for the general population during a disaster. It is also responsible for compiling and reporting information on shelter-seeking populations. The information includes the number of displaced individuals, the number of individuals residing within the shelter, and any unmet needs. The American Red Cross recently revised their concept of operations for nursing. The concept allows registered nurses and licensed vocational nurses (RN and LVN), and those they supervise, to practice nursing at the community level scope of practice.

  - Medical Reserve Corps

    The Medical Reserve Corps are units of volunteers registered through the Federal Office of the Surgeon General. Each Medical Reserve Corps Unit comprises local volunteer medical and public health professionals such as physicians, nurses, pharmacists, dentists, veterinarians, and epidemiologists, as well as auxiliary support staff. Medical Reserve Corps members may provide staffing and support for ACS.

  - Community Emergency Response Teams

    Community Emergency Response Teams organized by local law enforcement, fire, or emergency management agencies, are provided training in basic disaster response skills such as fire safety, light search and rescue, team organization, and disaster medical operations. The trained response teams also educate volunteers within the community to prepare for hazards that may impact their area.

  - Spontaneous Unaffiliated Volunteers

    Spontaneous unaffiliated volunteers often arrive at shelters ready to help. Clients may arrive with family members who could also be incorporated into shelter operations as volunteers. These volunteers may be skilled and capable of meeting significant needs within an ACS. In order to leverage this potentially valuable workforce, planning efforts should anticipate and manage them in supportive (e.g., personal assistance services) and administrative capacities (e.g., personnel timekeeping).

- Emergency System for Advance Registry of Volunteer Health Professionals
  Volunteers may provide support to a variety of emergency response activities within the ACS. Close coordination should occur with sources of anticipated volunteers to ensure capability to meet projected needs. The St. Louis Region will rely on Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) system for credentialing clinical staff, including: Missouri Show-Me Response (https://www.showmeresponse.org/) and Illinois Helps (https://www.illinoishelps.net/).

  Each hospital will make determination on the extent of use of ESAR-VHP and how this system will be integrated into the staffing of an ACS. ESAR-VHP may provide expedited response in terms of the ability to credential key staff and volunteers following a disaster.

- Other Participants and Programs
  - Healthcare, Skilled Nursing and Long-Term Care
    Each healthcare facility is responsible for having a detailed written plan and procedures to address potential emergencies and disasters. These plans include the identification of "like facilities" to accommodate residents if evacuation is required. If evacuated, the healthcare facility may be a source of skilled staff, pharmaceuticals, and portable equipment needed to sustain care at the ACS.

    In planning for staffing prior to an event, each hospital should determine if relationships exist with other healthcare, skilled nursing, and long-term care facilities that would assist with surge staffing or resource gaps. Medical schools, nursing schools, or other specialty programs might be considered for assistance in carrying out the ACS mission.

    For resources outside the immediate vicinity or network of the individual hospital, the SMOC should be viewed as the central point for regional coordination and resource sharing, making allocation decisions if the need exceeds the availability of total resources.

  - Private Sector
    The private sector includes private health care facilities, pharmacies, contractors, facility owners, and other stakeholders. The private sector is often the primary provider of critical services to the public and possesses knowledge and resources to supplement and enhance public efforts.

    One specific area of interest are private pharmacies and clinics (e.g., Walgreens), that operate in or around the regional hospitals. It is recommended that hospitals pursue agreements with these organizations as a means of building the just-in-time capacity of the organization to meet increased needs and to lessen any impact that the incident may have on an individual supply chain.

    It is generally understood that Memoranda of Understanding and Memoranda of Agreement (MOUs/MOAs) can be developed with certain private sector organizations so that an increased number of certain items are always retained and available for the region. This vendor-managed inventory concept is a viable option for items that must be available in quantity, but are unrealistic to be stored in a cache for prolonged periods.

    The private sector will likely be engaged by the hospital command center at the local hospital level. However, in larger events, it is possible that this coordination occurs through the SMOC, with emergency management, or in coordination with public health.

6.11 Demobilization

Demobilization is the process by which an ACS is closed and ceases operation. Demobilization includes scaling back or shutting down the ACS operations and transitioning patients back to the hospital or discharging them from the medical system.

Trigger for Demobilization

This decision will be strongly influenced by the needs of the incident and resources available. In the case of an ACS this decision is likely to be led by the hospital incident command center (ICC) within each healthcare facility and will be influenced by many stakeholders, such as the SMOC, and working through ESF-8 (Public Health and Medical), EMAs, and other authorities outside the hospital. It is assumed that the ICC at the host hospital will have ultimate authority for the decision to deactivate. If a decision is made to demobilize an ACS, coordination with various response partners will be required to return patients to pre-incident conditions and properly restore the ACS site.

The decision on when to close the ACS should incorporate the following factors:

- Impact of the incident on the community.
- Urgency of need to return the site to normal conditions.
- Time of day.
- Political impact.
- Medical impact.
- Availability of transportation resources.

Patients should be transitioned to the most appropriate facility, based on status. It is important to allow a reasonable amount of time and assistance for locating suitable locations for the sustainment of care.

Procedures for Closure

- Notify SMOC of demobilization timeline.
- Transfer/discharge all patients.
- Arrange for the transfer of medical records and/or establish storage procedures and locations to ensure future availability of records and documentation.
- Terminate ongoing contracts or arrangements.
- Identify resources and equipment that are no longer needed.
- Coordinate pickup and transportation of supplies.
- Ensure that all areas of the site are restored to pre-ACS conditions.
- Prepare an after-action report and conduct an assessment of efforts, resources, actions, leadership, coordination, and communication in order to improve future operations.

Financial Considerations and Reporting

Accounting for the costs associated with the operation of an ACS may occur away from the site and should be coordinated with the local jurisdiction and according to any activated MOUs/MOAs. The cost accounting system utilized must separate all disaster-related costs from other activities and capture the information necessary to justify disaster-related costs. The accounting system should identify and document separate costs in each of the following categories:

<u>Labor Costs</u>

- Force account labor hours by individual, rates of pay, duty assignment, and work locations.
    - The Federal Emergency Management Agency (FEMA) uses the term “force account” to refer to local government personnel and equipment.

- Temporary hires by individual, hours of work, and rates of pay.
- Breakdown of fringe benefits for regular employees and emergency hires, including both regular and overtime rates.

Equipment and Contract Costs

- Equipment used for eligible disaster recovery work, hours of use, applicable equipment rates charged (local rates or government cost code), location of work, and name of employee operator.
- Services contracted for and/or purchased for use on eligible work, location of work purchase orders, costs, and invoices to support the costs.
- Listing of damaged equipment and cost to repair or replace.

Other Supporting Records

- Labor policies in effect at the time of disaster.
- Insurance adjustments, settlements, and other documents and records related to project worksheets.
- Volunteer labor and equipment records to include, for each volunteer, a record of hours, location, description of work performed, and equivalent information for equipment and materials.
    - FEMA recommends that each volunteer's time in and time out be recorded as a means to capture the total hours worked per day.
- Photographs of work sites before and after, labeled with location and date.
- Mutual aid and assistance agreements in effect.
- All other documents or costs associated with the disaster.

Accounting records must be supported by source documentation such as cancelled checks, copies of paid bills, payroll sheets, time and attendance records, etc.

Charge capture is the process of collecting charges for services, supplies, and pharmaceuticals provided to patients during a healthcare encounter. The suggested minimum data list for charge capture consists of the following:

- Patient name.
- Medical record number.
- Date of service.
- Medication units/dose/quantity.
- Department in which services were provided.
- Service description.

The tracking and monitoring of potentially eligible expenses is critical so that when and if funding becomes available, the applicant is in a position to maximize reimbursement and other forms of assistance as part of the recovery process. Jurisdictions also need to consider if they will be seeking reimbursement of costs through long term care facilities and if Medicare/Medicaid will be sought for reimbursement for services provided.

- Federal funds may not be available until a disaster is federally declared by the president. Although in the past FEMA has focused on property losses due to a disaster, temporary but substantial population displacement has resulted in funds being appropriated for the payment of some medical services.
- Procedures for reimbursement are managed by the emergency management agency of the state in which the hospital is located.
- Participating hospitals may enter into other mutual aid agreements with governmental or non-governmental agencies including other hospitals and health systems that provide for reimbursement during medical disasters and

participating hospitals may be eligible for reimbursement under laws other than the Stafford Act that may be in effect at the time of a medical disaster.

- When a participating hospital is reimbursed for part or all of its expenses under another mutual aid agreement or law, it is not entitled to duplicate reimbursement from another participating hospital. If a hospital receives reimbursement under the Stafford Act and has not reimbursed a transferring hospital, the hospital must reimburse the transferring hospital within sixty (60) days of receiving the Stafford Act funds.

Section 7
Concept of Logistical Operations

7.1 Resource Management

Hospital incident command centers (ICC) within each healthcare facility will make decisions on whether or not to establish an ACS and the level of care for which it is to provide. As such, each ACS will follow the incident command processes established by the activating hospital. Each role within the ACS should have pre-established or just-in-time job action criteria and organizational charts. Each healthcare facility is required to have an incident command structure and resource management procedures, which should include alternate care site integration.

The hospital incident command structure will direct movement of patients along with staff, medical equipment, and supplies for their ACS. The hospital ICC will be responsible for the resource management at the ACS and will work with the SMOC to provide timely situational awareness, as appropriate. Through the standard operating guidelines of the SMOC, the hospital's ACS will be made aware of available resources, including transportation, fixed facility ED capacity, and inpatient bed availability throughout the region.

While the Hospital Template is primarily focused on Operational Approach 2, it should be noted that there are two other Operational Approaches that may be considered in meeting the medical needs on the impacted population. Each Operational Approach will have its own unique response requirements and resource needs. The Operational Approaches are:

- Operational Approach 1 - General Population Shelter Support Teams
- Operational Approach 2 - Hospital-Based Alternate Care Site
- Operational Approach 3 – Regional Alternate Care Site

Where feasible, hospitals should coordinate with private sector partners to supplement or augment ACS resource needs. Establishing MOUs/MOAs in advance of a disaster ensures that these mechanisms for resource sharing are viable when needed. Partnering with private sector entities provides an additional layer of resources that could sustain an ACS operation.

7.2 Regional Resource Coordination

The entire operations of the ACS will be aligned with the National Incident Management System's (NIMS) standards using an Incident Command System (ICS) structure. All operations should be documented on appropriate ICS forms, either electronically or in written form. A 214 (unit log) should be completed by each unit for each operational period and provided to the SMOC. Various levels of command may be inserted as incident scope affects the span of control and will be highly dependent upon the size and scope of the ACS.

The ACS will face unique challenges related to its deployment and operation. Specifically, given the large and complex scope of most foreseeable mission profiles it is apparent that the ACS may require an extensive level of organizational support during the incident. Consistent with the ICS, each staff position should receive a Job Action Sheet (JAS), which is a simple checklist that describes the role, responsibility, and reporting structure of each position within the ICS structure. These JASs comprise the larger Staffing Plan, outlined in the next section. These forms should be prepared in advance of the incident for rapid distribution to participating staff on their arrival to the ACS.

Operationally, all medical supplies should be stored in a secure, climate-controlled area in close proximity to the patient treatment area. Consideration for this guideline should be made when selecting the physical make-up of the ACS.

The ACS is designed to rapidly surge healthcare capacity into an affected region. To align to that mission, this plan recommends that supply caches be configured based on interventions to be performed, rather than in bulk caches. This will limit the set up time required to stock treatment areas in the ACS, thus shortening the deployment to open time as well as aid in demobilization and restocking.

ACS supplies (outlined in the Operational Toolkit) may be broken out into categories of care, both to aid in par stocking levels (related to expected patient loads) and cache configuration. The recommended categories are as follows:

- General ACS Supplies related to all patient care areas (sheets, personal hygiene, gowns, isolation, etc.)
- Emergency Room (ER)
- Skilled Nursing Facility (SNF)
- Orthopedics
- Obstetrics (OB)
- Pediatrics
- Infection Control (IC)
- Mental Health

Of these categories, historically the SNF unit has represented the highest demand for disposable supplies. Attached to this plan as part of the Operational Toolkit is an example supply list.

7.3 Patient Record Keeping

Personnel should establish a medical record for every individual treated at the ACS, including but not limited to, patient demographics, assessment, medical history, medications, allergies, and all treatments and interventions conducted. All care providers (vocational, technical, and professional) should document patient activities within the medical record. The medical record should also include related admission, discharge, and transfer details. A medical record should accompany each patient throughout their care at the ACS. Patients transferred out of the ACS should be sent with a copy of the medical record and the original medical record should remain within the ACS. All records must be complete, legible, and thorough and should exclude abbreviations whenever possible. Consult the Operational Toolkit for a myriad of example patient forms.

7.4 Patient Tracking

Patients are tracked throughout the ACS operation process and should be followed by case management wherever possible. All patients will be tracked consistent with the regional patient tracking guidelines and procedures, including at a minimum the dates/times of reception, discharge, and any transfer into/out of the ACS. Case management personnel will be integral to transition for outpatient to inpatient status, discharge, and transfer to a fixed facility. Note that general population shelters do not have patients, but rather clients who are not typically tracked.

Hospitals and healthcare facilities are responsible for maintaining situational awareness of all patients within their care responsibility. This will be extremely important for reimbursement, patient safety, and continuity of care. The patient tracking form can be found in the Operational Toolkit.

Section 8
Staffing Plan

8.1 General Staffing Management Strategy

The ACS Staffing Plan encompasses both clinical roles and nonclinical staff. This includes site set-up, site administration, clinical operations, support functions, and command staff. It is important that ACS staff understand that the incident may require them to fill various positions and take on new responsibilities over time.

Staff Planning

If activated, it is assumed that staff planning should project out a minimum of seven days of operation. In the initial stages of response, ACS hours are generally assigned as two 12-hour shifts per day. The benefit of a longer shift is that it provides consistency for ACS management and patients and is generally more efficient coordination because of comfort with operations. Staff should remain assigned to the same site for the duration of the operation or until their skills are no longer required. ACS management should also enforce a system for mandatory breaks to prevent overwork.

Staff should ensure that they arrive at the ACS for their shift in sufficient time to overlap with outgoing staff for the shift debriefs or as dictated by the hospital. Upon arrival, staff should sign in and record their time worked on a timesheet in addition to using whatever system is currently operationalized by the host hospital. Detailed record keeping is essential to tracking associated costs for the potential reimbursement of expenses.

Staff-to-patient ratios are an important consideration for clinical operations. Where applicable, this ratio can be guided by union contract parameters. The staffing pattern should be adjusted based on the site layout, as well as the actual number and needs of individuals and availability of resources. Levels of care and specific operational care categories within the ACS dictate the number and type of staff present; thus, continual assessment is required to ensure adequate support. It is important to note that although a baseline ACS layout encompasses a 25 bed subunit, this approach can be scaled up or down based on incident needs in accordance with the appropriate Operational Approach. To scale staffing needs up as the ACS capacity grows, multiply each staffing allocation by the number of 25 bed increases.

The table below outlines the suggested minimum staffing for an Alternate Care Site, to include additional surge staffing considerations for the following specialized areas:

- Emergency Room (ER)
- Skilled Nursing Facility (SNF)
- Orthopedics (Ortho)
- Obstetrics (OB)
- Pediatrics (Pedi)
- Infection Control (IC)
- Mental Health (MH)

Table 3: Suggested Minimum Staffing Considerations per 12-hour Shift for a 25 bed subunit for ACS and ACS+Specialty Area

Assignment	Priority	ACS	+ER	+SNF	+Ortho	+OB	+Pedi	+IC	+MH
Physician	High	1	1	1	1	1	2	1	1
Physician extender (PA/NP)[2]	High	1	1	1	2	2	2	1	1
RNs or RNs/LPNs	High	3	5	3	5	5	5	5	5
Health technicians	High	2	2	2	1	1	1	2	2
Unit secretaries	Medium	1	1	1	1	1	1	1	1
Respiratory therapist	Medium	1	1	1	0	0	1	2	0
Case manager	Medium	1	1	1	1	1	1	1	2
Social worker	Medium	1	1	1	0	0	0	0	2
Housekeepers	Medium	1	1	1	1	1	1	1	1
Lab personnel	Low	1	1	1	0	1	1	1	1
Medical assistant/phlebotomy	Low	1	1	1	0	0	0	1	1
Food service	Low	1	1	2	0	0	1	1	1
Chaplain/pastoral	Low	1	1	1	0	1	1	1	1
Volunteers/care assistants	Medium	2	2	2	1	1	1	1	1
Engineering/maintenance	Medium	1	1	1	1	1	1	1	1
Biomed-to set up equipment	High	1	1	1	1	1	1	2	1
Security	Medium	1	1	1	1	1	1	1	1
Patient transporters	Medium	1	1	1	1	1	1	1	1
Total ACS staff / 12-hour shift:	-	22	24	23	17	19	22	24	24

Coordination between ESF #6 and ESF #8

Continual coordination with emergency management, specifically Emergency Support Function #6 – Mass Care and ESF #8 – Health and Medical, will enhance overall ACS operations. ESF #6 and #8 can, in some cases, provide emergency staffing support to supplement hospital ACSs and can also ensure coordination is happening across the region in a significant catastrophic incident.

In addition, it is recommended that hospitals establish an Emergency Medical Services (EMS) field liaison to coordinate emergency response in the field with incoming client flow for a hospital ACS. Coordination between field operations and ACS operations ensures that capability and capacity of an ACS is managed in real-time and can inform decisions of whether or not to open up additional ACSs or reroute clients to different area hospitals.

[2] Physician's Assistant/Nurse Practitioner (PA/NP)

Sources for Surge Staffing

A hospital's first option to address staffing demands is to depend on their existing staff (e.g., increasing the number of hours per work shift, calling back staff who have been on leave, etc.) and reassign non-essential roles (e.g. educators, public outreach, etc.). When hospitals have maximized the productivity of their existing staff, the next option would be to call upon external sources for temporary staff, as they normally would when there is a staff shortage. Hospital human resources and medical staff departments should use existing processes for contacting these sources. Additional sources of temporary staff may include nurse agencies and locum tenens registries. Once these sources are exhausted, additional staffing resources will be requested through the SMOC structure under the mechanisms outlined in the *Hospital Mutual Aid Agreement, Memorandum of Understanding.*

Staff Training

Just-in-time training refers to rapid training courses designed to familiarize staff with processes and operations. This training must occur prior to staff engaging in operational activities, and should cover the operations and administration of the ACS as well as instructions on using equipment, medical supplies, and other materials. In addition, jurisdictions should consider their just-in-time training needs and develop the appropriate courses prior to the incident. On-site and/or just-in-time training courses may include:

- Site operations and procedures.
- Patient tracking and patient valuables tracking.
- Report procedures, check-in procedures, and credentialing.
- Personal protective equipment, medical evaluation and testing, infection control, and fit testing.
- Medical records keeping, storage, and chain of command.
- Communication procedures.
- Procedures for obtaining prescriptions.
- 911 protocols.
- Logistics.

Credentialing and Personnel Verification for Clinical Staff

The St. Louis Region will rely on the ESAR-VHP system for credentialing of clinical staff, including: Missouri Show-Me Response (https://www.showmeresponse.org/) and Illinois Helps (https://www.illinoishelps.net/). Coordination with state and local administrators for appropriate credential validation and personnel deployment prior to arriving is highly recommended. It is recommended that this occur away from the ACS site at a location focused on the administrative processing of incident-related volunteers or with the host hospital's human resources department. At the ACS, the ACS administrator will verify that all licensed professionals arriving to work have the required credentials according to local policy and procedures. On-site accreditation and credentialing is not recommended.

Medical Director

The host hospital should identify the medical director for the ACS. This individual should be a licensed physician, essential to the medical direction and medical authority for clinical staff operations within the ACS. The medical director should be available for the duration of the ACS operation for medical consultation, which can occur virtually or in person. This individual should be prepared to serve in an advisory role for all clinical staff and it is recommended he/she be board certified in the ACS category deployed (e.g., ED, Ortho, OB, etc.). Guidance from the medical director may be sought whenever clinical staff needs physician consultation.

ACS Management

All management activities within an ACS should be facilitated through the staffing plan command structure outlined in the ACS organizational chart. Utilization of this structure will facilitate the integration of all ACS staff into a single incident action plan. This coordinated effort will result in optimum medical care.

Setup Staff

The number of staff required to set up the ACS is included the staffing projections above. Factors to consider in setting up an ACS include, but are not limited to: site conditions, ease of cleaning, accessibility, Americans with Disabilities Act (ADA) compliance, availability of storage, and ability to lock valuables and medications. Resources from non-clinical sources may be sought to assist with setting up the ACS. In some instances, jurisdictions may wish to pursue memoranda of understanding/agreement and vendor agreements to support ACS activities. Setup staff should be given detailed instruction on how to appropriately establish the site. Layout schematics may help; a sample is available in this plan. Setup is generally overseen by the ACS administrator, who has the ultimate responsibility to ensure that the site is prepared to receive patients.

Support Staff

An ACS will require the participation of numerous support staff. The services such staff may need to provide include, but are not limited to, administrative, food service, child care, laundry, traffic control, security, engineering, housekeeping, transportation, and facility maintenance.

8.2 ACS Staffing Communications Protocols

Within the ACS and consistent with Operational Approach 2 – Hospital-Based ACS, a strong communication infrastructure must be present for adequate and timely notifications to outside agencies and personnel.

During active operational periods, the ACS will maintain communication with the agencies listed below. For more information, consult the Coordination with External Agencies section.

- SMOC
- ESF-8
- Local EMAs
- Supporting hospitals
- Supporting patient transportation agencies

Types of communication methods used within the ACS include:

- Telephones (land line)
- Cell phones
- Email
- Fax
- Radios
- Satellite phones
- Pagers
- Amateur radio

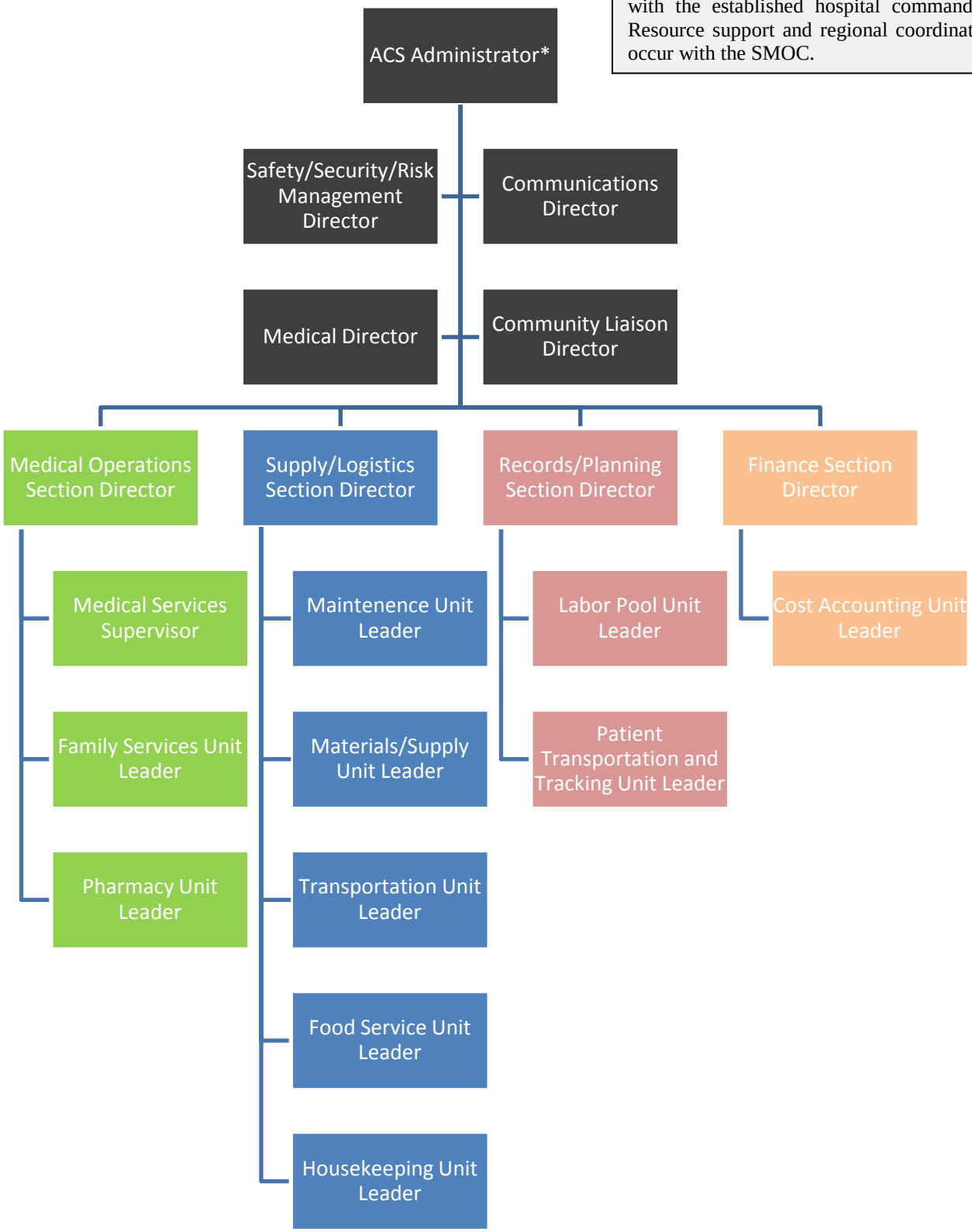
The communications section will issue two-way radios and/or cell phones at the beginning of each shift and collect them at the end of the shift. The communications director will announce the radio channel to be used at the beginning of each shift. Radio messages will be short, concise, and begin with a sector identifier. The ICS 205 form can be utilized to document

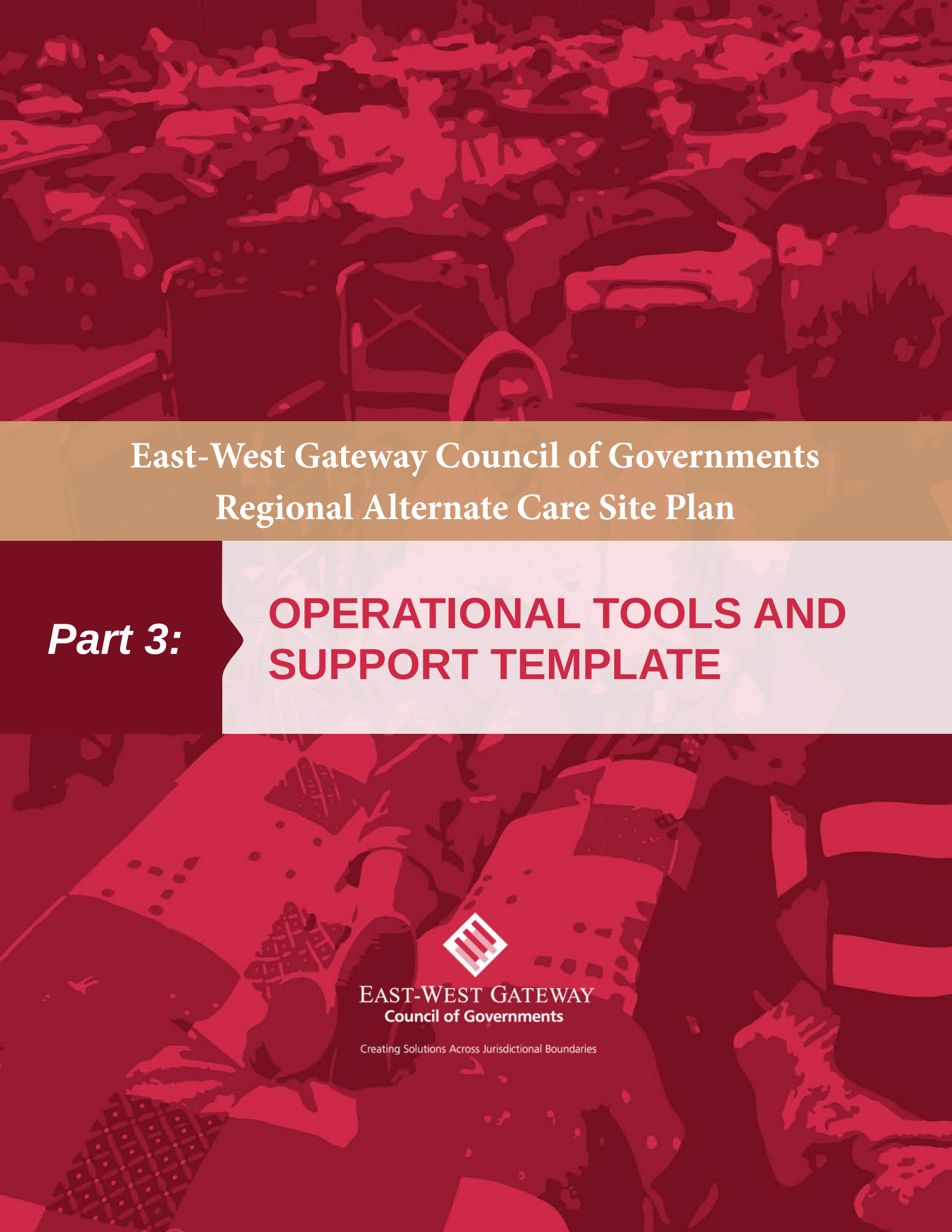
incident radio channels. In the absence of radios or cell phones, face-to-face communication, runners, and the written communication using the ICS 213 form shall be used. Voice amplification systems (bullhorn, public address system) should be appropriately used, if available.

8.3 ACS Organizational Structure

The organizational chart displayed below highlights the essential functions needed to carry out ACS operations. The chart is based on ICS principles, and therefore, the number of actual positions that are individually staffed is scalable based on operational needs, span of control, and resources available. In many cases, the situation will not require individual staffing for each function listed in the functional chart. In keeping with ICS principles, any function not staffed is rolled up into the responsibility of the next higher level of management. Appendix 1 provides job action sheets for each of the positions within the ACS organizational structure (found on the next page).

* ACS Administrator will report to and coordinate with the established hospital command center. Resource support and regional coordination will occur with the SMOC.





East-West Gateway Council of Governments
Regional Alternate Care Site Plan

Part 3:

OPERATIONAL TOOLS AND SUPPORT TEMPLATE

EAST-WEST GATEWAY
Council of Governments

Creating Solutions Across Jurisdictional Boundaries

Section 9
Staffing Plan

9.1 General Staffing Management Strategy

The Alternate Care Site (ACS) Staffing Plan encompasses both clinical roles and nonclinical staff. This includes site set-up, site administration, clinical operations, support functions, and command staff. It is important that ACS staff understand the incident may require them to fill various positions and take on new responsibilities over time.

Staff Planning

If activated, it is assumed that staff planning should project out a minimum of seven days of operation. In the initial stages of response, ACS hours are generally assigned as two 12-hour shifts per day. The benefit of a longer shift is that it provides consistency for ACS management and patients and is generally more efficient coordination because of comfort with operations. Staff should remain assigned to the same site for the duration of the operation or until their skills are no longer required. ACS management should also enforce a system for mandatory breaks to prevent overwork.

Staff should ensure that they arrive at the ACS for their shift in sufficient time to overlap with outgoing staff for the shift debrief or as dictated by the hospital. Upon arrival, staff should sign in and record their time worked on a timesheet in addition to using whatever system is currently operationalized by the host hospital. Detailed record keeping is essential to tracking associated costs for the potential reimbursement of expenses.

Staff-to-patient ratios are an important consideration for clinical operations. Where applicable, this ratio can be guided by union contract parameters. The staffing pattern should be adjusted based on the site layout, as well as the actual number and needs of individuals and availability of resources. Levels of care and specific operational care categories within the ACS dictate the number and type of staff present; thus, continual assessment is required to ensure adequate support. It is important to note that although a baseline ACS layout encompasses a 25 bed subunit, this approach can be scaled up or down based on incident needs in accordance with the appropriate Operational Approach. To scale staffing needs up as the ACS capacity grows, multiply each staffing allocation by the number of 25 bed increases.

The table below outlines the suggested minimum staffing for an ACS, to include additional surge staffing considerations for the following specialized areas:

- Emergency Room (ER)
- Skilled Nursing Facility (SNF)
- Orthopedics (Ortho)
- Obstetrics (OB)
- Pediatrics (Pedi)
- Infection Control (IC)
- Mental Health (MH)

Table 3: Suggested Minimum Staffing Considerations per 12-hour Shift for a 25 bed subunit for ACS and ACS+Specialty Area

Assignment	Priority	ACS	+ER	+SNF	+Ortho	+OB	+Pedi	+IC	+MH
Physician	High	1	1	1	1	1	2	1	1
Physician extender (PA/NP)	High	1	1	1	2	2	2	1	1
RNs or RNs/LPNs	High	3	5	3	5	5	5	5	5
Health technicians	High	2	2	2	1	1	1	2	2
Unit secretaries	Medium	1	1	1	1	1	1	1	1
Respiratory therapist	Medium	1	1	1	0	0	1	2	0
Case manager	Medium	1	1	1	1	1	1	1	2
Social worker	Medium	1	1	1	0	0	0	0	2
Housekeepers	Medium	1	1	1	1	1	1	1	1
Lab personnel	Low	1	1	1	0	1	1	1	1
Medical assistant/phlebotomy	Low	1	1	1	0	0	0	1	1
Food service	Low	1	1	2	0	0	1	1	1
Chaplain/pastoral	Low	1	1	1	0	1	1	1	1
Volunteers/care assistants	Medium	2	2	2	1	1	1	1	1
Engineering/maintenance	Medium	1	1	1	1	1	1	1	1
Biomed-to set up equipment	High	1	1	1	1	1	1	2	1
Security	Medium	1	1	1	1	1	1	1	1
Patient transporters	Medium	1	1	1	1	1	1	1	1
Total ACS staff / 12-hour shift:	-	22	24	23	17	19	22	24	24

Coordination between Emergency Support Function (ESF) #6 and ESF #8

Continual coordination with emergency management, specifically ESF #6 – Mass Care and ESF #8 – Health and Medical, will enhance overall ACS operations. ESF #6 and #8 can, in some cases, provide emergency staffing support to supplement hospital ACSs and can also ensure coordination is happening across the region in a significant catastrophic incident.

In addition, it is recommended that hospitals establish an emergency medical services (EMS) field liaison to coordinate emergency response in the field with incoming client flow for a hospital ACS. Coordination between field operations and ACS operations ensures that capability and capacity of an ACS is managed in real-time and can inform decisions of whether or not to open up additional ACSs or reroute clients to different area hospitals.

Sources for Surge Staffing

A hospital's first option to address staffing demands is to depend on their existing staff (e.g., increasing the number of hours per work shift, calling back staff who have been on leave, etc.) and reassign non-essential roles (e.g. educators, public outreach, etc.). When hospitals have maximized the productivity of their existing staff the next option would be to call upon external sources for temporary staff, as they normally would when there is a staff shortage. Hospital human resources and

medical staff departments should use existing processes for contacting these sources. Additional sources of temporary staff may include nurse agencies and locum tenens registries. Once these sources are exhausted, additional staffing resources will be requested through the St. Louis Medical Operations Section (SMOC) structure under the mechanisms outlined in the *Hospital Mutual Aid Agreement, Memorandum of Understanding*.

Staff Training

Just-in-time training refers to rapid training courses designed to familiarize staff with processes and operations. This training must occur prior to staff engaging in operational activities, and should cover the operations and administration of the ACS as well as instructions on using equipment, medical supplies, and other materials. In addition, jurisdictions should consider their just-in-time training needs and develop the appropriate courses prior to the incident. On-site and/or just-in-time training courses may include:

- Site operations and procedures.
- Patient tracking and patient valuables tracking.
- Report procedures, check-in procedures, and credentialing.
- Personal protective equipment, medical evaluation and testing, infection control, and fit testing.
- Medical records keeping, storage, and chain of command.
- Communication procedures.
- Procedures for obtaining prescriptions.
- 911 protocols.
- Logistics.

Credentialing and Personnel Verification for Clinical Staff

The St. Louis Region will rely on the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) system for credentialing of clinical staff, including: Missouri Show-Me Response (https://www.showmeresponse.org/) and Illinois Helps (https://www.illinoishelps.net/). Coordination with state and local administrators for appropriate credential validation and personnel deployment prior to arriving is highly recommended. It is recommended that this occur away from the ACS site at a location focused on the administrative processing of incident-related volunteers or with the host hospital's human resources department. At the ACS, the ACS administrator will verify that all licensed professionals arriving to work at the ACS have the required credentials according to local policy and procedures. On-site accreditation and credentialing is not recommended.

Medical Director

The host hospital should identify the medical director for the ACS. This individual, which should be filled by a licensed physician, is essential to the medical direction and medical authority for clinical staff operations within the ACS. The medical director should be available for the duration of the ACS operation for medical consultation, which can occur virtually or in person. This individual should be prepared to serve in an advisory role for all clinical staff and it is recommended he/she be board certified in the ACS category deployed (e.g., Emergency Department (ED), Ortho, OB, etc.). Guidance from the medical director may be sought whenever clinical staff needs physician consultation.

ACS Management

All management activities within an ACS should be facilitated through the staffing plan command structure outlined in the ACS Organizational Chart. Utilization of this structure will facilitate the integration of all ACS staff into a single incident action plan. This coordination of effort will result in optimum medical care.

Setup Staff

The number of staff required to set up the ACS is included the staffing projections above. Factors to consider in setting up an ACS include, but are not limited to: site conditions, ease of cleaning, accessibility, Americans with Disabilities Act (ADA) compliance, availability of storage, and ability to lock valuables and medications. Resources from non-clinical sources may be sought to assist with setting up the ACS. In some instances, jurisdictions may wish to pursue memorandum of understanding agreements and vendor agreements to support ACS activities. Setup staff should be given detailed instruction on how to appropriately establish the site. Layout schematics may help; a sample is available in this plan. Setup is generally overseen by the ACS administrator, who has the ultimate responsibility to ensure that the site is prepared to receive patients.

Support Staff

An ACS will require the participation of numerous support staff. The services such staff may need to provide include, but are not limited to, administrative, food service, child care, laundry, traffic control, security, engineering, housekeeping, transportation, and facility maintenance.

9.2 ACS Staffing Communications Protocols

Within the ACS and consistent with all operational approaches, a strong communication infrastructure must be present for adequate and timely notifications to outside agencies and personnel.

During active operational periods, the ACS will maintain communication with the agencies listed below. For more information, consult the Coordination with External Agencies section.

- SMOC
- ESF-8
- Local EMAs
- Supporting hospitals
- Supporting patient transportation agencies

Types of communication methods used within the ACS include:

- Telephones (land line).
- Cell phones.
- Email.
- Fax.
- Radios.
- Satellite phones.
- Pagers.
- Amateur radio.

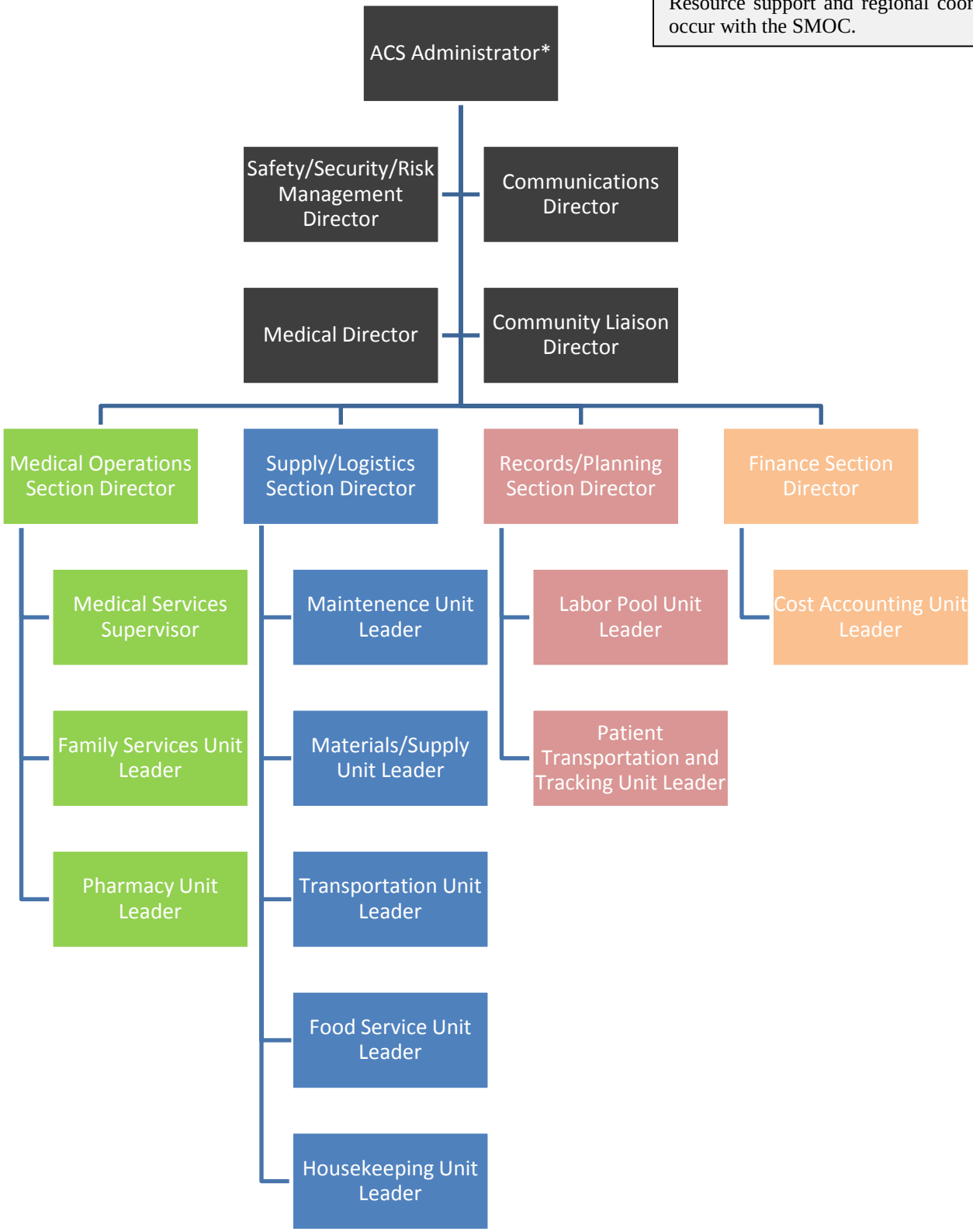
The communications director will issue two-way radios and/or cell phones at the beginning of each shift and collect them at the end of the shift. The communication director will announce the radio channel to be used at the beginning of each shift. Radio messages will be short, concise and begin with a sector identifier. The Incident Command System (ICS) 205 form can be utilized to document incident radio channels.

In the absence of radios or cell phones, face-to-face communication, runners, and the written communication using the ICS 213 form shall be used. Voice amplification systems (bullhorn, public address system) should be appropriately used, if available.

9.3 ACS Organizational Structure

The organizational chart displayed below highlights the essential functions needed to carry out ACS operations. The chart is based on ICS principles, and therefore, the number of actual positions that are individually staffed is scalable based on operational needs, span of control, and resources available. In many cases, the situation will not require individual staffing for each function listed in the functional chart. In keeping with ICS principles, any function not staffed is rolled up into the responsibility of the next higher level of management. Appendix 1 provides job action sheets for each of the positions within the ACS Organizational Structure (found on the next page).

* ACS Administrator will report to and coordinate with the established hospital command center. Resource support and regional coordination will occur with the SMOC.



10.1 Appendix 1: Job Action Sheets

The following pages present sample job action sheets for each potential operator of the 25-bed ACS. The job action sheets outline specific tasks for each operator within the ACS structure in accordance with the organization chart in the previous section. Each set of activities is broken out into the following Operational Phases:

- Activation and Mobilization
- Site Operations
- Demobilization

For purposes of these job action sheets, activation and mobilization phase activities have been grouped to indicate the set of initial actions required when triggering an ACS. Note that these job action sheets are not comprehensive and should be reviewed and modified prior to inclusion in any specific hospital ACS plan.

Command Staff Job Action Sheets

The following job action sheets encompass the duties of the command staff for each phase of ACS operations. These positions are a suggested minimal number for the deployment of the 25-bed Alternate Care Site. The command staff for an ACS includes the following roles:

- ACS Administrator
- Safety/Security/Risk Management Director
- Medical Director
- Communications Director
- Community Liaison Director

ACS Administrator

Name _____

Date _____

Shift _____

Reports to: Hospital Command Center/SMOC

Direct Reports: Security/Safety Director; Medical Director; Communications Director; Community Liaison Director; Medical Operations Section Director; Supply/Logistics Section Director; Records/Planning Section Director; and Finance Section Director

Mission:
Organize and direct the establishment, staffing, and overall operations of the ACS, including financials, documentation, supplies, logistics, and operations. Manage and supervise the day-to-day operations of the ACS in accordance with pre-determined policies and procedures.

	Action Checklist	Time Task Completed
	Activation and Mobilization	
☐	Obtain a situation briefing from the Hosptial Command Center/SMOC, or as instructed.	
☐	Provide staffing needs to the labor pool.	
☐	Read this entire job action sheet (and, if time, ACS plan), sign in, and review the ACS organizational chart.	
☐	Retrieve position identification (identification [ID] badge, vest, etc.) and wear at all times while on duty.	
☐	Appoint all command staff and distribute job action sheets.	
☐	Appoint all section directors and distribute the section packets that contain the following: ▪ Job action sheets for each position. ▪ Identification for each position (ID badge, vest, etc.). ▪ ICS/HICS forms pertinent to section and positions.	
☐	Ensure that staffing is secured for the next two 12-hour shifts using suggested staff-to-client ratios from ACS Staffing Plan.	
☐	Establish routine conference call schedule with Hospital Command Center/SMOC.	
☐	Announce a schedule of status/action plan meetings of all section directors.	
☐	Assemble and discuss the Initial Action Plan with section directors and unit leaders as the ACS is physically established. Determine appropriate level of care to be provided in the ACS based on planning guidance from the SMOC.	
☐	Obtain anticipated patient volume and acuity from Hospital Command Center/SMOC.	
☐	If co-located, coordinate shared logistics and client flow with the shelter management team.	

☐	Conduct a site walk-through to identify ingress, emergency egress, client flow, ADA accommodations, client capacity (and caregiver), areas for secured supply and pharmaceutical storage, support provisions.	
☐	Ensure that ADA accommodations exist for people with disabilities, which may include providing an on-site access specialist, personal care attendants, language interpreters, proper signage and/or a physical room for wheelchair/scooter space, toileting, and physical access abilities.	
☐	Coordinate with medical operations section director to ensure patient care operations are adequate before opening (e.g. staff, beds, etc.)	
☐	Coordinate with supply/logistics section director to ensure materials/supplies, transportation, food services, and housekeeping services are adequate before opening.	
	Coordinate with records/planning section director to ensure adequacy of labor plans and internal transport assistance before opening.	
	Coordinate with finance section to ensure adequate accounting processes are in place.	
☐	Establish shift transition procedures and times (e.g., 06:45 and 18:45)	
☐	Give an initial briefing with all direct reports. Cover the following: a summary of the incident, established level of care and goals for service, ACS set-up, ACS protocols, checklists and action plans; guidelines for ACS visitors, and media. Explain the process for resource requesting; plans for briefings, breaks, and shift transitions; and documentation and reports. Review Incident Command and "Chain of Command".	
☐	Once walk-through is completed and cache has been delivered, supervise the physical set-up of the ACS.	
☐	Establish contact and resource information with outside agencies through the community liaison director.	
☐	Other: _____	

Site Operations		
☐	Work with medical operations section director and medical director to determine medical priorities for the level of health care delivered.	
☐	Authorize resources as needed or requested by section directors.	
☐	Conduct detailed coordination with records/planning section to ensure that clients meet the level of care required and to ensure that the ACS works within capacity for space, clients, and staffing.	
☐	Establish routine briefings with section directors to receive status reports and update the Incident Action Plan regarding the continuance and termination of the IAP.	
☐	Communicate status of the ACS (e.g., bed availability, staffing, etc.) to the SMOC duty officer.	
☐	Conduct tours of facility every four hours to identify problems, treatment or capacity limitations, sanitation, or need for expanded resources; brief SMOC as directed.	
☐	Coordinate with medical operations section director and family service unit leader to implement ACS guidelines for visitors.	
☐	Other: _____	

Demobilization		
☐	Coordinate disposition of clients, including arranging transportation with logistics section director and collecting client information for follow up if necessary.	

☐	Supervise the physical demobilization of the ACS.	
☐	Assure sections complete all required section reports/ICS/HICS forms and turn them in to the appropriate agency/authority.	
☐	Conduct detailed demobilization briefing with all command and general staff before executing demobilization actions.	
☐	Coordinate community needs with Hospital Command Center/SMOC before executing demobilization actions.	
☐	Conduct exit interviews with subordinate staff.	
☐	Lead the after-action process (briefings, reports, etc.).	
☐	Assure personnel complete all required section reports/forms and turn them in to the appropriate agency/authority.	
☐	Create and distribute after-action report.	
☐	Collect all position identifications (ID badge, vest, etc.).	
☐	Other: _____	

Safety/Security/Risk Management Director

Name _____

Date _____

Shift _____

Reports to: ACS Administrator

Subordinates: none

Mission:
Monitor and have authority over the safety of patients, visitors, and staff in the ACS. Organize and enforce facility protection and traffic security. Oversee risk management practices at the ACS; take measures to manage or eliminate any identified risk.

	Action Checklist	Time Task Completed
	Activation and Mobilization	
☐	Report to ACS site following appointment by ACS administrator. Review plans and checklists.	
☐	Read this entire job action sheet (and, if time, the ACS plan); sign in, and review the ACS organizational chart.	
☐	Retrieve position identification (ID badge, vest, etc.) and wear at all times while on duty.	
☐	Conduct an ACS walk through to identify ingress, emergency egress, client flow, ADA accommodations, client capacity (and caregiver), secured areas for supply and pharmaceutical storage, and support provisions.	
☐	Accountable for emergency evacuation, identifying emergency exits, fire extinguishers, and signage. Provide emergency procedure orientation to all staff before first shift.	
☐	Meet with all general staff and ACS administrator for initial briefing.	
☐	Responsible for ensuring a safe setup for the ACS. Supervises set-up with the supply/logistics section director.	
☐	Ensure that the ACS is adequately supplied with items for PPE protection, ATD protection, infection control and general sanitation. Discuss any identified gaps in inventory with supply/logistics section director.	
☐	Ensure that ADA accommodations exist for people with disabilities, which may include providing an on-site access specialist, personal care attendants, language interpreters, proper signage and/or a physical room for wheelchair/scooter space, toileting and physical access abilities.	
☐	Assist ACS administrator with just-in-time training, especially as it relates to safety issues, PPE, and emergency procedures.	
☐	Consult with facility or building experts to ensure adequate room air flow; consult expert to evaluate positive and negative pressure operations particularly if isolation and quarantine strategies are implemented.	
☐	Establish ambulance entry and exit routes in cooperation with transportation unit leader.	
☐	Set up and maintain area for biohazard waste collections in conjunction with housekeeping unit leader.	

☐	Working with housekeeping unit leader, ensure an area for proper disinfection of reusable equipment and surfaces.	
☐	Ensure back up coverage with sufficient supplies to carry out safety duties for the next 12-24 hours.	
☐	Other: _____	

Site Operations		
☐	Stop unsafe activities.	
☐	Conduct tours of ACS at set up, every three hours, and during operations to identify unsafe practices, monitor food and safe drinking water standards, building system status, proper ATD protection, infection control procedures, general sanitation, and potential shortages in safety supplies.	
☐	Mitigate minor problems and consult with ACS administrator to mitigate major hazards. Coordinate with housekeeping unit leader for any sanitation mitigations.	
☐	Monitor ACS staff for fatigue and stress. Report any problems to the ACS administrator.	
☐	Complete personnel reports, such as incident reports and/or workers' compensation reports and blood borne pathogen exposure reports. Ensure that reports are submitted and filed. Follow up on report status.	
☐	Work with supply/logistics section director to ensure that facility common areas are routinely disinfected, including door handles, railings, bathrooms, etc.	
☐	Ensure staff follows recommended guidelines for disinfection of surfaces and sanitation of client bedding areas, especially before admitted or after discharged.	
☐	May authorize, assign, and supervise a security officer to identify and remove unauthorized persons from the ACS or restricted areas.	
☐	Consult with facility or building experts to ensure adequate room air flow; consult expert to evaluate positive and negative pressure operations particularly if isolation and quarantine strategies are implemented.	
☐	Ensure back up coverage with sufficient supplies to carry out safety duties for the next 12-24 hours.	
☐	Obtain support staff as necessary from labor pool.	
☐	Observe all staff, volunteers, and patients for signs of stress and inappropriate behavior. Report concerns to the labor pool unit leader. Provide for staff rest periods and relief.	
☐	Other: _____	

Demobilization		
☐	Ensure facility is secure until all activities are complete and physical plane is released to pre-ACS conditions.	
	Assist in demobilizing the ACS. Ensure staff safety.	
	Participate in the after-action process (briefings, reports, etc.).	
☐	Assure personnel complete all required section reports/forms and turn them in to the appropriate agency/authority.	

☐	Turn in position identification (ID badge, vest, etc.).	
☐	Other: _____	

Medical Director

Name _____

Date _____

Shift _____

Reports to: ACS Administrator

Subordinates: none

Mission:
Responsible for the direct administration, coordination and delivery of health/medical services in the ACS. The medical director should have current medical license as a MD/PA/NP with emergency care experience or other based upon ACS level of care.

	Action Checklist	Time Task Completed
	Activation and Mobilization	
☐	Check in upon arrival at the ACS.	
☐	Read this entire job action sheet (and, if time, the ACS plan), sign in, and review the ACS organizational chart.	
☐	Retrieve position identification (ID badge, vest, etc.) and wear at all times while on duty.	
☐	Ensure process for documentation or assessment and medical orders.	
☐	Determine level of care and care limitation of the ACS.	
☐	Establish transfer protocols for higher level of care needs.	
☐	Report to ACS administrator for briefing	
☐	Other: _____	

	Site Operations	
☐	Review the Incident Action Plan. Determine the specific staff to be activated in order to achieve the mission.	
☐	Ensure appropriate staff is assigned to ACS.	
☐	Provide direction to ACS staff.	
☐	Ensure licensure medical practitioners' assessments and interventions are completed, as appropriate.	
☐	Conduct periodic briefings.	
☐	Approve standard nursing protocols for the ACS staff.	
☐	Approve all medical procedures performed at the ACS.	
☐	Supervise or provide diagnosis and treatment orders for acute illnesses that occur among patients of the ACS.	

☐	Convene a meeting for all MD/PA/NP staff; communicate Incident Action Plan and assign tasks.	
☐	Obtain support staff as necessary from labor pool.	
☐	Observe all staff, volunteers, and patients for signs of stress and inappropriate behavior. Report concerns to the labor pool unit leader. Provide for staff rest periods and relief.	
☐	Other: _____	

Demobilization	
☐	Complete all required forms, reports, and other documentation. All forms should be submitted through your supervisor to the planning section, as appropriate, prior to your departure.	
☐	Deactivate staff as conditions allow.	
☐	Participate in the after-action process (briefings, reports, etc.).	
☐	Assure personnel complete all required section reports/ forms and turn them in to the appropriate agency/authority.	
☐	Turn in position identification (ID badge, vest, etc.).	
☐	Evaluate all patients and complete an assessment prior to discharge, transfer, and closing the ACS.	
☐	Other: _____	

Communications Director

Name _____

Date _____

Shift _____

Reports to: ACS Administrator

Subordinates: none

Mission:
Organize and coordinate internal and external communications; ensure provision of information technology; act as custodian of all logged and documented communications; ensure all communications are coordinated with Hospital Command Center/SMOC.

	Action Checklist	Time Task Completed
	Activation and Mobilization	
☐	Receive appointment from ACS administrator.	
☐	Read this entire job action sheet (and, if time, ACS plan), sign in, and review the ACS organizational chart.	
☐	Retrieve position identification (ID badge, vest, etc.) and wear at all times while on duty.	
☐	Report to ACS site. Read this entire job action sheet, sign in, and review the ACS organizational chart. Review plans and checklists.	
☐	Meet with all general staff and ACS administrator for initial briefing.	
☐	Retrieve position identification (ID badge, vest, etc.) and wear at all times while on duty.	
☐	Obtain briefing from ACS administrator. Assist ACS administrator with just-in-time training, as it relates to media relations and protocols.	
☐	Review and follow communications director protocols and instructions established by the Hospital Command Center/SMOC.	
☐	Assess current status of internal and external telephone systems, radios or other communications technology and report to ACS administrator.	
☐	Ensure information technology requirements at the ACS are met or coordinated with appropriate information technology staff.	
☐	Establish and maintain an area to track events, review PSAs, check media and handle public media requests.	
☐	Ensure distribution of two-way radios or other communications devices to pre-designated areas.	
☐	Receive and hold all documentation related to internal facility communications.	
☐	Ensure that language for ACS signage is appropriate. Help draft new language for signage as needed.	
☐	Ensure that signage and/or forms are made available in larger print or multiple languages, as needed.	

☐	Ensure that translation services or interpretation are made available to the clients, as needed. Ensure that TTY or sign language is available as needed.	
☐	Other: _____	

Site Operations		
☐	Establish and maintain an area to track events and handle public media requests.	
☐	Ensure that signage and/or forms are made available in larger print or multiple languages, as needed.	
☐	Coordinate with SMOC for all PIO releases.	
☐	In conjunction with ACS administrator, prepare regular statements for clients to keep them informed and updated on emergency status and information.	
☐	Keep ACS administrator advised of all unusual requests for information and all critical or unfavorable media comments. Work with ACS administrator, as necessary, to respond to any media coverage.	
☐	Establish strategies for rumor control within ACS.	
☐	Coordinate on-site visits with Hospital Command Center/SMOC, as appropriate.	
☐	Set up in-person interviews between media and ACS personnel or clients if requested.	
☐	In conjunction with ACS administrator and Hospital Command Center/SMOC, ensure that the media has limited access to the ACS and follows the following rules while onsite: ▪ Media may visit ACS by appointment only. ▪ Media must be escorted by communications director or staff member at all times while on site ▪ Media must display press badges at all times. ▪ Media may only photograph clients or staff after consent form has been completed.	
☐	Ensure that all clients agree to complete a consent form before being photographed.	
☐	Ensure that HIPAA privacy for clients is protected in all media relations.	
☐	Brief ACS administrator on all PIO activity.	
☐	May provide instructions to ACS staff on disposition of any media request for information.	
☐	Obtain support staff as necessary from labor pool.	
☐	Observe all staff, volunteers, and patients for signs of stress and inappropriate behavior. Report concerns to the labor pool unit leader. Provide for staff rest periods and relief.	
☐	Other: _____	

Demobilization		
☐	Specified by ACS administrator.	
☐	Participate in the after-action process (briefings, reports, etc.).	
☐	Assure personnel complete all required section reports/forms and turn them in to the appropriate agency/authority.	
☐	Turn in position identification (ID badge, vest, etc.).	

☐	Other: _____	

Community Liaison Director

Name _____

Date _____

Shift _____

Reports to: ACS Administrator

Subordinates: none

Mission:
Coordinate with external organizations and agencies that may be impacted by the ACS or that impact the ACS.

	Action Checklist	Time Task Completed
	Activation and Mobilization	
☐	Report to the ACS site, following appointment.	
☐	Read this entire job action sheet (and, if time, ACS plan), sign in, and review the ACS organizational chart.	
☐	Retrieve position identification (ID badge, vest, etc.) and wear at all times while on duty.	
☐	Attend briefing held by ACS administrator.	
☐	Review ACS plans and checklists.	
☐	Meet with general staff and ACS administrator for initial briefing.	
☐	Other: _____	

	Site Operations	
☐	Responsible for all communications with outside agencies (e.g. EMS, faith-based organizations, NGOs, etc.)	
☐	Participate in planning meetings to formulate and evaluate the Incident Action Plan.	
☐	Respond to requests and complaints from incident personnel regarding inter-agency issues.	
☐	Relay any special information obtained to appropriate personnel in the receiving facility (e.g., information regarding toxic decontamination or any special emergency conditions).	
☐	Keep agencies supporting the incident response aware of the ACS status.	
☐	Monitor the incident to identify current or potential inter-organizational problems.	
☐	Obtain support staff as necessary from labor pool.	
☐	Observe all staff, volunteers, and patients for signs of stress and inappropriate behavior. Report concerns to the labor pool unit leader. Provide for staff rest periods and relief.	

☐	Other: _____	

Demobilization		
☐	Ensure all records and reports are submitted to support organizations coordinator.	
☐	Close the loop with external agencies regarding any pending communications issues.	
☐	Participate in the after-action process (briefings, reports, etc.).	
☐	Assure personnel complete all required section reports/ forms and turn them in to the appropriate agency/authority.	
☐	Turn in position identification (ID badge, vest, etc.).	
☐	Participate in debriefing with ACS administrator.	
☐	Other: _____	

Medical Operations Section Job Action Sheets

The following job action sheets encompass the duties of the medical operations section staff for each phase of the 25-bed ACS operations. The medical operations section for an ACS includes the following roles:

- Medical Operations Section Director
- Medical Services Supervisor
- Family Services Unit Leader
- Pharmacy Unit Leader

Medical Operations Section Director

Name _____

Date _____

Shift _____

Reports to: ACS Administrator

Subordinates: Nursing Subunit Coordinator, Family Services Unit Leader, Pharmacy Unit Leader

Mission:
In conjunction with medical practitioners, organize and deliver all medical care in all areas of the ACS.

	Action Checklist	Time Task Completed
	Activation and Mobilization	
☐	Report to ACS site. Review plans and checklists.	
☐	Appoint and brief all subordinates.	
☐	Read this entire job action sheet (and, if time, ACS plan), sign in, and review the ACS organizational chart.	
☐	Retrieve position identification (ID badge, vest, etc.) and wear at all times while on duty.	
☐	Provide staffing needs to the labor pool.	
☐	If needed, assist the ACS administrator in conducting an ACS walk through to identify ingress, emergency egress, client flow, ADA accommodations, client (and caregiver) capacity, areas for secured supply and pharmaceutical storage, and support provisions.	
☐	Meet with ACS administrator on level of care and clinical patient expectations.	
☐	Establish medical orders and intervention process with medical director.	
☐	Establish transfer protocols and documentation needs with transportation leader.	
☐	Establish pharmaceutical and supply request process with supply/logistics section director.	
☐	Ensure documentation procedures for all patient contact/care/intervention.	
☐	Meet with all general staff and ACS administrator for Initial Briefing.	
☐	Ensure that medical and nursing stations are in place, staffing levels are sufficient and supplies are available before opening of ACS. Consult with the medical operations section director as necessary.	
☐	Assist the ACS administrator and medical operations section director with the just-in-time training by providing direction on specific nursing procedures, e.g., use of PPE, communicable diseases, isolation/quarantine, or infection control measures.	
☐	Ensure that ADA accommodations exist for people with disabilities, which may include providing an on-site access specialist, personal care attendants, language interpreters, proper signage and/or a physical room for wheelchair/scooter space, toileting, and physical access abilities.	

☐	Ensure sufficient staffing-to-client ratio. Monitor capacity to provide health care services as ACS capacity increases. Advise ACS Administrator when ACS reaches 70% of capacity.	
☐	Other: _____	

Site Operations		
☐	Trouble shoot communications issues with communication director.	
☐	Consult with medical director for approval of all extraordinary medical procedures and evaluation for higher level of care transfer	
☐	Coordinate the clinical staffing support and ensure that all medical personnel (e.g., RNs, LVNs, MA's, CNAs, HSA's) are working within the scope of clinical care for ACS.	
☐	Oversee clinical staff in their duties.	
☐	Working with the transportation leader, ensure all patients are tracked for admission, discharge, transfer, etc.	
☐	With the medical operations director and/or ACS administrator, assess the need for access to specialists and/or the provision of special medical, nursing, or other health care services on site; direct and supervise subordinate units in obtaining access to and delivery of these special services.	
☐	Assist in patient transfer, as appropriate.	
☐	Receive requests for medical supplies and/or pharmaceuticals from subordinates.	
☐	In conjunction with supply/logistics section director, anticipate the need for additional supplies or medication at 12-, 24-, and 36-hour periods.	
☐	Obtain support staff as necessary from labor pool.	
☐	Observe all staff, volunteers, and patients for signs of stress and inappropriate behavior. Report concerns to the labor pool unit leader. Provide for staff rest periods and relief.	
☐	Other: _____	

Demobilization		
☐	Ensure all logs, reports, and actionable documentation are completed.	
☐	Ensure all patient records are completed.	
☐	Ensure all patient movements have been tracked.	
☐	Participate in the after-action process (briefings, reports, etc.).	
☐	Ensure personnel complete all required section reports/forms and turn them in to the appropriate agency/authority.	
☐	Turn in position identification (ID badge, vest, etc.).	
☐	Other: _____	

Medical Services Supervisor

Name _____

Date _____

Shift _____

Reports to: Medical Operations Section Director

Subordinates: RNs/LVNs

Mission:
Ensure treatment of all patients and manage the patient care area(s). Complete documentation of entire patient encounter.

	Action Checklist	Time Task Completed
	Activation and Mobilization	
☐	Participate in just-in-time training to obtain detailed information about the nature of the incident and about your clinical role.	
☐	Read this entire job action sheet (and, if time, ACS plan), sign in, and review the ACS organizational chart.	
☐	Retrieve position identification (ID badge, vest, etc.) and wear at all times while on duty.	
	Other: _____	

	Site Operations	
☐	Remain on site during 12-hour shift.	
☐	Provide nursing care, nursing support and comfort measures (including the care provided by unlicensed assistive personnel) in accordance to standard of nursing practice and within scope of nursing practice.	
☐	Help with just-in-time training and competency testing as necessary.	
☐	RN/NP/LVNs conduct rounds on all clients as appropriate based upon acuity and care needs.	
☐	Nursing support personnel will conduct rounds no less than every two hours and report any client who is becoming unstable.	
☐	Receive and/or implement provider orders for treatment or medications.	
☐	Ensure patient tracking is completed.	
☐	Ensure ACS guidelines are followed and reports any unsafe acts. Identify any health concerns or sanitation issues.	
☐	Ensure clients receive approved follow-up information, medication information, aftercare for ACS care and all personal possessions upon discharge from the ACS, and document accordingly.	
☐	Document all actions taken on behalf of client in client disaster record (e.g., nursing care, medications, or treatment administered).	

☐	Obtain support staff as necessary from labor pool.	
☐	Observe all staff, volunteers, and patients for signs of stress and inappropriate behavior. Report concerns to the labor pool unit leader. Provide for staff rest periods and relief.	
☐	Other: _____	

Demobilization	
☐	Specified by ACS administrator.
☐	Ensure each patient is assessed upon transfer or discharge.
☐	Participate in the after-action process (briefings, reports, etc.).
☐	Assure personnel complete all required section reports/forms and turn them in to the appropriate agency/authority.
☐	Turn in position identification (ID badge, vest, etc.).
☐	Other: _____

Family Services Unit Leader

Name _____

Date _____

Shift _____

Reports to: Medical Operations Section Director

Subordinates: none

Mission:
Ensure the availability of social services, victim assistance activities, referral, translator services, and child care.

	Action Checklist	Time Task Completed
	Activation and Mobilization	
☐	Receive appointment from medical operations director.	
☐	Read this entire job action sheet (and, if time, the ACS plan), sign in, and review the ACS organizational chart.	
☐	Retrieve position identification (ID badge, vest, etc.) and wear at all times while on duty.	
☐	Receive briefing from medical operations section director with other subsection unit leaders; develop a subsection action plan.	
☐	Provide an area separate from patient care areas for family members and visitors to sit and relax.	
☐	Other: _____	
	Site Operations	
☐	Coordinate with security/safety director on all visitor hours and plans.	
☐	Coordinate social services and victim assistance activities.	
☐	Coordinate for child care and/or translator services, if needed.	
☐	Assist family with access to community resources.	
☐	Obtain support staff as necessary from labor pool.	
☐	Observe and assist all staff, volunteers, and patients for signs of stress and inappropriate behavior. Report concerns to the Labor Pool Unit Leader. Provide for staff rest periods and relief.	
☐	Other: _____	
	Demobilization	
☐	Conduct exit interviews with direct reports.	

☐	Participate in the after-action process (briefings, reports, etc.).	
☐	Assure that personnel complete all required section reports/forms and turn them in to the appropriate agency/authority.	
☐	Turn in position identification (ID badge, vest, etc.).	
☐	Other: _____	

Pharmacy Unit Leader

Name _____

Date _____

Shift _____

Reports to: Medical Operation Section Director

Subordinates: none

Mission:
Ensure the availability of emergency, incident-specific, pharmaceutical and pharmacy services.

	Action Checklist	Time Task Completed
	Activation and Mobilization	
☐	Initiate and maintain log of events and key actions.	
☐	Read this entire job action sheet (and, if time, ACS plan), sign in, and review the ACS organizational chart.	
☐	Retrieve position identification (ID badge, vest, etc.) and wear at all times while on duty.	
☐	Obtain briefing from medical operations section director.	
☐	Verify inventory (medical supplies and nonprescription medications) for ACS.	
☐	Verify appropriate secured space for supplies, as needed. Items requiring refrigeration are to be stored in a secured refrigerator with access allowed only to ACS staff.	
☐	Review example medication listing.	
☐	Coordinate with Hospital Command Center/SMOC pharmacy lead on medication order process.	
☐	Mobilize all staff that will be assisting in pharmacy services at the ACS.	
☐	Determine as soon as possible whether mobile pharmacies should be requested and if so, how many and to which locations. Alert the participating pharmacy chains as well as local pharmacies.	
☐	Obtain support staff as necessary from labor pool.	
☐	Observe all staff, volunteers, and patients for signs of stress and inappropriate behavior. Report concerns to the labor pool unit leader. Provide for staff rest periods and relief.	
☐	Other: _____	

	Site Operations	
☐	Maintain updated lists of inventory (medical supplies and nonprescription medications) for ACS.	
☐	Document/maintain log of pertinent events and incidents.	
☐	Coordinate with pharmaceutical suppliers: local pharmacy, public health pharmacy, and/or mobile pharmacy.	

☐	Establish offsite discharge medication refill (prescription) locations and process.	
☐	Work with triage and intake unit to obtain, check in, and store pharmaceuticals from arriving patients.	
☐	Other: _____	

Demobilization		
☐	Return pharmaceuticals to clients.	
☐	Collect all remaining medications and medical supplies.	
☐	When possible, unopened factory-sealed containers should be returned for credit and opened containers should be properly disposed.	
☐	Participate in the after-action process (briefings, reports, etc.).	
☐	Assure personnel complete all required section reports/forms and turn them in to the appropriate agency/authority.	
☐	Turn in position identification (ID badge, vest, etc.).	
☐	Other: _____	

Supply/Logistics Section Job Action Sheets

The following job action sheets encompass the duties of the supply/logistics section staff for each phase of the 25-bed ACS operations. The logistics section for an ACS includes the following roles:

- Supply/Logistics Section Director
- Maintenance Unit Leader
- Materials/Supply Unit Leader
- Transportation Unit Leader
- Food Service Unit Leader
- Housekeeping Unit Leader

Supply/Logistics Section Director

Name _____

Date _____

Shift _____

Reports to: ACS Administrator

Subordinates: Maintenance Unit Leader; Materials/Supply Unit Leader; Materials/Supply Unit Leader; Transportation Unit leader; Food Service Unit Leader: Housekeeping Unit Leader

Mission:
Organize and direct ancillary logistics, supplies, and support services associated with maintenance of the physical environment and to support the medical objectives.

	Action Checklist	Time Task Completed
	Activation and Mobilization	
☐	Work with staff and volunteers to ensure the deployment and delivery of the ACS cache, including supplies, equipment, and medications. NOTE: May be incorporated with shelter medical support group.	
☐	Read this entire job action sheet (and, if time, the ACS plan), sign in, and review the ACS organizational chart.	
☐	Retrieve position identification (ID badge, vest, etc.) and wear at all times while on duty.	
☐	Report to ACS site. Review plans and checklists.	
☐	Meet with all general staff and ACS administrator for initial briefing and determine ACS type and needed cache deployments.	
☐	Supervise the unloading, staging, and assembly of medical cache materials in the setup of the ACS, including the setup of signage.	
☐	Provide staffing needs to the labor pool.	
☐	Work with ACS administrator to ensure admission criteria for the ACS is commensurate with resources and based on walk through.	
☐	Meet with medical operations section director to establish on-site methods of communicating resource requests and anticipated needs for 12, 24, and 36 hours.	
☐	Assist communication director with communications equipment and establish a communications plan for the ACS.	
☐	Determine any initial gaps in supply inventories and make requests through ACS administrator in conjunction with Hospital Command Center/SMOC, as appropriate.	
☐	Assist the ACS administrator with the just-in-time training by providing direction on resource request processes, information about facility (e.g., location of restrooms, details on parking, power, lighting, facility contacts, etc.), information about ACS layout (e.g., biohazardous waste disposal areas, media check-in area, ADA accommodations, etc.), food/dietary services, communications, and other logistics information.	

☐	Assist the ACS administrator in conducting an ACS walk through to identify ingress, emergency egress, client flow, ADA accommodations, client (and caregiver) capacity, areas for secured supply and pharmaceutical storage, and support provisions.	
☐	Determine details of the physical layout based on walk through and outline plan for set up with schematic (if not already established). Make copies for the logistics staff.	
☐	Other: _____	

Site Operations		
	Assist ACS administrator in providing logistical support for overall operations.	
☐	Ensure the delivery of: • Maintenance upkeep and necessary backup systems. • Material and supply (anticipated at 12, 24, and 36 hours). • Coordination of transportation resources into/out of ACS. • Setup, delivery, and removal for patient and staff food services. • Routine cleaning, trash, and janitorial services, performed in restrooms and common areas.	
☐	Ensure preparation and delivery of food/water to clients and staff. Ensure safe storage and proper disposal of food.	
☐	Ensure process for all supply requests (medical and non-medical) from ACS staff. May fulfill request directly if item is available in on-site inventory. If not available onsite, forward request to SMOC.	
☐	Ensure specificity when ordering resources (source, number, type, size, weight, delivery location, special considerations).	
☐	Consult with medical operations section director should deliveries need to coincide with client use (i.e., delivery of oxygen gases).	
☐	Track requests and actions associated with obtaining resources or personnel (who needed what and where and when). Develop inventory tracking to ensure proper paper trail for all activities.	
☐	Notify medical operations section director or another supervisor about the status of resource requests, especially delays.	
☐	Ensure the delivery of requested items to the supervisor of the requestor. If item is not immediately available, make it known to medical operations director.	
☐	Meet with finance section director at least twice per shift to review financial support needs and guidelines, including purchasing authority and limits of purchases.	
☐	Assess security needs depending on type of supplies delivered (i.e., pharmaceuticals), in coordination with security/safety director.	
☐	Ensure ongoing access to potable and non-potable water, power, telecommunications, computers, ADA accommodations, and secure facility cleaning.	
	Obtain support staff as necessary from labor pool.	
☐	Observe all staff, volunteers, and patients for signs of stress and inappropriate behavior. Report concerns to the labor pool unit leader. Provide for staff rest periods and relief.	
	Other: _____	

Demobilization		
☐	Work with staff, and volunteers to ensure the proper demobilization of ACS, including proper disposal of all biohazardous waste, proper disposal of all non-reusable items,	

	cleaning and/or disposal of linens, disassembly and staging of all items returning to warehouse, loading and delivery of medical cache back to the warehouse.	
☐	Ensure that all waste, cache items, and other materials are removed from site and that facility is properly cleaned before ACS unit leaves.	
☐	Participate in the after-action process (briefings, reports, etc.).	
☐	Assure personnel complete all required section reports/forms and turn them in to the appropriate agency/authority.	
☐	Turn in position identification (ID badge, vest, etc.).	
☐	Other: _____	

Maintenance Unit Leader

Name _____

Date _____

Shift _____

Reports to: Supply/Logistics Section Director

Subordinates: none

Mission:
Maintain the integrity of the physical facility to the best level. Provide adequate environmental controls to perform the medical mission by ensuring all equipment and supplies are fully functional.

	Action Checklist	Time Task Completed
	Activation and Mobilization	
☐	Report to ACS site. Review plans, checklists, and position responsibilities. Familiarize self with supply list and storage area.	
☐	Read this entire job action sheet (and, if time, the ACS plan), sign in, and review the ACS organizational chart.	
☐	Retrieve position identification (ID badge, vest, etc.) and wear at all times while on duty.	
☐	Obtain briefing from the supply/logistic section director and determine ACS footprint and type.	
☐	Conduct a comprehensive facility status report.	
☐	Assist with ACS setup as directed by supply/logistics section director.	
☐	Unloading, staging, and assembling cache according to plan/layout.	
☐	Participate in just-in-time training to learn about the nature of the incident and your role.	
☐	Other: _____	
	Site Operations	
☐	Anticipate and address problems arising in the facility such as power/lighting outages, plumbing issues, and HVAC concerns.	
☐	Assist in keeping the facility clean. Assist in disposing of garbage and maintain routine waste collection.	
☐	Establish with section director redundancy and backup equipment plans.	
☐	Establish and communicate facility needs to the supply/logistics section director.	
☐	Maintain documentation for reporting purposes.	
☐	Establish and conduct maintenance rounds on all equipment each shift.	
☐	Obtain support staff as necessary from labor pool.	

☐	Observe all staff, volunteers, and patients for signs of stress and inappropriate behavior. Report concerns to the labor pool unit leader. Provide for staff rest periods and relief.	
☐	Other: _____	

Demobilization		
☐	Ensure that all waste, cache items, and other materials are removed from site and that facility is properly cleaned before ACS unit leaves.	
☐	Coordinate on-site and/or off-site disposal of ACS materials. Some waste must be disposed according to biohazard waste standards (consult with logistics section director).	
☐	Assist in cleaning the facility.	
☐	Return all equipment and supplies to their original location/working order.	
☐	Documentation of all actions/activities.	
☐	Participate in the after-action process (briefings, reports, etc.).	
☐	Assure personnel complete all required section reports/forms and turn them in to the appropriate agency/authority.	
☐	Turn in position identification (ID badge, vest, etc.).	
☐	Other: _____	

Materials/Supply Unit Leader

Name _____

Date _____

Shift _____

Reports to: Supply/Logistics Section Director

Subordinates: none

Mission:
Ensure the anticipation, delivery, and maintenance of all materials and supplies, both medical and nonmedical.

	Action Checklist	Time Task Completed
	Activation and Mobilization	
☐	Report to ACS site. Review plans, checklists, and position responsibilities. Familiarize self with supply list and storage area.	
☐	Read this entire job action sheet (and, if time, the ACS plan), sign in, and review the ACS organizational chart.	
☐	Retrieve position identification (ID badge, vest, etc.) and wear at all times while on duty.	
☐	Obtain briefing from supply/logistics section director.	
☐	Assist with ACS setup as directed by supply/logistics section director.	
☐	Communication with logistics staff to coordinate delivery of ACS cache, as appropriate to ACS type.	
☐	Coordinate with medical operations section director to ensure all supply gaps are identified and escalated.	
☐	Report any additional supply needs or facility problems to supply/logistics director.	
☐	Participate in just-in-time training to learn about the nature of the incident and your role.	
☐	Other: _____	
	Site Operations	
☐	Manage the procurement, storage, distribution, and safeguarding of ACS supplies and equipment.	
☐	Identify needed resources and request them through chain of command.	
☐	Coordinate ongoing 12, 24, and 36-hour anticipated needs lists with section director.	
☐	Establish and communicate the supply status to the supply/logistics director.	
☐	Provide documentation of all receipts and distributions to finance section director each shift.	
☐	Maintain documentation and receipts for reporting purposes of all receipts and distributions.	

☐	Obtain support staff as necessary from labor pool.	
☐	Observe all staff, volunteers, and patients for signs of stress and inappropriate behavior. Report concerns to the labor pool unit leader. Provide for staff rest periods and relief.	
☐	Other: _____	

Demobilization		
☐	Coordinate the pickup of items returning to the cache, ensuring they are sealed, clean, and not expired, as appropriate.	
☐	Participate in the after-action process (briefings, reports, etc.).	
☐	Assure personnel complete all required section reports/forms and turn them in to the appropriate agency/authority.	
☐	Turn in position identification (ID badge, vest, etc.).	
☐	Other: _____	

Transportation Unit Leader

Name _____

Date _____

Shift _____

Reports to: Supply/Logistics Section Director

Subordinates: none

Mission:
Organize and coordinate the transportation of all patients to from the ACS. Arrange for transportation of staff, supplies, and resources.

	Action Checklist	Time Task Completed
	Activation and Mobilization	
☐	Read this entire job action sheet (and, if time, the ACS plan), sign in, and review the ACS organizational chart.	
☐	Retrieve position identification (ID badge, vest, etc.) and wear at all times while on duty.	
☐	Identify parking and loading/unloading zones.	
☐	Establish the flow of vehicular traffic to the ACS and around ACS facilities, including areas for ambulances and pick-up/drop off for staff and patients.	
☐	Other: _____	
	Site Operations	
☐	Obtain a list of available transportation resources.	
☐	Arrange external transportation for patients/staff as requested.	
☐	Coordinate with nursing staff to identify staff and equipment needed during transportation.	
☐	Coordinate information with receiving facility.	
☐	Ensure ACS guidelines are followed and report any unsafe acts.	
☐	Establish clean and “dirty” egress paths for deliveries or food, supplies vs. trash and waste.	
☐	Maintain transportation schedules and staffing levels, as appropriate to meet needs.	
☐	Obtain support staff as necessary from labor pool.	
☐	Observe all staff, volunteers, and patients for signs of stress and inappropriate behavior. Report concerns to the labor pool unit leader. Provide for staff rest periods and relief.	
☐	Other: _____	
	Demobilization	

☐	Receive directive to demobilize from ACS administrator.	
☐	Participate in the after-action process (briefings, reports, etc.).	
☐	Assure personnel complete all required section reports/forms and turn them in to the appropriate agency/authority.	
☐	Turn in position identification (ID badge, vest, etc.).	
☐	Other: _____	

Food Service Unit Leader

Name _____

Date _____

Shift _____

Reports to: Supply/Logistics Section Director

Subordinates: none

Mission:
Ensure the delivery of all food and water and other nutritional needs (Ensure, MREs, formula, puree equipment, etc.) stores for staff and patients. Manage preparation of food. Coordinate rationing during periods of anticipated or actual shortage.

	Action Checklist	Time Task Completed
	Activation and Mobilization	
☐	Assist with unloading, staging, and assembly of medical cache materials in the setup of the ACS, including the setup of signage.	
☐	Read this entire job action sheet (and, if time, ACS plan), sign in, and review the ACS organizational chart.	
☐	Retrieve position identification (ID badge, vest, etc.) and wear at all times while on duty.	
☐	Participate in the just-in-time training to gain information about the nature of the incident.	
☐	Report for duty; receive briefing from supply/logistics section director.	
☐	Other: _____	

	Site Operations	
☐	Obtain copies of staff and client census data from ACS administrator for dietary planning.	
☐	Responsible for the preparation and delivery of food/water to clients and staff, including those for specialized or restricted diets.	
☐	Ensure safe storage and proper disposal of food and that all food serving areas are sanitized.	
☐	Immediately report any power or other facility issues that may affect safe storage of food to maintenance unit leader.	
☐	Report any food-related shortages or supply requests to supply/logistics section director.	
☐	Work with finance section director to procure all drinks, snacks, and meals for staff and clients. Arrange the delivery of food and drink to the ACS.	
☐	Establish and coordinate food plan to meet current needs 24 hours in advance.	
☐	Obtain support staff as necessary from labor pool.	

☐	Observe all staff, volunteers, and patients for signs of stress and inappropriate behavior. Report concerns to the labor pool unit leader. Provide for staff rest periods and relief.	
☐	Other: _____	

Demobilization		
☐	Help with proper demobilization of ACS, especially in relation to cleaning the kitchen area and disposing of food-related items.	
☐	Participate in the after-action process (briefings, reports, etc.).	
☐	Assure personnel complete all required section reports/forms and turn them in to the appropriate agency/authority.	
☐	Turn in position identification (ID badge, vest, etc.).	
☐	Other: _____	

Housekeeping Unit Leader

Name _____

Date _____

Shift _____

Reports to: Supply/Logistics Section Director

Subordinates: none

Mission:
Evaluate and monitor the cleanliness of the ACS facility, including patient care areas.

	Action Checklist	Time Task Completed
	Activation and Mobilization	
☐	Receive appointment from supply/logistics section director.	
☐	Read this entire job action sheet (and, if time, ACS plan), sign in, and review the ACS organizational chart.	
☐	Retrieve position identification (ID badge, vest, etc.) and wear at all times while on duty.	
☐	Read this entire job action sheet, sign in, and review the ACS organizational chart.	
☐	Retrieve position identification (ID badge, vest, etc.) and wear at all times while on duty.	
☐	Obtain briefing from supply/logistics director.	
☐	Set up housekeeping supply area.	
☐	Brief and assign all housekeepers to appropriate areas and ensure housekeepers perform all duties, as appropriate.	
☐	Other: _____	
	Site Operations	
☐	Implement pre-established alternative waste disposal/collection plan, if necessary.	
☐	Ensure that all sections and areas of the ACS are informed of the implementation of the housekeeping plan.	
☐	Ensure an adequate number of hand washing areas are operational near patient care and food preparation areas and adjacent to portable toilet facilities.	
☐	Monitor levels of supplies, equipment, and needs relevant to all sanitation operations.	
☐	Brief supply/logistics section director on current condition of all sanitation operations; communicate anticipated needs for 12, 24, and 36 hours.	
☐	Obtain support staff as necessary from labor pool.	
☐	Observe all staff, volunteers, and patients for signs of stress and inappropriate behavior. Report concerns to the labor pool unit leader. Provide for staff rest periods and relief.	

☐	Obtain support staff as necessary from labor pool.	
☐	Other: _____	

Demobilization		
☐	Conduct exit interviews with direct reports.	
☐	Participate in the after-action process (briefings, reports, etc.).	
☐	Assure personnel complete all required section reports/ICS/HICS forms and turn them in to the appropriate agency/authority.	
☐	Turn in position identification (ID badge, vest, etc.).	
☐	Ensure all items are clean/decontaminated prior to demobilization.	
☐	Participate in the after-action process (briefings, reports, etc.).	
☐	Assure personnel complete all required section reports/forms and turn them in to the appropriate agency/authority.	
☐	Turn in position identification (ID badge, vest, etc.).	
☐	Other: _____	

Records/Planning Job Action Sheets

The following job action sheets encompass the duties of the records/planning section staff for each phase of the 25-bed ACS operations. The records/planning section for an ACS includes the following roles:

- Records/Planning Section Director
- Labor Pool Unit Leader
- Patient Transportation and Tracking Unit Leader

Records/Planning Section Director

Name _____

Date _____

Shift _____

Reports to: ACS Administrator

Subordinates: Labor Pool Unit Leader; and Patient Transportation and Tracking Unit Leader

Mission:
Organize and direct all aspects of records/planning section. Ensure the distribution of critical information and data. Compile scenario and resource projections from all section chiefs and effect long-range planning. Document and distribute facility action plans.

	Action Checklist	Time Task Completed
	Activation and Mobilization	
☐	Report to ACS site. Review plans and checklists.	
☐	Read this entire job action sheet (and, if time, ACS plan), sign in, and review the ACS organizational chart.	
☐	Retrieve position identification (ID badge, vest, etc.) and wear at all times while on duty.	
☐	Meet with all general staff and ACS administrator for initial briefing.	
☐	Provide staffing needs to the labor pool.	
☐	Coordinate and implement Incident Action Plan process, including development, approval, and dissemination.	
☐	Explain planning function, including situation status reporting and client/staff census in just-in-time training.	
☐	Other: _____	
	Site Operations	
☐	In collaboration with command staff, anticipate, and plan for the next 12-24 hours of ACS care including capacity, staffing, and resource capacity.	
☐	Coordinate all plans with Hospital Command Center/SMOC.	
☐	Make short-term and long-term projections about weather conditions, transportation limitations, anticipated supply or personnel shortages, or other emergency-relevant facts. Report projections to the ACS administrator, discuss potential impact to the ACS, and help decide upon the appropriate response.	
☐	Identify potential problems and work with ACS administrator to prepare solutions	
☐	Keep ACS administrator informed of significant findings, projected reductions in resources, or any other relevant issues.	
☐	Communicate with all section directors to ascertain and anticipate problem areas or ensure transmission of key information.	

☐	Supervise the compilation of client and staffing census data. Ensure that census reports and status reports are completed twice every shift. Submit these reports to records/planning section and give a copy to the ACS administrator and Hospital Command Center/SMOC.	
☐	Provide goals and objectives for the next shift period and evaluate milestones for current shift.	
☐	Obtain support staff as necessary from labor pool.	
☐	Observe all staff, volunteers, and patients for signs of stress and inappropriate behavior. Report concerns to the labor pool unit leader. Provide for staff rest periods and relief.	
☐	Other: _____	

Demobilization		
☐	Develop demobilization plan for implementation (when directed by ACS Administrator) to include detailed timeline of actions for each command/general staff/section.	
☐	Participate in the after-action process (briefings, reports, etc.).	
☐	Assure personnel complete all required section reports/forms and turn them in to the appropriate agency/authority.	
☐	Turn in position identification (ID badge, vest, etc.).	
☐	Other: _____	

Labor Pool Unit Leader

Name _____

Date _____

Shift _____

Reports to: Records/Planning Section Director

Subordinates: none

Mission:
Collect and inventory available staff and volunteers at a central point. Receive requests and assign available, vetted, and credentialed staff. Maintain adequate numbers of both medical and non-medical personnel. Assist in maintenance of staff morale.

	Action Checklist	Time Task Completed
	Activation and Mobilization	
☐	Establish labor pool documentation system in coordination with Hospital Command Center/SMOC.	
☐	Read this entire job action sheet (and, if time, ACS plan), sign in, and review the ACS organizational chart.	
☐	Retrieve position identification (ID badge, vest, etc.) and wear at all times while on duty.	
☐	Ensure system to validate credentials/licensure, as needed; including hospital human resources, medical staff services, and regional/statewide volunteer pools.	
☐	Assist with unloading, staging, and assembly of medical cache materials in the setup of the ACS, including the setup of signage.	
☐	Participate in just-in-time training to learn about the nature of the incident and your role.	
☐	Other: _____	
	Site Operations	
☐	Receive staffing needs from section directors.	
☐	Maintain a list of reporting staff (also, make sure staff show up, order more staff as requested, call to cancel staff if asked, etc.).	
☐	Report staffing issues (such as “no shows”) to supply/logistics director.	
☐	Provide copies of staff and client census data to records/planning section for situation status reporting and to the food unit for dietary planning.	
☐	Obtain support staff as necessary from labor pool.	
☐	Observe all staff, volunteers, and patients for signs of stress and inappropriate behavior. Report concerns to the labor pool unit leader. Provide for staff rest periods and relief.	
☐	Other: _____	
	Demobilization	

☐	Facilitate proper demobilization of ACS, including proper disposal of all materials, cleaning and/or disposal of linens, disassembly and staging of all items returning to warehouse, and loading and delivery of medical cache back to the warehouse.	
☐	Ensure that all waste, cache items, and other materials are removed from site and that facility is properly cleaned before ACS unit leaves.	
☐	Participate in the after-action process (briefings, reports, etc.).	
☐	Assure personnel complete all required section reports/forms and turn them in to the appropriate agency/authority.	
☐	Turn in position identification (ID badge, vest, etc.).	
☐	Other: _____	

Transportation/Tracking/Discharge Unit Leader

Name _____

Date _____

Shift _____

Reports to: Records/Planning Section Director

Subordinates: none

Mission:
Coordinate the movement and tracking of all ACS patients and visitors.

	Action Checklist	Time Task Completed
	Activation and Mobilization	
☐	Report to ACS site. Review plans, checklists and position responsibilities. Familiarize self with supply list and storage area.	
☐	Read this entire job action sheet (and, if time, ACS plan), sign in, and review the ACS organizational chart.	
☐	Retrieve position identification (ID badge, vest, etc.) and wear at all times while on duty.	
☐	Obtain briefing from records/planning section director.	
☐	Assist with ACS setup as directed by records/planning section director.	
☐	Initiate HICS Form 254 for all patient movement tracking.	
☐	Other: _____	

	Site Operations	
☐	Assist with the patient movement within the ACS.	
☐	Maintain HICS Form 254 for all movements and report on a routinely established cycle to Hospital Command Center/SMOC.	
☐	Maintain list of all authorized visitors per patient and coordinate with security/safety director.	
☐	Obtain support staff as necessary from labor pool.	
☐	Observe all staff, volunteers, and patients for signs of stress and inappropriate behavior. Report concerns to the labor pool unit leader. Provide for staff rest periods and relief.	
☐	Other: _____	

	Demobilization	
☐	Ensure all documentation is complete.	
☐	Participate in the after-action process (briefings, reports, etc.).	

☐	Assure that personnel complete all required section reports/forms and turn them in to the appropriate agency/authority.	
☐	Turn in position identification (ID badge, vest, etc.).	
☐	Other: _____	

Finance Job Action Sheets

The following job action sheets encompass the duties of the finance section staff for each phase of the 25-bed ACS operations. The finance section for an ACS includes the following roles:

- Finance Section Director
- Cost Accounting Unit Leader

Finance and Administration Director

Name _____

Date _____

Shift _____

Reports to: ACS Administrator

Subordinates: Finance Section Director; Cost Accounting Unit Leader

Mission:
Monitor financial aspects of the overall operations. Oversee the acquisition of resources and services necessary to carry out the ACS mission. Supervise the documentation of expenditures related to the emergency incident and approve all expenditures

	Action Checklist	Time Task Completed
	Activation and Mobilization	
☐	Report to ACS site. Review plans and checklists.	
☐	Read this entire job action sheet (and, if time, ACS plan), sign in, and review the ACS organizational chart.	
☐	Retrieve position identification (ID badge, vest, etc.) and wear at all times while on duty.	
☐	Meet with all general staff and ACS administrator for initial briefing.	
☐	Provide staffing needs to the labor pool.	
☐	Explain finance function and any fiscal protocols in just-in-time training.	
☐	Other: _____	
	Site Operations	
☐	Responsible for documenting and/or ensuring the documentation for all financial matters relating to the operations of the ACS throughout response, including food orders, supply requests, and demobilization and/or restoration of facility in original condition.	
☐	May also require basic information for client registration, medical insurance documentation, record preparation, client tracking; forms availability; communications; and support to the administration functions.	
☐	Obtain support staff as necessary from labor pool.	
☐	Observe all staff, volunteers, and patients for signs of stress and inappropriate behavior. Report concerns to the labor pool unit leader. Provide for staff rest periods and relief.	
☐	Other: _____	
	Demobilization	

☐	Receive directive to demobilize from ACS administrator.	
☐	Participate in the after-action process (briefings, reports, etc.).	
☐	Assure that personnel complete all required section reports/forms and turn them in to the appropriate agency/authority.	
☐	Turn in position identification (ID badge, vest, etc.).	
☐	Other: _____	

Cost Accounting Unit Leader

Name _____

Date _____

Shift _____

Reports to: Finance Section Director

Subordinates: none

Mission:
Provide cost analysis data for all documented actions.

	Action Checklist	Time Task Completed
	Activation and Mobilization	
☐	Check in upon arrival at the ACS.	
☐	Read this entire job action sheet (and, if time, ACS plan), sign in, and review the ACS organizational chart.	
☐	Retrieve position identification (ID badge, vest, etc.) and wear at all times while on duty.	
☐	Report to finance section director for briefing.	
☐	Establish and maintain a position log that chronologically describes actions taken during the shift.	
☐	Other: _____	
	Site Operations	
☐	Establish and maintain a position log and other necessary files.	
☐	Obtain and establish financial impact assessment from each section director at the end of every shift. Calculate costs for all aspects (e.g., staffing, supplies, equipment, utilities, food, medications, etc.).	
☐	Keep the finance section director informed of significant issues affecting the cost accounting unit.	
☐	Forward all equipment or property damage claims to the ACS administrator.	
☐	Obtain support staff as necessary from labor pool.	
☐	Observe all staff, volunteers, and patients for signs of stress and inappropriate behavior. Report concerns to the labor pool unit leader. Provide for staff rest periods and relief.	
☐	Other: _____	
	Demobilization	
☐	Deactivate your assigned position and close out logs when authorized by the ACS administrator.	

☐	Complete all required forms, reports, and other documentation.	
☐	Participate in the after-action process (briefings, reports, etc.).	
☐	Assure that personnel complete all required section reports/ forms and turn them in to the appropriate agency/authority.	
☐	Turn in position identification (ID badge, vest, etc.).	
☐	Other: _____	

10.2 Appendix 2: Sample Triage Planning Aid Table

As a means of planning, in terms clearly communicated throughout the medical system, hospitals might consider the development and distribution of a triage aid, such as the table below, which clearly defines the relationship between the general population shelters, the alternate care site(s), and more acute healthcare facilities. While it may be populated before an incident, it should be updated upon activation so that the capabilities and limitations are understood.

Medical Need	General Population Shelter	Alternate Care Site	Healthcare facility
Dialysis hemo and peritoneal	*Stable with access to hemodialysis services.* *Access to clean area and supplies for peritoneal dialysis.* *Can tolerate disruption of access with diet control for 3-5 days.*	*Disruption of access to services and/or lack of supplies or diet control.*	*Symptomatic.*
Ambulation (walker, cane, crutches, wheelchair) • Arthritis • Osteoporosis • Parkinson's Disease • Muscular Dystrophy • Neuromuscular disorders	*Ambulates with replacement of durable medical equipment.* *Bedridden with own caregiver or replacement of caregiver.*	*Unresolved declining health status requiring invasive procedures unable to be monitored by volunteer skill set in general population shelter.*	*Acute disease process.*
Cardiac abnormalities	*Stable or controlled with medication and/or medication replacement or adjustment and volunteer staff to monitor or assess for changes.*	*Symptomatic but controlled with frequent medication adjustment.*	*Stable or controlled with medication and/or medication replacement or adjustment and volunteer staff to monitor or assess for changes.*
Contagious disease and/or infection (e.g., MRSA, VRE, TB, respiratory infection, diarrheal illness)			
Diabetes: Type 1 or Type 2 Hyperglycemia Hypoglycemia			
Eating and swallowing disorders			
Fluid replacement			
Ileostomy/colostomy			
Medical conditions which require IV hydration, therapy, or ventilator support			
Pain management			
Respiratory • Asthma • Chronic Obstructive Pulmonary Disease			
Mental health			
Wounds, burns, and fractures			

10.3 Appendix 3: ACS Activation Execution Checklist

The Execution Checklist provides a detailed operational checklist for the activation of a hospital-specific ACS, including considerations for coordination and resource allocation. A hospital-based ACS is fully activated once the site is deemed "operational" and begins receiving individuals (estimated within 24-48 hours). In order to accomplish these tasks effectively and ensure efficient operations, checklist processes have been "phased" within the specific steps outlined below. Note that phases and activities may overlap or reoccur based on incident specifics.

Activation: The Activation Phase begins when a threat or hazard is identified that could lead to a hospital standing up a hospital-based ACS. This phase focuses on the considerations for activating an ACS and necessary decisions and coordination elements for standing up an ACS. The actual movement of resources to stand up the ACS are covered in the next phase of operations.

Mobilization: The Mobilization Phase initiates the movement of resources, including staff, to the selected ACS. This phase begins the notification of people, systems, and resources to establish Incident Command and management structures, make coordinated decisions about priorities and resources, and to disseminate clear messaging to the public. For purposes of a hospital-specific ACS, mobilization of a site could take anywhere from 18-36 hours.

Site Operations: This phase includes all actions involved with actually running a hospital-based ACS, including attending to patients, requesting additional resources, and maintaining situational awareness. Processes in this phase ensure that coordination is occurring where necessary.

Demobilization: The Demobilization Phase initiates the deactivation of a hospital-based ACS. This includes the return of resources to their original state, documenting any necessary expenditures, and ramping down ACS operations.

Activation	
☐	Receive notification of an incident and monitor incident progression.
☐	Obtain necessary situational awareness on incident, including size and scale of incident.
☐	Determine capacity and capability to stand up ACS.
☐	Determine operational approach for ACS, based on situational awareness information.
☐	Determine additional ACS specialty area operations that supplement general ACS operations, such as: — Critical Care Unit (CCU) — Emergency Room (ER) — Skilled Nursing Facility (SNF) — Orthopedics — Obstetrics (OB) — Pediatrics — Infection Control (IC) — Mental Health
☐	Preliminarily sketch out potential resource and staffing needs based on size and scale of incident. Identify the location of these resources.
☐	Review possible ACS locations based on hospital-specific plans, policies, and procedures. Make selections based on incident needs and projected influx of individuals to ACS.

☐	Inform the chief hospital official of the situation and obtain approval from senior leadership, as needed.
☐	Collaborate with local and, where needed, state emergency management to determine level of support.
☐	Determine operational periods, priorities, and rotation shifts for hospital personnel.
☐	Activate any relevant plans, polices, and procedures, including hospital-specific mass fatality plans and ACS plans.
☐	Communicate courses of action with relevant stakeholders, including the SMOC and other hospitals. Request situational awareness from these entities as needed.

Mobilization	
☐	Alert all relevant service providers and partners of ACS activation.
☐	Coordinate the identification and mobilization of resource staging areas for assets, equipment, and personnel to manage resource intake. Communicate to resource providers.
☐	Mobilize equipment and personnel, including nurses, medical supplies, and communications equipment.
☐	Reassess need for additional specialty areas to support ACS operations. Activate additional staff as needed.
☐	Communicate current operations to the SMOC. Request situational awareness and additional assistance as needed.
☐	Continue to collaborate with local and, where needed, state emergency management to determine level of support.
☐	Brief hospital leadership on mobilization of ACS, including estimated timeline for receipt of patients.
☐	Determine operational objectives, priorities, and rotation shifts for personnel for next phase.
☐	Intake and track resources as they are received.

Site Operations	
☐	Begin to receive patients based on the determined ACS scope. Triage patients accordingly.
☐	Initiate patient intake and tracking.
☐	Reassess need for additional specialty areas to support ACS operations. Activate additional staff as needed.
☐	Communicate current operations to the SMOC. Request situational awareness and additional assistance as needed.
☐	Reassess current resources, identify any gaps, and request additional resources if applicable. Activate any relevant mutual aid/private sector agreements to augment resources, as needed.
☐	Continually monitor progress of operations and resolve any issues in operations.
☐	Brief hospital leadership on ACS site operations.
☐	Maintain incident situational awareness, including potential for additional patient surge and threat escalation.
☐	Continue to collaborate with local and, where needed, state emergency management to determine level of support.

☐	Determine operational objectives, priorities, and rotation shifts for personnel for demobilization.

Demobilization	
☐	Determine the need to demobilize ACS based on incident progression.
☐	Alert all relevant staff, service providers, and partners of ACS demobilization.
☐	Determine operational priorities and rotation shifts for personnel to support demobilization.
☐	Reassess any additional resource needs and submit requests to determine mutual aid needs.
☐	Communicate current operations to the SMOC. Request situational awareness and additional assistance as needed.
☐	Continue to collaborate with local and, where needed, state emergency management to determine level of support.
☐	Initiate the breakdown and demobilization of equipment and personnel. Ensure deployed equipment is reset, restored, and maintained.
☐	Log all expenditures for resources and staffing.
☐	Notify hospital leadership on resumption of normal operations.
☐	Debrief on operations as needed.

10.4 Appendix 4: ACS Site Layout and Function Tool

Hospitals should maintain a list or database of potential facilities that will satisfy the requirements of a hospital-based ACS. Arrangements should be made in advance with the managers of the sites. These agreements should allow for rapid activation and deployment. The diagrams below provide examples of three possible ACS configurations, scalable based on incident needs and availability of wraparound services.

Figure 5: Independently Operated ACS Configuration

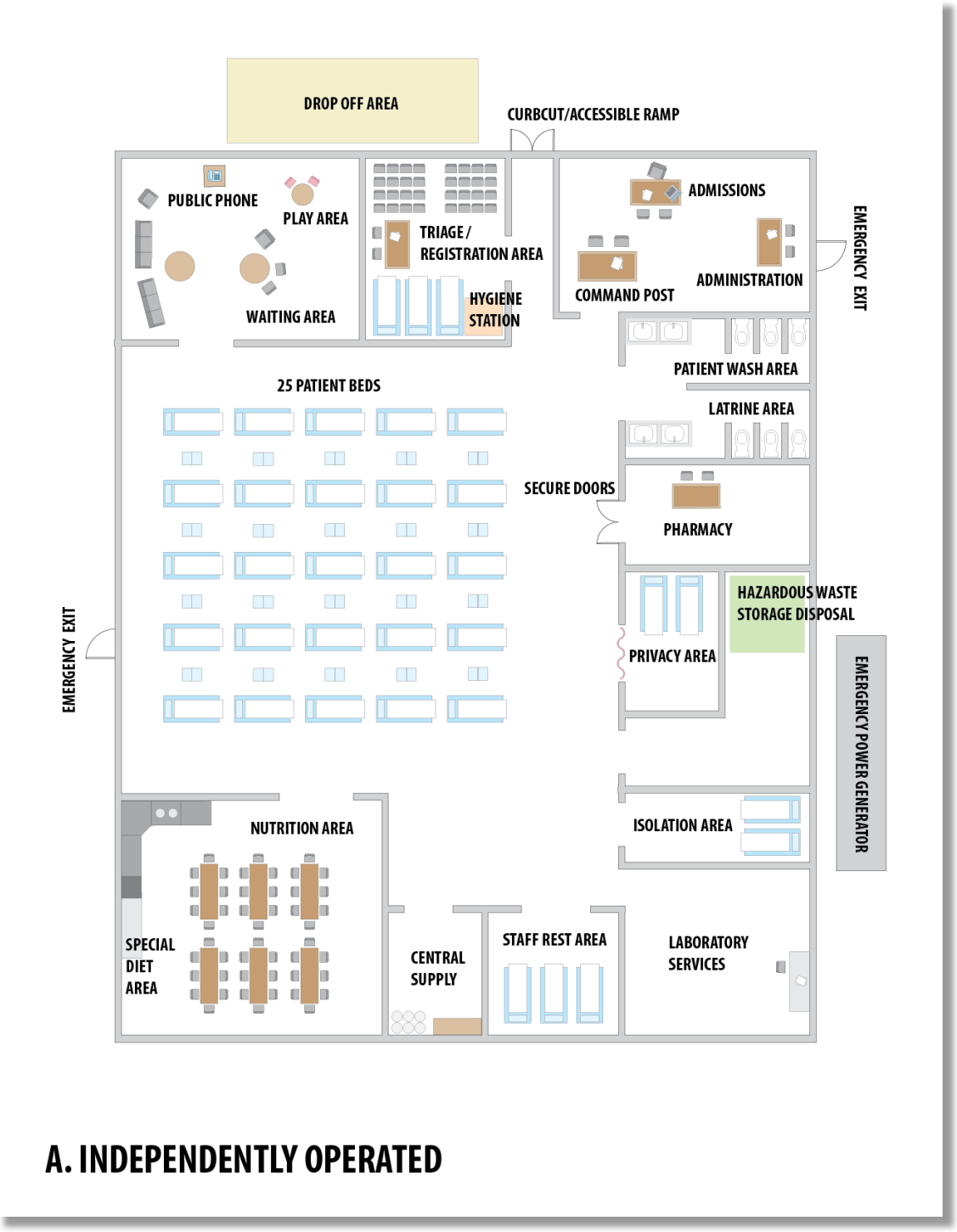


Figure 6: Minimal Services-Wraparound Dependent ACS Configuration

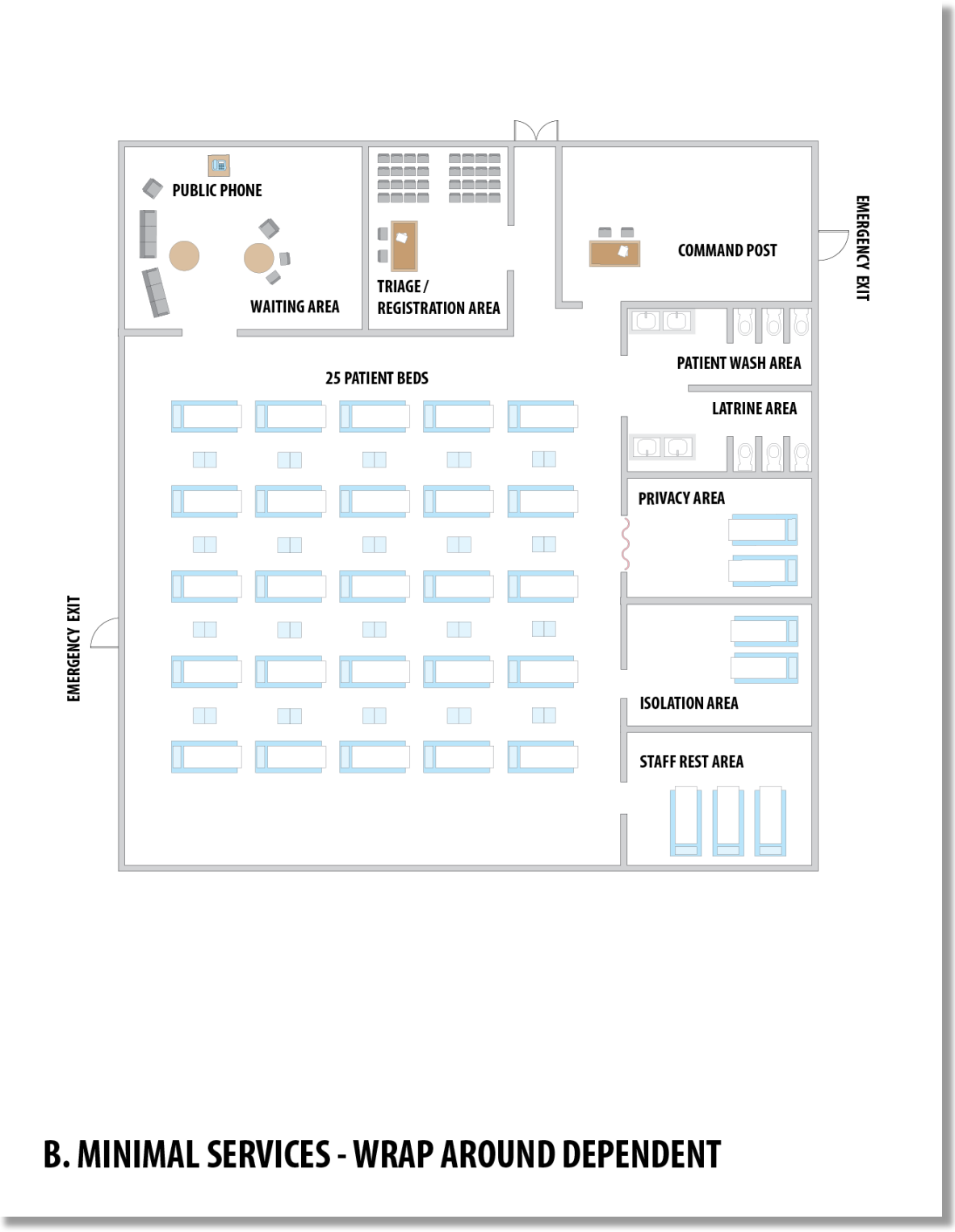
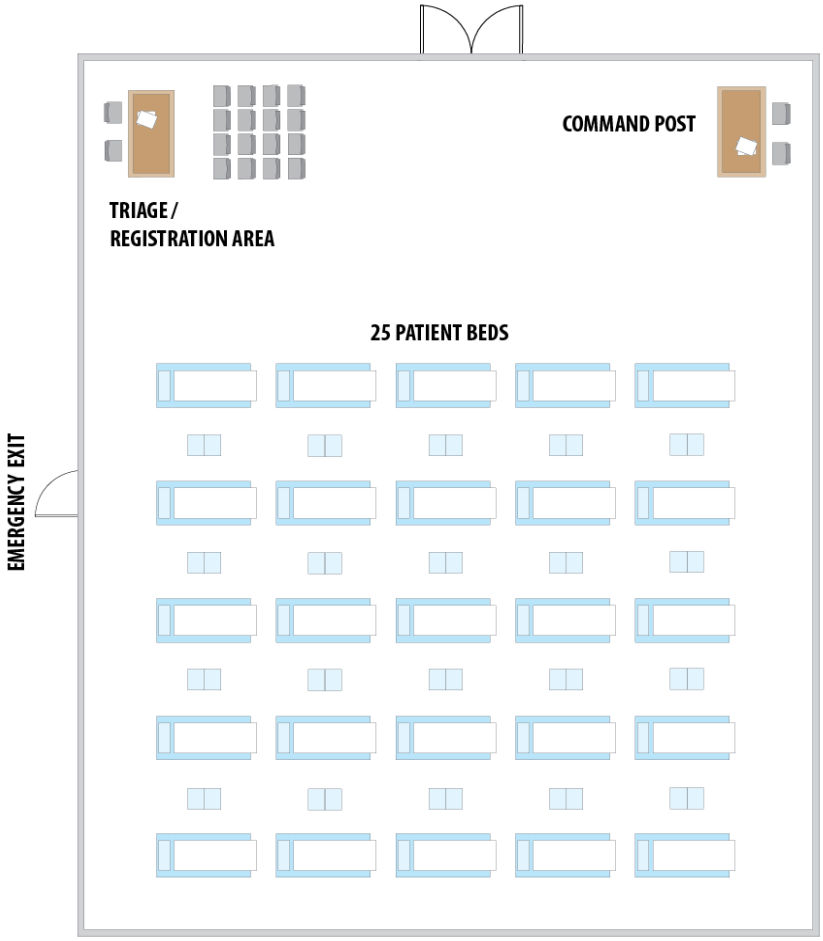


Figure 7: Fully Integrated ACS Configuration



C. FULLY INTEGRATED

At its most basic level, a hospital-based ACS should have:

- Emergency power (fixed generators).
- Close proximity to emergency medical services.
- Heating and cooling capabilities.
- Refrigeration.
- Back-up or portable oxygen supplies.
- Water supply and waste disposal system.
- Food supply and preparation area for special diets.
- Drop-off areas that are clearly marked, close to the entrance, and have curb cuts (35 inches in width).
- An entrance that is well marked with automatic doors (or less than 5 lb. resistance, appropriate door handles, and doorways, minimum width of 35 inches).
- A path of wide and clear travel to registration, sleeping area, food area, toilet and shower area, medical area, TV/computer area, phone/communication area, and quiet area.
- Signage that is clear and easy to understand in exterior area, sleeping area, toilet and shower area, food area, medical area, TV/computer area, phone/communication area including TTY, and quiet area.
- Access to laundry facilities.
- Access and functional needs compliance.

In addition, the toilet and shower area should have:

- One stall/shower for every 15 persons.
- Shower stalls - 36 inches by 36 inches, roll-in accessible.
- Toilet stalls - 38 inches in width (some with raised toilets).
- Grab bars - 33-36 inches in height.
- Shower head - 48 inches in height.
- Paper dispenser - 19 inches in height.
- Sink - 34 inches in height.
- Towel dispensers - 39 inches in height.
- Automatic doors or manual doors with no more than 5 lb. resistance.

If an ADA-compliant site is not available, certain temporary accommodations can be made so it is suitable for ACS operations. These accommodations include:

- Portable ramps.
- Shower seats.
- Portable commodes with screens.
- Grab bars.
- Transfer boards.
- Portable accessible restrooms.
- Table-level public phones or access to cellular phones.

Other accommodations may include minor modifications to the building itself. These modifications may require the written permission of the owner/operator of the site. Coordination with building code enforcement may be necessary to ensure that the use of the site and any modifications to the building are within regulations. Building modifications may include but are not limited to:

- Widening doorways by removing doors not designated as fire doors.
- Widening work areas by repositioning furniture, partitions, or equipment.
- Installing a temporary ramp.
- Repositioning paper towel dispensers in restrooms.
- Designating parking spaces for disabled workers and patients.

An ACS should be accessible to at least two roadways to provide continued access in the event that one roadway becomes blocked or inaccessible. Roadways should connect directly to the ACS property.

Site Assessment

Once a site has been identified, a thorough on-site assessment should be conducted. This assessment should confirm that the location is structurally sound and safe for patients. The following should be assessed:

- Environmental safety (ensure the building is safe for patients and staff to enter).
- Functionality of utilities including electrical power, ventilation, heating, air conditioning, water, and plumbing.
- Functionality of telephone and other communications systems.
- Functionality of backup power, if available.
- Proper space needed for patient care (this may involve contacting an identified moving company to move furniture from the facility such as desks, etc.).
- Proper level of cleanliness.
- Availability of fire extinguishers.
- Availability of a supplemental morgue (consider alternatives that would place morgue outside the ACS site. This may include refrigerator trucks or other viable alternatives).
- Security (identify exits and entrances; ensure the building can be "locked down").
- Storage (locate supply rooms and identify areas where pharmaceuticals and other sensitive material will be safely stored).
- Disposal (identify an area where hazardous waste and other disposal materials can be stored until they can be picked up).

Site Size

During initial activation, the number of patients who can safely be served in a selected facility should be confirmed. The allocation of space will be determined by the incident. The total size and number of beds will be directly influenced by factors such as site layout, number of patients, patient acuity, and resource availability.

The American Red Cross recommends 40 square feet per patient for persons sheltering longer than 72 hours. Patients with wheelchair lift equipment, personal care assistants, and service animals may require approximately 100 square feet of space per patient.

Physical Configuration

The variation of site types, medical needs, and the duration of the incident will dictate the physical requirements and configuration of the ACS. The following considerations should be taken into account when choosing the physical configuration of the ACS; however, jurisdictions may decide that not all of these areas are required:

- Entrance: The main entrance to the ACS maintains the flow of staff and patients coming into and out of the ACS. A secondary entrance may be utilized for the delivery of resources.
- Command post: The command post may be set up in the main office area of the site.

- Registration and triage: Registration and triage may be set up near the main entrance. There should be adequate shelter/cover for those waiting to register.
- Central supply: An area should be designated as central supply where all supplies coming to the ACS will be secured and maintained.
- Staff quarters: These may be designated rooms apart from patient areas.
- Patient care area: The patient care area should be set up using medical cots, bariatric cots, and pediatric-focused sleeping accommodations, if available. Medical cots are larger and higher off the ground than standard general population shelter cots. The patient care area configuration may include divided sections for the following patient care units:
    - Prescriptions/minor care.
    - Adult unit.
    - Pediatric unit.
    - Psychiatric unit.
    - Isolation unit (large enough for at least four persons).
- Aisles: Should be at least 36 inches wide to allow wheelchairs to pass through. Cots should be placed so that adjacent cots are aligned "head-to-toe". Some medical cots should be set up against the wall to make them more stable and thus easier for patients who are wheelchair users to transfer in and out of them. Patients with respiratory illness should be housed in a separate room from other ACS patients.
- Pharmacy and drug dispensing area
- Waiting areas
- Childcare area
- Privacy area: If privacy screens are available, they may be set up in the patient care area or in a separate, designated room to allow patients privacy when performing necessary self-care. For example, for patients who are not ambulatory and thus cannot walk to bathrooms, perform personal hygiene, and/or change clothes without assistance, portable privacy screens may be a suitable option for providing privacy at the individual's cot.
- Food service: Areas used for serving food should be located away from patient care areas. Availability of food services for staff and patients may be required 24 hours a day/7 days a week.
- Hygiene: Portable hand washing stations should be located in triage areas, patient care units, and pharmacy areas.
- Emergency exits: Must be clearly marked.
- Security: Controlled entrances should be established for all staff, volunteers, patients and visitors.

Housekeeping and Environmental Services

Maintaining the ACS site involves both housekeeping and environmental services considerations. Depending on the size of the ACS, teams can be established or vendors can be contracted to perform these services. If the facility has a pre-existing agreement with janitorial services, jurisdictions may consider extending these services.

At the onset of activating the ACS, housekeeping is required to bring the ACS site to sanitary standards appropriate for staff and patients prior to opening the site for patient intake. Once the ACS is opened, orderliness and cleanliness must be maintained throughout operations. As ACS operations are demobilized, plans should include returning the site to a sanitary condition.

Considerations for housekeeping activities include the following:

- General cleaning of surfaces and walls within patient areas using appropriate detergents and disinfectants.
- Picking up trash in and around the site.
- Laundering bedding and other cloth goods.

- Ensuring cleanliness of ACS support areas such as kitchen facilities, staff sleeping quarters, and restroom and shower facilities.
- Providing special care of carpeting and other cloth furnishings.
- Cleaning spills of bodily fluids.

The ACS may enlist the support of environmental services staff to complete more complex tasks related to the ACS environment. A primary consideration for environmental services at an ACS is waste management. Aspects of waste management that should be considered include:

- Evaluation of the capacity of on-site sewage or septic systems to handle increased sewage flow; an assessment of the potential public health risk of a septic system failure or overflow should be conducted.
- Projecting the need for commercial chemical toilets including number required, delivery, servicing, and location in relation to the ACS.
- Projecting the need for additional solid waste disposal resources, such as adequate number and size of garbage bins, trash receptacles, trash bags, and location to store solid waste until trash collection service resumes.
- Disposal of sharps, bio-hazardous waste, medical, and other waste (solid and liquid).

Medical waste disposal presents additional considerations for ACSs including:

- Separation of medical waste from the solid waste stream needs to be maintained.
- Chemical and radiological wastes must be separated and triaged from medical waste to avoid contamination; waste not contaminated with bodily fluids may be disposed of in regular trash cans.
- The designated storage area for medical waste must display the appropriate “bio-hazard” symbols.

Decontamination

Decontamination may be needed at the ACS as patients may have been exposed to hazardous substances as a result of the incident or another spill. Many jurisdictions choose to coordinate this activity with the fire or local hazardous materials response team. ACS plans should include procedures for runoff containment and management. Most hazardous waste and decontamination efforts will require specific personal protective equipment and specialized training for staff. Local, state, and federal laws that regulate these activities must be followed.

Security

Selecting a site where access can be easily controlled is preferable and will ensure the safety of both staff and patients and help maintain the orderly flow of personnel and patients coming into and out of the ACS. When securing the facility, primary and secondary entrances should be established. The primary entrance is for patients and staff; the secondary entrance may be utilized for resources delivered to the ACS.

ACS staff should ensure that unused areas are secured and clearly identified as “off-limits” to patients. All ACS staff should assist in monitoring these areas to ensure compliance. Traffic control strategies need to be instituted for vehicles and foot traffic. Once operational, security personnel have an ongoing responsibility to ensure that staff and patients are provided with a safe environment.

Transportation

Patients may require transportation while residing within an ACS. Advanced life support ambulances may be needed to transport patients to a hospital when their medical condition has deteriorated, requiring a higher level of care. Other patients may need transportation to specialized medical services such as dialysis. Non-medical transport needs may include relocating

patients to a general population shelter when their condition has improved to the point where staying in an ACS is no longer appropriate or needed.

Food Services

Food and potable water are essential services in all ACSs. In most communities, if an ACS is co-located with a general population shelter, feeding falls under the mass care function. Coordination with the mass care lead and select non-governmental organizations should be considered. If an ACS is not co-located, consideration should be given to the strategies listed below.

Dietary Planning

In order to meet the needs of the greatest number of people in the ACS, menus that are low sodium, low fat, and low sugar should be developed. Planning and contingency strategies to ensure the provision of food and water are paramount. Basic food services planning and operational considerations include coordinating for external delivery of food, snacks, and drinks. Jurisdictions may consider arranging support services with external facilities that may have extra capacity to prepare and deliver meals to ACS sites during early operations.

Signage

Having proper signage in place when the ACS opens will help staff move patients more efficiently throughout the facility and assist in communication to individuals with access and functional needs. Signage should direct patients to key locations throughout the facility. The following table represents possible signs and recommended placement. Signage should be appropriate to the needs of the population; this may require signs to be published in multiple languages and formats. Braille should be incorporated into all signs, and all signs should be placed at a standard height throughout the ACS when possible. If this is done on-site, the use of a handheld braille label maker will accommodate this requirement.

Heating, Ventilation, Air Conditioning, Power, and Lighting

Jurisdictions should ensure that the selected site is capable of supporting heating, ventilation and air conditioning, electrical power, and lighting for ACS operations. The availability of a primary and auxiliary power supply should be a critical consideration when deciding whether to open an ACS, as power is needed for a number of life sustaining devices patients may require. The power grid and auxiliary emergency electric power capability need to be sufficient to power receptacles used to run oxygen concentrators, oxygen nebulizers, and other medical equipment.

Lighting is also a critical consideration at an ACS site. In many instances, the selected site will already have some degree of lighting; the ACS staff should determine its adequacy. Jurisdictions should ensure the availability of additional lighting (fixed or mobile). This may be especially true for areas designated for providing patient medical care (e.g., wound care or dressing change). In addition, local jurisdictions should consider that in the evening and during night shifts, sleeping areas are traditionally kept darker while patient care and common areas remain lit. As such, local jurisdictions may consider an appropriate lighting plan to account for those differences.

Medical Gases

Depending on the nature of the event, individuals who require the assistance of medical gases, such as oxygen, may register at the ACS with limited or no additional supplies of those gases. In anticipation of this situation, agreements should be established with multiple oxygen providers for the provision of medical gas during ACS operations. During activation, these providers should be contacted immediately to begin transporting oxygen and other gases.

Medical Devices

Patients who regularly use medical devices such as ventilators, dialysis machines, pumps, and monitors may present to the ACS. In preparation for these patients, jurisdictions may consider developing a list of the most commonly used devices. This list could be used to identify devices present at the ACS and those which may have to be obtained. For devices which are

more complicated to use, general handling and operating guidelines should be made available. Prior to an event, work should be done to identify vendors and healthcare providers with the resources to supply medical devices for patients who do not bring their own with them to the ACS. Jurisdictions should ensure pre-identified locations contain wide doorways, hallways, and ramps so patients with access and functional needs are able to access the devices.

10.5 Appendix 5: Site Selection Tool

This tool provides sample criteria for selecting an Alternate Care Site, including, but not limited to, facility information, basic contact information, and considerations for access and functional needs.

ACS ASSESSMENT AND SELECTION

REQUIRED ATTACHMENTS: site map and/or floor plan drawing of facility.

DATE ASSESSED: _____

SITE INSPECTED AND ACCEPTABLE FOR:

Medical: ☐ Alternate Care Site ☐ Mass Vaccination/Point of Distribution

FACILITY AVAILABILITY: ☐ Available any time ☐ Blackout dates: _____

FACILITY CONTACT(S) – (Include Facility Maintenance and/or Custodial Contacts):

Point of Contact (Site Access) _____ Title: _____ Email: _____

Daytime Phone: ( ) _____ Alternate Phone: ( ) _____ After Hours: ( ) _____

Point of Contact (Site Security) _____ Title: _____ Email: _____

Daytime Phone: ( ) _____ Alternate Phone: ( ) _____ After Hours: ( ) _____

Point of Contact (Maintenance) _____ Title: _____ Email: _____

Daytime Phone: ( ) _____ Alternate Phone: ( ) _____ After Hours: ( ) _____

ADDRESS INFORMATION:

Site Name: _____ Thomas Guide Map Page#: _____ Grid#: _____

Street Address: _____ Cross Street: _____

City/State/Zip: _____ Mailing Address (if different): _____

SITE INFORMATION:

☐ Access to more than one major road or highway from site (+2 lanes)

☐ Access to public transit – distance from nearest public bus or train stop _____

☐ Multi-level

Parking: List any available parking lots on site (e.g., Parking Lot 1, Parking Lot 2, etc.)

List Parking Lot	# of Spaces	# of Disabled Spaces	Type of Surface	Trucks OK?
				☐
				☐
				☐

Exterior Spaces: List any usable space on the site (e.g., athletic field, courtyard, playground, etc.)

Exterior Space	Size (SF)	Fenced?	Equipment (seating, play, etc.)
		☐	
		☐	
		☐	

Whether answer is yes or no, please put actual measurements where indicated

Parking: If off street parking is available	Yes	No	N/A	Min/Max	Actual
1. Is there one (or more) off-street parking space, either permanently or temporarily designated for people with disabilities? (If "Yes" then proceed to question 8) (One van-accessible space for every 25 regular spaces, e.g., 1-25 = one van-accessible space).				Car 9 ft. wide 18 ft. long 5 ft. aisle	
2. Is there at least one parking space that is van accessible for every 25 spaces?				Van 9 ft. wide 18 ft. long 8 ft. aisle	
3. Are parking spaces on level ground?				Max: 2% slope	
4. Is the parking area surface stable, firm, and slip resistant?				Concrete Asphalt No gravel	
5. Is the disabled parking space in the closest location to the accessible entrance/pathway to the ACS?				N/A	
6. Is there signage at the front of the parking stall that identifies the space as reserved, by displaying the international symbol of accessibility so that it is readily visible to passing traffic even if the space is occupied?				80" at the lowest edge of the sign	
7. Is there an accessible route from the parking area to an accessible path of travel (continuous common surface)?				48" min wide 36" min at a single point	
8. Grates – (If the walking space has grating) (Perpendicular to the path of travel)				No greater than ½" wide	

Comments:

_____
_____
_____

BUILDING EXTERIOR:

☐ Access ramps? ☐ Accessible doorways (min 35" wide)? ☐ Auto-doors or appropriate door handles?

Path of Travel - Parking Area to the ACS Entrance	Yes	No	N/A	Min/Max	Actual
1. Is an accessible route provided from accessible parking spaces to the accessible entrance to the building?				48" wide 36" wide at a single point	
2. Is an accessible route provided from public sidewalks and public transportation stops on the emergency ACS to the accessible entrance of the building? (If provided) (You must survey the surrounding block where the ACS is located.)				48" wide 36" wide at a single point	
3. Is the surface of the path of travel stable, firm, and slip resistant?				Concrete, asphalt, no gravel	
4. Is the path of travel to the building an accessible width?				48" wide 36" wide at a single point	
5. Is there a continuous common surface not interrupted by un-ramped steps or by abrupt changes in level in the path of travel to the entrance?				¼" high or beveled from ¼" to ½" high.	
6. Is the path of travel to the building entrance free of obstructions (fire hydrants, tree trunks, etc.)?				Min of 36" wide	
7. Is the path of travel to the emergency ACS free of any objects (e.g., wall mounted boxes, signs, tree branches, etc.)				Bottom edge lower than 27" high or higher than 80" extending no more than four inches into the path of travel.	
7a. If no, can the object be lowered, removed or modified?					

Path of Travel - Parking Area to the ACS Entrance. (Continued)	Yes	No	N/A	Min/Max	Actual
8. If there is an alternative path of travel for accessibility, is there a sign to identify the accessible route?				Bottom edge lower than 27" high or higher than 80" extending no more than four inches into the path of travel.	
9. Alternate Accessible Entrance Signage: If the main entrance is inaccessible, is the accessible alternate entrance clearly marked?				Same as Item #8	
Ramps	**Yes**	**No**	**N/A**	**Min/Max**	**Actual**
1. If there are stairs at the main entrance, is there also a ramp or lift, or is there an alternative accessible entrance?				N/A	
2. Do all ramps have a slope no greater than 1-inch rise in 12 inches of horizontal run?				1:50 or 2% max slope	
3. Ramp Width?				48" min.	
4. Does the ramp have edge protection in the form of walls on each side, wheel guides, or raised curbs?				N/A	
5. Do ramps have a slip-resistant surface?				N/A	
6. If a ramp rises more than six inches, or if it is longer than 72 inches, does it have handrails on both sides?				Between 34 – 38" above the surface of the ramp	
7. Is there a landing at both the top and bottom of the ramp? **NOTE – Requirement also needed at every change of direction				5'x5' level landing at the top, bottom, and at every 30" of rise	

Ramps (Continued)	Yes	No	N/A	Min/Max	Actual
8. If there are stairs at the main entrance, is there also a ramp or lift, or is there an alternative accessible entrance?				N/A	

9. Do all ramps have a slope no greater than 1-inch rise in 12 inches of horizontal run?				1:50 or 2% max slope	
10. Ramp width?				48" min.	
11. Does the ramp have edge protection in the form of walls on each side, or wheel guides, or raised curbs?				N/A	
12. Do ramps have a slip-resistant surface?				N/A	
13. If a ramp rises more than 6 inches, or if it is longer than 72 inches, does it have handrails on both sides?				Between 34"-38" above the surface of the ramp	
14. Is there a landing at both the top and bottom of the ramp?				5'x5' level landing at the top, bottom, and at every 30" of rise, and every change of direction	

Comments:

_____
_____
_____
_____
_____

Structure: ☐ Wood Frame ☐ Metal/Steel Frame ☐ Concrete (Reinforced) ☐ Prefabricated

☐ Reinforced Masonry (Brick) ☐ Unreinforced Masonry ☐ Trailer ☐ Bungalow ☐ Pod

Construction Year: _____ Earthquake Retrofit? ☐ If checked, date of last retrofit _____

☐ Loading Dock? - Description: _____ ☐ Staging Area? - Description: _____

☐ External electrical outlets? ☐ Sufficient lighting?

Comments:

_____
_____

BUILDING INTERIOR SPACES:
# of Stories: _____ ☐ Elevator(s)? ☐ Movement between floors ADA accessible?

Elevators	Yes	No	N/A	Min/Max	Actual
1. If an elevator is required to reach the waiting area, is the elevator doorway wide enough for a wheelchair user?				At least 36" clearance	
2. Is the elevator cab size?				68" wide x 51" deep	
3. Are elevator controls clearly marked with raised lettering for visually impaired persons?				Braille Lettering	
4. Are the elevator controls low enough for a person in a wheelchair to reach them?				No higher than 54" from the elevator floor	

Comments:
_____
_____
_____
_____

Features inside the ACS area

Sketch and attach a space diagram for each of the following (if applicable), include pictures:

☐ Dormitory (sleeping or alternate care area) ☐ Dining ☐ Office(s) ☐ Interviewing ☐ Disaster Health Station

☐ Recreation/meeting area ☐ Patient storage area ☐ Staff break area ☐ Bathroom/Shower area ☐ Isolation

☐ Lighting (dimmers, switches, etc.) ☐ Electrical (outlets, mains, etc.)

BUILDING FURNITURE:

Furniture	Description/Quantity/Size
Tables	
Chairs	
Cafeteria Tables/Benches	
Desks	
Portable Room Dividers	

Comments:
_____
_____
_____
_____
_____

FOOD PREPARATION FACILITIES:

☐ None on site ☐ Warming oven kitchen ☐ Full-service kitchen with a capacity of _____ meals a day

☐ Facility representative required on site when using kitchen? Contact name/phone _____

Equipment	Quantity/Size	Equipment	Quantity/Size	Equipment	Quantity/Size
Refrigerator		Walk-in Refrigerator		Ice Machine	
Freezer		Walk-in Freezer		Braising Pan	
Burner		Griddle		Warmer	
Oven		Convection Oven		Microwave	
Steamers		Steam Kettles		Sinks	
Dishwasher		Deep Fryer		Coffee Maker	

☐ Kitchen with valid health permit ☐ Kitchen without valid health permit

Comments:

_____

_____

_____

SANITATION:

Potable water source: ☐ City ☐ Small Public Water System ☐ Private Well

Solid waste collection service/company: _____

Sewer: ☐ City ☐ Aerobic Onsite Wastewater ☐ Septic Onsite Wastewater

	Men	Women	Unisex	Disabled (M/W)	Hot Water?
# of Toilets					
# of Diaper Changing Stations					
# of Sinks					
# of Showers					

Restrooms	Yes	No	N/A	Min/Max	Actual
1. Is there sufficient clearance area on the floor in the direction of the door swing for a wheelchair user to maneuver?				60" diameter turning space or 56" x 63" clear space	
Is there a(n): a. Accessible toilet area? b. Stall door automatic closing device? c. Handle below latch on door? d. Grab bars? e. Toilet seat height? f. Sufficient clearance?	☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐	a. loop or U-shaped handle below the latch b. on one side and behind the toilet c. 17" – 19" high d. 60" in width	
2. Sufficient floor clearance in the room?				60" diameter or a T-turn clearance	

3. Where urinals are provided, is there sufficient clear floor space in front of the urinal for a wheelchair user to approach?				30" x 48"	
4. a. Is there a clear floor space in front of and underneath the sink area to accommodate a wheelchair user? b. Counter height? c. Knee space? d. Faucet hardware?				a. 30" x 48" b. 34" from the floor max c. 29" reducing to 27" high at 8" back d. Shall be operable with a single effort.	
5. Are the following within reach of a person in a wheelchair? a. towel b. mirror c. sanitary napkins d. waste receptacles				All: 40" high max	

Other building features	Yes	No	N/A	Min/Max	Actual
1. Door widths: Are doorways in the path of travel wide enough to accommodate a wheelchair?				32" with door open at 90 degrees	
2. Is there adequate space for a person in a wheelchair to turn around at the entrance?				5' diameter circle	
3. Are doorway thresholds no more than ½ inch in height?				¼" high or beveled from ¼" to ½" high.	
4. Are all doors equipped with either arch or lever-type handles, push plates, or automatic openers that can be used with a closed fist and are all handles no higher than 48 inches?				Door handle to be no more than 48" high	
4a. If no, will the doors remain open?				N/A	
5. Hallways and corridors in the path of travel?				44" wide min	
6. Is there an adequate maneuvering clearance for a wheelchair on each side of the doorway?				60" on the pull side 48" on the push	

☐ Laundry facilities available for ACS use? # of Washers _____ # of Dryers _____

UTILITIES:

☐ Generators? If generators are portable, list type and location: _____

Generator fuel type: _____ Fuel capacity: _____ Kilowatt capacity: _____

What does the generator power? _____ Operating time: _____hours at rated capacity.

Usage	Utility Provider	Energy Source
Heating		☐ Electric ☐ Natural Gas ☐ Propane ☐ Fuel Oil
Cooling		☐ Electric ☐ Natural Gas ☐ Propane ☐ Fuel Oil
Cooking		☐ Electric ☐ Natural Gas ☐ Propane ☐ Fuel Oil
Usage	**Yes/No**	**Description**
Lighting		
Water		

COMMUNICATIONS:

Item	Location	How Many	Phone Number
Office Phone			
Pay Phone			
TTY Phone			
Fax			
Network/Internet Access			
PA System			
Audio Visual Equipment			

SAFETY/SECURITY:

☐ Facility grounds are securable (gates, fences) ☐ Full-time emergency vehicle access (police, fire, ambulance)

☐ Building areas are securable (gates, fences) ☐ Buildings have key-card or other access method

☐ Security Alarm System If checked, ☐ Automatically alerts Police

☐ Fire Alarm If checked, ☐ Manual (pull station) ☐ Automatic ☐ Automatically alerts Fire Department

☐ Sprinkler system ☐ Fire Extinguishers on site

☐ Alarm Systems are regularly maintained and tested ☐ Alarm systems are easily used by facility staff

10.6 Appendix 6: Command Job Aid

The Command Job Aid outlines specific processes and considerations for decision-making with regards to SMOC coordination and resource identification for hospital senior leadership in hospital-based ACS operations. This tool is specifically designed for a member of hospital senior leadership who has:

- A basic understanding of emergency management.
- An understanding of hospital operations and specific clinical needs that would be required of an ACS.
- The authority to command ACS operations and make decisions on behalf of the impacted hospital.

This Command Job Aid is meant to coincide with the hospital plans, particularly pertaining to identifying who has the authority to oversee critical operations. The goal of this tool is to guide coordination considerations when facing a threat that could initiate the activation of a hospital-based ACS.

Like the Execution Checklist, the Command Job Aid is broken down into four time-based phases:

- Activation
- Mobilization
- Site Operations
- Demobilization

As possible, checklist activities are time sequential so that senior leadership can quickly run through the checklist and delegate tasks to the appropriate partners accordingly in rapid succession. However, as many tasks may be ongoing, reoccurring, or conducted simultaneous to others, time sequence is only provided as a guide; final determination and sequence will be incident specific.

Activation	
☐	Fully activate hospital command center, including staff recall procedures.
☐	Fully activate internal surge capacity plans, including mandatory clinical rounds by all physicians.
☐	Fully execute internal patient decompression activities (e.g., elective procedures cancelled).
☐	Activate Hospital-based Alternate Care Site and identify level of care: ☐ ER ☐ SNF ☐ Orthopedics ☐ OB ☐ Pediatrics ☐ IC ☐ Mental Health
☐	Coordinate with St. Louis Medical Operation Center leadership and local Emergency Management Office via Hospital Command Center.
☐	Approve ACS site selection based on incident needs and patient needs.
☐	Coordinate with local emergency medical services and inbound referral networks.
☐	Activate necessary mutual aid agreements and emergency contracting.

☐	Establish coordination with local other hospitals for patient transfers, as appropriate.
☐	Brief staff and physicians related to operational goals and alternate care site activation timelines.
☐	Begin assessment on known and anticipated resource needs: ☐ Approve resource management strategy ☐ Staffing ☐ Supplies ☐ Equipment ☐ Medications

Mobilization	
☐	Conduct Incident Action Plan briefing by hospital command center for all staff and physicians
☐	Request and maintain incident situational awareness: ☐ Alternate Care Site objectives ☐ Alternate Care Site location and traffic management plan ☐ Limitations ☐ Ongoing assessment of anticipated patient volumes
☐	Coordinate with Hospital Command Center, St. Louis Medical Operations Center, local Emergency management Agency, and Emergency Medical Services agencies
☐	Continue to communicate through public information officer: ☐ Identify a media staging area, if not already accomplished ☐ Develop press release about hospital's activity to accommodate increased levels of patients, if not already accomplished
☐	Review overall operational phases with senior leadership and key staff
☐	Implement resource coordination and management systems
☐	Implement medical record systems
☐	Implement patient tracking systems

Site Operations	
☐	Ongoing assessment by the Alternate Care Site administrator in coordination with the hospital command center, for: ☐ Patient intake ☐ Discharge/transfer/tracking ☐ Resource requests ☐ Patient acuity and outcomes
☐	On-going coordination with Hospital Coordination Center regarding incident situational awareness. Based on guidance: ☐ Patient volumes and anticipated volumes at 12, 24, 36 hours ☐ Staffing requests ☐ Medical supply and medication requests

☐	Coordinate with Hospital Coordination Center and local Emergency Management Agency on logistical needs (power, traffic flow, etc.).
☐	Coordinate with hospital infection control and local public health for ongoing surveillance
☐	Coordinate with hospital command center via Alternate Care Site administrator on all activities

Demobilization	
☐	Alternate Care Site administrator coordinates demobilization criteria, based upon incident.
☐	Coordinate with Hospital Command Center and St. Louis Medical Operations Center on patient transfer and discharge.
☐	Coordinate through Alternate Care Site administrator for long-term documentation and storage.
☐	Debrief and schedule after-action review.

10.7 Appendix 7: ED Saturation Worksheet

This worksheet provides saturation estimates for understanding and predicting the staffing need for an ACS.

ST. LOUIS REGION ED SATURATION WORKSHEET				
DATE (MM/DD/YYYY)	**TIME**	**FACILITY[3]**		
CHARGE NURSE/MANAGER				
PHYSICIAN(S)				
HOUSE SUPERVISOR				

	ED BED SATURATION	**NOTES**
	NUMBER OF BEDS OCCUPIED INCLUDING OVERFLOW / HALL BEDS	**PTS. Holding for Pre-Admit/Admit:**
	NUMBER OF ASSIGNED ED BEDS EXCLUDING OVERFLOW / HALL BEDS	
	PATIENTS IN WAITING AREA	
	NUMBER OF PATIENTS IN LOBBY	
	LOBBY CAPACITY (50% OF ASSIGNED BEDS)	
	AMBULANCE PATIENTS	
	NUMBER OF AMBULANCE PATIENTS WAITING OR EN ROUTE	
	ADMISSION ACUITY	**NOTES**
	Add 1 for every telemetry or Med/Surg. admit	**Name of Units w/ Unstaffed Beds:**
	Add 2 for every ICU admit	
	Add 3 for every patient requiring one-on-one nursing care	
	LOBBY WAIT TIME	
	Add two if average wait time is in excess of four hours	
	STAFFING	
	Add 5 points for every 1 number of nurses you are down if your number of ER beds is 1-15	
	Add 5 points for every 2 nurses you are down if your number of ER beds is 16-30	
	Add 5 points for every 3 nurses you are down if your number of ER beds is 31-45	
	Add 5 points for every 4 nurses you are down if your number of ER beds is over 45	
TOTAL	**TOTAL**	**SATURATION LEVEL**

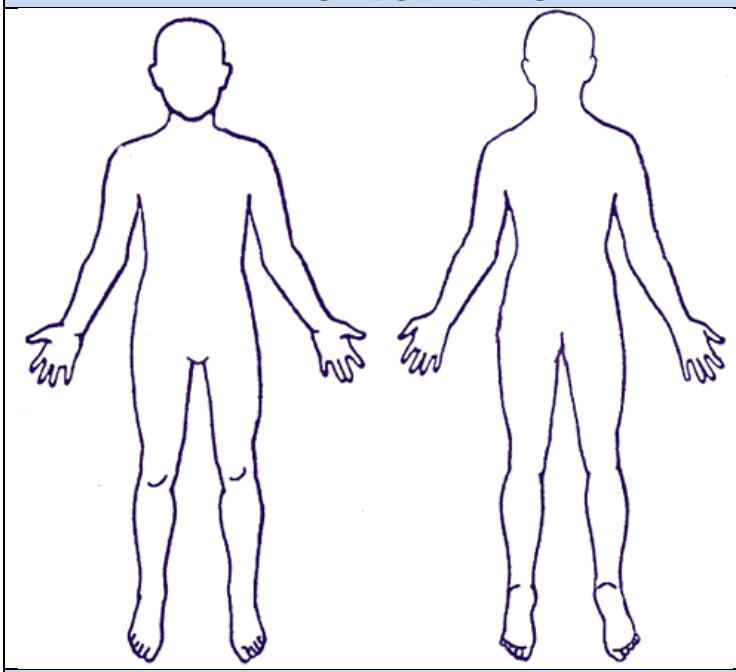
[3] This document was originally drafted by the SLU Hospital as a means for gauging emergency departmentsaturation and informing staff capability.

10.8 Appendix 8: Patient Intake and Assessment Form

This tool provides a form for receiving patients at the ACS and guides initial triage.

ALTERNATE CARE SITE PATIENT INTAKE AND ASSESSMENT FORM									
INCIDENT NAME	**LOCATION (ACS, City/Town, County)**						**DATE (MM/DD/YYYY)**		
NAME LAST, FIRST, MI	**DATE OF BIRTH** (MM/DD/YYYY)	**GENDER** (Circle)					**IF UNDER 18, IS LEGAL GUARDIAN PRESENT?**		
		M / F					**Y / N**		
CHIEF COMPLAINT / DURATION							**CODE STATUS /ADV DIR**		
ALLERGIES									
MODE OF ARRIVAL	**Patient's primary language**						**SPECIAL DIET**		
Ambulatory / Wheelchair / Stretcher	English / Spanish / Other _____								
PRIMARY CARE PHYSICIAN	**NAME:**						**PHONE:**		
MEDICAL/ SURGICAL HISTORY									
PMHX:									
PSHX:									
SOCIAL HISTORY (Alcohol/Drug Abuse, Tobacco, STD)									
TOBACCO	YEARS SMOKED	PACKS / DAY	PASSIVE EXP. YRS	**ALCOHOL**	AMOUNT	FREQ/ LAST USE	**IV DRUGS**	DRUG	FREQ/ LAST USE
Y / N				**Y / N**			**Y / N**		
VITALS	**HEIGHT** INCHES	**WEIGHT** KG.	**BP**	**PULSE**	**RESP RATE**	**TEMP**	**PAIN SCALE** (0 – 10)	**O2 SAT**	
			/						

PHYSICAL EXAM	**REMARKS**	**See Body Diagram Below**
GENERAL		
HEENT	**PUPILS _____**	
NEURO		
NECK		
CHEST	**HEART** **LUNGS**	
ABDOMEN		
GENITAL		
ARMS		
LEGS		
SKIN		
PSYCH		
OTHER	**IF FEMALE, LNMP?** **PREGNANT? Y / N** **EDC?**	
PAIN		

EXAMINATION BODY DIAGRAM	ASSESSMENT / IMPRESSION
	☐ VISION IMPAIRED ☐ HEARING IMPAIRED

PLAN/PREVENTION/EDUCATION

PLEASE PRINT NAME	PROVIDER TYPE	SIGNATURE

CURRENT MEDICATIONS - (PRESCRIPTIONS CONFIRMED? Y / N)

MEDICATION	DOSE	FREQ.	LAST DOSE	Prescription Confirmed
				Y / N
				Y / N
				Y / N
				Y / N
				Y / N
				Y / N
				Y / N
				Y / N
				Y / N
				Y / N
				Y / N

MEDICAL EQUIPMENT

Equipment	Brought to ACS?	Equipment	Brought to ACS?
	Y / N		Y / N
	Y / N		Y / N
	Y / N		Y / N
	Y / N		Y / N

COMMENTS

10.9 Appendix 9: Patient Ongoing Medical Record Form

This tool provides a base form for tracking medical conditions of a patient once received into an ACS.

PATIENT ONGOING MEDICAL RECORD

ACS Site Name:

Patient Name:

CHIEF COMPLAINT: Please check all main categories (e.g., INJURY, ILLNESS or EXACERBATION OF CHRONIC ILLNESS) and associated chief complaints related to the patient's current main reason for seeking care. Specify 'Other' when appropriate.

INJURY

DATE OF INJURY:

TYPE OF INJURY:

- ☐ abrasion, laceration, cut
- ☐ concussion
- ☐ avulsion, amputation
- ☐ sprain, strain
- ☐ bruise, contusion
- ☐ fracture

MECHANISM OF INJURY:

- ☐ bite, specify:
  - ☐ insect
  - ☐ dog
  - ☐ snake
  - ☐ human
  - ☐ other_____
- ☐ burn, specify: __thermal (e.g., fire) __chemical
- ☐ drowning / submersion in water
- ☐ foreign body (e.g., splinter)
- ☐ fall, slip, trip
- ☐ carbon monoxide poisoning/ingestion of poison
- ☐ motor vehicle accident, specify: __driver/occupant __pedestrian/bicyclist
- ☐ operating machinery, tools, or equipment
- ☐ recreational, playing sports
- ☐ assault (e.g., gunshot, domestic violence)
- ☐ sexual assault or rape
- ☐ other, specify: _____

MENTAL HEALTH

- ☐ agitated behavior: anxiety or stress
- ☐ depressed mood
- ☐ suicidal thoughts
- ☐ drug/alcohol intoxication/withdrawal
- ☐ other, specify: _____

ILLNESS/ SYMPTOMS

- ☐ fever > 100.4°F (>38°C)
- ☐ conjunctivitis / pink eye / eye irritation
- ☐ extreme fatigue or overexertion dehydration
- ☐ heat stress or heat exhaustion

- ☐ **Pain:** if 'other' specify below:
  - ☐ abdominal pain or stomach ache
  - ☐ chest pain or angina
  - ☐ ear pain or earache (e.g., otitis)
  - ☐ headache or migraine
  - ☐ muscle or joint pain (e.g., back, hip pain)
- ☐ **Gastrointestinal,** if 'other' specify below:
  - ☐ diarrhea, specify: __watery __bloody
  - ☐ nausea or vomiting
- ☐ **Respiratory**, if 'other' specify below:
  - ☐ congestion, runny nose, sinusitis cough
  - ☐ sore throat
  - ☐ shortness of breath, difficult breathing
  - ☐ suspected pneumonia or bronchitis
  - ☐ wheezing in chest
- ☐ **Skin,** if 'other' specify below:
  - ☐ generalized rash (e.g., chickenpox)
  - ☐ localized rash (e.g., dermatitis, eczema)
  - ☐ soft tissue infection (e.g., pustule, abscess)
  - ☐ fungus, ring worm, tinea
- ☐ **Obstetrics/Gynecological**, specify below:
  - ☐ vaginal discharge (e.g., yeast infection)
  - ☐ vaginal bleeding outside of pregnancy
  - ☐ complication of pregnancy (e.g., preterm)
- ☐ **Neurological**, specify below:

- ☐ **Not specified elsewhere:** *(please print)*

FOLLOW-UP CARE

- ☐ blood pressure check
- ☐ blood sugar check
- ☐ dressing change / wound care
- ☐ immunization / vaccination
- ☐ medication refill
- ☐ pregnancy check-up
- ☐ other, specify: _____

EXACERBATION OF CHRONIC ILLNESS

ONLY if current visit is related. Do not record patient's HX.

- ☐ asthma
- ☐ cerebrovascular disease / stroke
- ☐ chronic joint pain (e.g., arthritis)
- ☐ congestive heart failure
- ☐ coronary heart disease (e.g., MI)
- ☐ diabetes
- ☐ epilepsy (e.g., seizures)
- ☐ hypertension
- ☐ obstructive pulmonary disease
- ☐ other, specify: _____

DISPOSITION TREATED:

Referred to:

- ☐ at ACS
- ☐ not treated
- ☐ refused
- hospital / clinic
- pharmacy
- physician

- ☐ Other, specify: _____

Comments:

Print Name/Title: **Signature:** **Date:**

10.10 Appendix 10: Medication Administration Record Form

This tool provides a tracking mechanism for the dissemination of medication within an ACS.

MEDICATION ADMINISTRATION RECORD

Month: ______________, Year: 20_______

Patient Name: ______________________________ Allergies: ________________________________ DOB: _______________

Ordering MD Date Ordered	Medication Name, Dose, Route	Administered Date, Time, By	Notes		Ordering MD Date Ordered	Medication Name, Dose, Route	Administered Date, Time, By	Notes
MD: Date:		Date: Time: By:			MD: Date:		Date: Time: By:	
MD: Date:		Date: Time: By:			MD: Date:		Date: Time: By:	
MD: Date:		Date: Time: By:			MD: Date:		Date: Time: By:	
MD: Date:		Date: Time: By:			MD: Date:		Date: Time: By:	
MD: Date:		Date: Time: By:			MD: Date:		Date: Time: By:	
MD:		Date:			MD:		Date:	

Ordering MD Date Ordered	Medication Name, Dose, Route	Administered Date, Time, By	Notes		Ordering MD Date Ordered	Medication Name, Dose, Route	Administered Date, Time, By	Notes
Date:		Time: By:			Date:		Time: By:	
MD: Date:		Date: Time: By:			MD: Date:		Date: Time: By:	
MD: Date:		Date: Time: By:			MD: Date:		Date: Time: By:	
MD: Date		Date: Time: By:			MD: Date:		Date: Time: By:	

Signature	Initials	Notes:	Signature	Initials	Notes:

10.11 Appendix 11: Insulin and Blood Glucose Monitoring Form

This tool assists ACS staff in monitoring insulin and blood glucose levels of ACS patients.

ACS INSULIN AND BLOOD GLUCOSE MONITORING FORM

Patient Name: _____ **Date of Birth:** _____

Type of insulin therapy: Split/Mixed___ Insulin Pump___ Basal/bolus___

Carb ratio for food: 1 unit for ___ grams of carbohydrates

Correction target BG: _____mg/dL

Correction factor: 1 unit for every _____mg/dL above correction target

Insulin pen cartridge/vial change dates:

_____ _____ _____ _____ _____ _____ _____ _____ _____

Date	Time	Blood Glucose	Insulin dose	Ketones (neg, S, M, or L)	Comments (note any unusual circumstances, i.e., extra food intake, hypoglycemia treatment, physical activity, change in routine, illness)	Initials

Signature of staff providing care	Initials	Date and Time	Signature of staff providing care	Initials	Date and Time

10.12 Appendix 12: Vital Signs Monitoring Form

This tool assists ACS staff in monitoring vital signs of ACS patients.

VITAL SIGNS MONITORING FORM

Patient Name: _____ **Date of Birth:** _____

Date	Time	Blood Pressure	Pulse Rate	Resp Rate	SpO2	Weight			Initials
		/							
		/							
		/							
		/							
		/							
		/							
		/							
		/							
		/							
		/							
		/							
		/							
		/							
		/							
		/							

Signature of staff providing care	Initials	Signature of staff providing care	Initials

10.13 Appendix 13: Volunteer Request Form

This tool provides a tracking mechanism for ACS volunteer requests.

Request Date: _____ Time: _____ Requesting Person: _____

Situation and Facility Information

Task	Information/Details	Notes
Contact made to: *List name and number*	☐ Formal local emergency request: Contact your county's Emergency Operations Center ☐ Non-formal information sharing during local emergency ☐ Recruiting for local, non-emergency activity, contact local administrator during regular business hours	*Emergency volunteers must be activated formally through EOC. Information can be shared non-formally with the local administrator to help arrange the details prior to request and to speed up activation.*
Requesting agency/facility:	Name and contact info: Alternate name and contact info:	
Relevant information about incident/event including a brief description and severity		
Incident/event location	Location name: Address: Date:	
Description of mission assignment	☐ ACS ☐ MCM dispensing ☐ Evacuation ☐ Shelter ☐ PFA ☐ Exercise ☐ MMT ☐ Other:_____	
Occupation/specialty being requested and number	☐ RN____ ☐ LPN_____ ☐ CNA_____ ☐ PharmD_____ ☐ First Responder/EMT_____ ☐ Vet_____ ☐ RT_____ ☐ Paramedic: ALS___BLS_____ ☐ Support staff_____ ☐ Interpreter/language _____ ☐ Other_____	Be prepared to identify specific training, skill, or clinical specialty needed.

Task	Information/Details	Notes
Start date and time for volunteers, shift lengths		
Hardships at incident/event (work and environmental risks)		

Volunteer Support Details

Task	Information/Details	Status	Notes
Training	Online course needed: _____ JITT will be provided ☐ Yes ☐ No Topic: _____	☐ Complete ☐ In process ☐ Unsure	
Housing ☐ N/A	Provided details ☐ Yes ☐ No	☐ Complete ☐ In process ☐ Unsure	
Meals ☐ N/A	Provided details ☐ Yes ☐ No	☐ Complete ☐ In Process ☐ Unsure	
Transportation/parking ☐ N/A	Provided details ☐ Yes ☐ No	☐ Complete ☐ In process ☐ Unsure	
Required documentation ☐ N/A	☐ Driver's license ☐ Medical insurance ☐ MN Responds ID ☐ Other: _____ ID to access site: ☐ Yes ☐ No Type: _____	☐ Complete ☐ In process ☐ Unsure	
Family emergency contact ☐ N/A	Contact name/number for family to use for emergency contact: Communication lines available:	☐ Complete ☐ In process ☐ Unsure	*Details on how a family member may be able to reach volunteer in emergency.*

Task	Information/Details	Status	Notes
Personal equipment requested	Cell phone: ☐ Yes ☐ No Other: _____	☐ Complete ☐ In process ☐ Unsure	
Functional needs/health status assessment for volunteers ☐ N/A	Factors: ☐ Lifting required: ☐ Light (10 lb) ☐ Med (50 lb) ☐ Hvy (>50 lb) ☐ Environment: ☐ Extreme weather ☐ Mobility/debris restrictions ☐ Other: _____	☐ Complete ☐ In process ☐ Unsure	

Operations Considerations

Task	Information/Details	Notes
Check in/out Staging Orientation	Check in location: _____ Contact name/info: _____ Secondary contact name/info: _____ Orientation provided: ☐ Yes ☐ No Check out location same as Check in location: ☐ Yes ☐ No	
Job assignment	Job action sheet/guide provided: ☐ Yes ☐ No JITT: ☐ Yes ☐ No Supervisors listed: ☐ Yes ☐ No Shift details, including scheduled breaks, available: ☐ Yes ☐ No	
Equipment	PPE: ☐ Yes ☐ No Level: ☐ Universal ☐ BBP ☐ Airborne ☐ Other:_____ Vest: ☐ Yes ☐ No Communications (list available): _____ Other:	

Demobilization

Task	Information/Details	Notes
Shift completion	Released with chain of command: ☐ Yes ☐ No Debriefing available: ☐ Yes ☐ No Location: ☐ Yes ☐ No If yes, where?	
Agency notification	Releasing agency to notify MN responds administrator of volunteer reassignment/completion: ☐ Yes ☐ No	

Notes:

Acronyms

ACS – Alternative Care Site **CNA** – Certified Nursing Assistant **EMT** – Emergency Medical Technician **HSEM** – Homeland Security Emergency Management **JIT** – Just in Time **JITT** – Just in Time Training **LPN** – Licensed Practical Nurse **MAC** – Multi Agency Coordination **MCM** – Medical Countermeasure **MMMT** – Mobile Medical Team **PFA** – Psychological First Aid **PharmD** – Pharmacist **PPE** – Personal Protective Equipment **RN** – Registered Nurse **RT** – Respiratory Therapist **Vet** – Veterinarian

10.14 Appendix 14: Patient Tracking Form

Purpose

The Hospital Incident Command System (HICS) 254 Disaster Victim / Patient Tracking records the triage, treatment, and disposition of victims/patients of the event seeking medical attention. This form is to be completed by the patient tracking manager or team members. In addition, it should be distributed to the situation unit leader, with copies to patient registration unit Leader, planning section patient tracking manager, medical care branch director, and the documentation unit leader.

Note: Some jurisdictions in the St. Louis Area Regional Response System (STARRS) region have opted to use of SMART Triage Tag system, which provides a standard tool for triage in large incidents.

Form Usage

The form is completed upon arrival of the first patient and updated periodically. Copies of the form are sent to the planning section patient tracking manager each hour and at the end of each operational period until disposition of the last victim(s) are known. If additional pages are needed, use a blank HICS 254 and repaginate as needed. Additions may be made to the form to meet the organization's needs.

1. Incident Name	**2. Operational Period** (#) DATE: FROM: _____ TO: _____ TIME: FROM: _____ TO: _____

3. Area (Triage or Specific Treatment Area)

FIELD TAG NUMBER	**MEDICAL RECORD NUMBER**	**NAME** (LAST NAME, FIRST NAME)	**SEX** (M/F)	**DOB / AGE**	**TRIAGE CATEGORY** IMMEDIATE DELAYED MINOR EXPECTANT EXPIRED	*LOCATION / TIME OF PROCEDURES* *(CT, X-RAY, ETC.)*	**DISPOSITION / TIME** (D) DISCHARGE (A) ADMIT (S) SURGERY (T) TRANSFER (M) MORGUE

4. Prepared by

PRINT NAME: _____ SIGNATURE: _____

DATE/TIME: _____ FACILITY: _____

10.15 Appendix 15: Example Equipment Lists

This tool provides a list of needed equipment to run a 25-bed ACS, as well as implement any of the several additional services.

Assignment	ACS	+ER	+SNF	+Ortho	+OB	+Pedi
Adapter, Airway Tube, EA	1					
Adapter, IV, Injection, w/MLL, EA	12	20				
Airway, Berman, Adult, Red, EA		2				
Airway, Berman, Green, EA		9				
Airway, Berman, Infant, Pink, EA		1				
Airway, Berman, Pediatric, Green, EA		2				
Airway, Berman, Pink, EA		4				
Airway, Berman, Red, EA		3				
Airway, Endotracheal, Esophageal, 5.5, EA		1				
Airway, Endotracheal, Esophageal, 6.0, EA		1				
Airway, Endotracheal, Esophageal, 6.5, EA		1				
Airway, Endotracheal, Esophageal, 7.0, EA		1				
Airway, Endotracheal, Esophageal, 7.5, EA		2				
Airway, Endotracheal, Esophageal, 8.0, EA		1				
Airway, Endotracheal, Esophageal, 8.5, EA		2				
Airway, Nasopharyngeal, 24 Fr, EA		1				
Airway, Nasopharyngeal, 32 Fr, EA		1				
Applicator, Chlora Prep, EA		20				
Arm Board, IV, Adult, EA		5				
Arm Board, IV, Infant, EA		9				
Bag, Biohazard, 25" X 34" X 1.2 ML, EA	25					
Bag, Post-Mortem, EA		1				
Bag, Specimen, Biohazard, EA	5					
Bandage, 2" X 4 1/2", EA	10					
Bandage, 2" X 4 1/2", Sterile, EA	10					
Bandage, 6-ply, Roll, 4.5" X 147", EA		2				
Bandage, Conforming, Sterile, 2" X 4.1YD, EA	3					

Assignment	ACS	+ER	+SNF	+Ortho	+OB	+Pedi
Bandage, Conforming, Sterile, 2", EA	2					
Bandage, Conforming, Sterile, 3" X 4.1YD, EA	1					
Bandage, Conforming, Sterile, 4" X 4.1YD, EA	3					
Bandage, Conforming, Sterile, 6" X 4.5YD, EA	2					
Bandage, Elastic, 2", EA	1					
Bandage, Elastic, 4", EA	1					
Bandage, Elastic, 6", EA	1					
Bandage, Elastic, NS, 2" X 4.5YD, EA				3		
Bandage, Elastic, NS, 6" X 4.5YD, EA				2		
Bandage, Elastic, Roll, 2" X 4.5 YD, EA				10		
Bandage, Elastic, Roll, 4", EA	10					
Bandage, Elastic, Roll, 6", EA	8					
Bandage, Flexible, Sterile, 2" X 4 1/2", EA	5					
Bandage, Flexible, Sterile, 2" X 4 1/2", EA	5					
Bandage, Gauze, 33cm X 13cm X 26cm, EA			70			
Bandage, Gauze, Conforming, 3" X 4.1 YD , EA			5			
Bandage, Gauze, Conforming, Stretch, 2" X 4.1YD, EA			10			
Bandage, Gauze, Conforming, Stretch, 4", EA	1					
Bandage, Gauze, Conforming, Stretch, 6", EA	1					
Bandage, Gauze, Stretch, Conforming, 2" X 1.4YD, EA			29			
Bandage, Gauze, Stretch, Conforming, 3" X 4.1YD, EA			10			
Bandage, Gauze, Stretch, Conforming, 4" X 4.1YD, EA			10			
Bandage, Gauze, Stretch, Conforming, 6" X 4.5YD, EA			5			
Bandage, Knuckle, 1 1/2" X 3", EA		20				
Bandage, Knuckle, Sterile, 1 1/2" X 3", EA		10				
Bandage, Roll, Sterile, 6-ply, 4.5" X 147", EA		1				
Bandage, Strip, Sterile, 1.2" X 5YD, EA		5				
Bandage, Triangular, NS, EA	3					
Basin, Emesis, 16oz, EA	3					
Basin, Wash, EA	10					
Bed Pan, EA	4		10			

Assignment	ACS	+ER	+SNF	+Ortho	+OB	+Pedi
Bed, Folding, w/IV Pole, EA	1					
Blade, Laryngoscope, Macintosh, Size 2, EA		1				
Blade, Laryngoscope, Macintosh, Size 3, EA		2				
Blade, Laryngoscope, Macintosh, Size 4, EA		1				
Blade, Laryngoscope, Macintosh, SZ 2, EA		1				
Blade, Laryngoscope, Miller, Size 0, EA		1				1
Blade, Laryngoscope, Miller, Size 1, EA						1
Blade, Laryngoscope, Miller, Size 2, EA						1
Blade, Laryngoscope, Miller, Size 3, EA		1				
Blade, Ring Cutter, EA		1				
Blanket, Emergency, EA	21					
Brush, Double Scrub, Foam care, EA	4	11				
Cannula, ETCO2, Pediatric, EA						3
Cannula, O2, Nasal, Adult, EA		1				
Cannula, O2/CO2, Oral/Nasal, Adult/Intermediate, EA		3				
Cannula, O2/CO2, Oral/Nasal, Pediatric, EA						1
Cannula, Oxygen, Nasal, Adult, EA		10				
Catheter, 2-way, Foley, 10 Fr, EA			6			
Catheter, 2-way, Foley, 14 Fr, EA			6			
Catheter, Graduated, Coiled, 14 Fr., EA			10			
Catheter, Graduated, Coiled, 6 Fr., EA			8			
Catheter, Graduated, Coiled, 8 Fr., EA		3	5			
Catheter, IV, 14G, 1 1/4", EA		7				
Catheter, IV, 16G, 1 1/4", EA		6				
Catheter, IV, 18G, 1 1/4", EA		6				
Catheter, IV, 20G, 1 1/4", EA		7				
Catheter, IV, 22G, 1", EA		5				
Catheter, IV, 24G, 5/8", EA						5
Catheter, IV, Safety, 1 1.4" X 16 GA, EA						
Catheter, IV, Safety, 1 1/4" X 14 GA, EA						
Catheter, IV, Safety, 1 1/4" X 18 GA, EA						

Assignment	ACS	+ER	+SNF	+Ortho	+OB	+Pedi
Catheter, IV, Safety, 1 1/4" X 20 GA, EA						
Catheter, IV, Safety, 1" X 20 GA, EA						
Catheter, IV, Safety, 5/8" X 24 GA, EA						
Catheter, Suction, 14 Fr, EA		3				
Catheter, Suction, 6 Fr, EA						
Catheter, Suction, 8 Fr, EA						
Cloth, Dry Wash, 10" X 13", EA			20			
Collar, Extrication, No-Neck, EA		1				
Collar, Extrication, No-Neck, Infant, EA						1
Collar, Extrication, Pediatric, EA						1
Collar, Extrication, Reg, EA		3				
Collar, Extrication, Short, EA		1				
Collar, Extrication, Tall, EA		1				
Collection System, Capillary Blood, EA						1
Connector, IV, T, EA		5				
Container, Sharps, 1.7 QT, EA	3					
Cover, Probe, Temperature, EA	40					
Crutches, Adult, EA	1					
Crutches, Adult, PR		5				
Crutches, Youth, EA						2
Cuff, Blood Pressure, Adult, EA	1					
Cuff, Blood Pressure, Child, EA						1
Cuff, Blood Pressure, Infant, EA						1
Cup, Medicine, 4oz, EA	10					
Cutter, Ring, EA	1					
Depressor, Tongue, Reg, 6", EA	10					
Detector, ETCO2, Adult, EA		1				
Detector, ETCO2, Pediatric, EA						1
Diaper, SZ 1, EA	40					
Diaper, SZ 3, EA	40					
Diaper, SZ 4, EA	20					

Assignment	ACS	+ER	+SNF	+Ortho	+OB	+Pedi
Divider, Patient Privacy Curtin	25					
Doppler, Tria II, EA		1				
Downloader, I-Stat, EA		1				
Dressing, Multi-Trauma, EA		4				
Dressing, Multi-Trauma, Sterile, 12" X 30", EA		1				
Dressing, Transparent, 10 X 12cm, EA			5			
Dressing, Transparent, 6 X 7cm, Sterile, EA			10			
Dressing, Transparent, w/Label, EA		5				
Dressing, Trauma, 12" X 30", EA						
Electrode, ECG, Adult 4-PK, EA		5				
Electrode, External Pacing, Adult, PK		1				
Electrode, Pacing/Defibrillation, Adult, PK		1				
Electrode, Pacing/Defibrillation, Pediatric, PK		1				
Envelope, Pill, EA			100			
Forceps, Magil, LG, EA		1				
Forceps, Magil, Med, EA		1				
Forceps, Magil, Sm, EA		1				
Gauze, Conforming, 2", Sterile, EA	1					
Gauze, Conforming, 4" X 4.1YD, Sterile, EA		2				
Gauze, Conforming, Sterile, 2" X 4.1YD, EA		2				
Gauze, Conforming, Sterile, 3" X 4.1YD, EA		2				
Gauze, Over wrap, Petrolatum, 3"X36", EA			22			
Gauze, Petrolatum, 3"X36", EA		2				
Gauze, Surgical Sponge, 8-ply, 4" X 4", EA		5				
Glasses, Safety, EA	2					
Glove, Casting, L, BX				1		
Glove, Exam, Nitrile, LG, BX	1					
Glove, Exam, Nitrile, Med, BX	1					
Glove, Exam, Nonsterile, L, BX	1					
Glove, Exam, Nonsterile, M, BX	1					
Glove, Exam, Nonsterile, S, BX	1					

Assignment	ACS	+ER	+SNF	+Ortho	+OB	+Pedi
Glove, Exam, Sterile, SZ 7 1/2, EA		4				
Glove, Exam, Sterile, SZ 7, EA		4				
Glove, Exam, Sterile, SZ 8, EA		4				
Glucometer, Ascencia Elite, EA	1	1				
Gown, Isolation, EA		3	10			
Hand wash, Antiseptic, 4oz, EA		2	10			
Holder, Blood Collection, Vacutainer, EA	4					
Immobilizer, Knee Large		2				
Immobilizer, Knee Medium		2				
Immobilizer, Knee Small		2				
I-Stat, EA		1				
Jelly, Lubricating, 4oz, EA		12				
Kit, Cricothyrotomy, Emergency, Adult, EA		1				
Kit, Cricothyrotomy, Emergency, Pediatric, EA		1				
Kit, IV, Start, EA	6	5				
Kit, Nosebleed Tray		5				
Kit, Obstetrics					10	
Kit, Pelvic Exam Tray					10	
Kit, Staple Remover, Skin, EA		5				
Kit, Suture Removal, EA		5				
Life Pak 12, EA		1				
Light, Headlamp, 2610, LED, EA		1				
LMA, Size 1.0, EA		1				
LMA, Size 1.5, EA		1				
LMA, Size 2.0, EA		1				
LMA, Size 2.5, EA		1				
LMA, Size 3, EA		1				
LMA, Size 4, EA		1				
LMA, Size 5, EA		1				
Mask, Fluid-Shield, PFR95, Reg, EA	4					
Mask, Fluid-Shield, PFR95, S, EA	4					

Assignment	ACS	+ER	+SNF	+Ortho	+OB	+Pedi
Mask, O2, Non-rebreather, Pediatric, EA		1				1
Mask, Oxygen, Non-rebreather, Adult, EA		4				
Mask, Procedure, EA	10	15	25			
Mask, Procedure, Fluid shield, EA		10				
Meter, Peak Flow, EA		5				
Nebulizer, Small Volume, 7' Tubing, Adult, EA		15				
Nebulizer, Small Volume, 7' Tubing, Pediatric, EA		10				
Needle, Intraosseous, 18ga, EA		2				
Needle, IV, Winged, 21G, 0.75" X 3", EA		5				
Pack, Cold, EA	3	18				
Pack, Thoracostomy, EA		1				
Pad, ABD, Combine, 5" X 9", Sterile, EA		1				
Pad, Bladder Control, Capri, EA			13			
Pad, Chux, EA			15			
Pad, Eye, Sterile, EA		10				
Pad, Non-adherent, Sterile, 2" X 3", EA	20	10				
Pad, Prep, Alcohol, Med, EA	10	50				
Padding, Undercast, 4 X 4 YD, EA				14		
Paddle, Defibrillation, Adult, EA		1				
Paddle, Defibrillation, Pediatric, EA						1
Pulse Oximeter/CO2 Detector, EA	1					
Resuscitator, Manual, Adult, w/Mask, EA		2				
Resuscitator, Manual, Neonatal, w/Mask, EA						10
Resuscitator, Manual, Pediatric, w/Mask, EA						1
Sanitizer, Hand, 4oz, EA	8					
Scalpel, #11					5	
Scalpel, #15					5	
Scissors, Utility, EA	1					
Set, Extension, IV, 6", EA		3				
Set, IV, Administration, w/Extension, 89", 60ggt, EA		5				
Sheet, Drape, 2-ply, 40" X 48", EA					14	

Assignment	ACS	+ER	+SNF	+Ortho	+OB	+Pedi
Sheet, Stretcher, 40" X 72", EA		10				
Sheet, Stretcher, EA		20				
Specula, Otoscope, 4.25mm, Adult, EA		12				
Splint, Aluminum, Foam				2		
Splint, Corregated, Orange, EA				4		
Splint, Foam, EA	1					
Splint, Wire, EA	2					
Sponge, Lap, Sterile, 18" X 18", EA		2				
Sponge, Surgical, 8-ply, 4" X 4", NS, EA		20				
Stapler, Skin, 35 Staple,5.0 X3.5mm, EA		5				
Stockinet, Cotton, 2" X 25YD, EA				1		
Stockinet, Cotton, 3" X 25 YD, EA				1		
Strip, Blood Glucose Test, EA	3					
Stylette, ET, 10 Fr, EA		1				
Stylette, ET, 14 Fr, EA		1				
Stylette, ET, 8 Fr, EA		3				
Suction, Manual	1	5				
Suture, Blue, Mono, 0, CT-1, EA		4				
Suture, Braided Black, Silk-O, EA		4				
Suture, Braided, Silk, 2-0, EA		4				
Suture, Braided, Silk, O, EA		4				
Suture, Nylon, 1, TP-1, EA		2				
Suture, Nylon, 4-0, PS-2, EA		4				
Suture, Nylon, 5-0, PS-2, EA		4				
Suture, Nylon, 6.0, EA		10				
Suture, Nylon, 6-0, DS16, EA		3				
Suture, Nylon, Reverse Cutting, 18" 5.0, EA		34				
Suture, Plastic, Reverse Cutting, 30", 3.0, EA		4				
Suture, Vicryl, 4.0, EA		4				
Suture, Vicryl, 4-0, PS-2, EA		4				
Swab, Cotton, EA		17				

Assignment	ACS	+ER	+SNF	+Ortho	+OB	+Pedi
Syringe, 10cc, Luer Lock, EA		9				
Syringe, 10cc, Luer Lock, No Needle, EA		8				
Syringe, 30cc, EA		3				
Syringe, 6cc, 20G X 1 1/2", EA		2				
Syringe, Insulin, 1cc, EA	3					
Syringe, Insulin, w/Detachable Needle, 1cc, EA	38					
Syringe, Luer Lock, 10cc, EA		1				
Syringe, Luer Lock, 60cc, EA	2	3				
Syringe, No Needle, 10cc, EA		20				
Syringe, No needle, 30cc, EA		8				
Syringe, Safety, 1cc, 28G X 1/2", EA		3				
Syringe, Safety, Tuberculin, 1ML, EA		100				
Tape, Cast, Fiberglass, 4" X 4YD, EA				1		
Tape, Casting, 4" X 4YD, EA				1		
Tape, Cloth, 1", EA	2	2				
Tape, Cloth, 3", EA	2					
Tape, Paper, 1", EA	1		9			
Tape, Surgical, Cloth, 2.5cm X 9m, EA		3				
Tape, Surgical, Paper, 7.5cm X 9m, EA		1				
Thermometer, Turbo Temp, EA	1	1				
Tourniquet, 1" X 18", EA		3				
Traction, Leg, QD-4 Unit, Adult, EA		1				
Tray, Incision and Drainage, EA	1					
Tray, Instrument, Incision and Drainage, EA	1					
Tray, Irrigation, Bulb Syringe, EA		2			2	2
Tube, Feeding, 6 Fr, Pediatric, EA						1
Tube, Feeding, Single Port, Pediatric, 8fr, EA						1
Tube, Feeding, Single Port, Pediatric, w/o Stylet, 8fr, EA						5
Tube, Nasogastric, 10 Fr, EA		1	9			
Tube, Nasogastric, 16 Fr, EA		3	9			
Tube, Nasogastric, 6 Fr, EA						1

Assignment	ACS	+ER	+SNF	+Ortho	+OB	+Pedi
Urinal, 32oz, Male, EA	4	3	6			
Wash Cloth, Dry, EA			18			
Wheelchair, 18", EA	1	1	1			
Wipe, Antimicrobial, EA	10	10				

10.16 Appendix 16: Example Pharmaceutical Supply List

This tool provides lists of potential pharmaceutical needs for a 25-bed ACS, as well as any of the several additional services. All ACS types have been developed in alignment with regional plans and ACS assumptions. Advanced level ACS types are excluded due to power or oxygen dependency.

Assignment	ACS	+ER	+SNF	+Ortho	+OB	+Pedi	+IC	+MH
Acetaminophen Oral Liquid 160mg/5mL; 120mL	5					10		
Acetaminophen Suppositories 120mg; 12's						5		
Acetaminophen Suppositories 325mg; 12's			5					
Acetaminophen Tablets, 325mg; 100s	2							
Acetazolamide Tablets 250 mg; 100's			5					
Activated Charcoal; 50gm; 30mL		4						
Adenosine Injection 3mg/mL; 2mL; 3's		2						
Albuterol Inhalation Solution 0.083%; 3mL; 25's	1	2				1		
Albuterol Inhalers; 17gm	5	10						
Albuterol Syrup 2mg/5mL 480mL	1	2				1		
Albuterol Tablets, 4 mg; 100's		1						
Amiodarone HCl Injection, 150 mg/3ml; 25 SDV		2						
Ammonia ampules	10							
Amoxicillin Capsules 250mg; 100's	1							
Amoxicillin Oral Susp. 250mg/5mL; 150mL						1		
Amoxicillin/Clavulanic Chewable 400mg/57mg; 20s						1		
Ampicillin Sodium 1GM vials 10's		1						
Antacid Liquid Reg Str; 150mL; 48 bottles	10	5						
Antipyrine/Benzocaine Otic Solution, 15 ml		1						
Artificial Tears 15 ml	5		10					
Aspirin Chewable Tablets, 81mg; 36's		1						
Aspirin Tablets, 325mg, 100's UD		1						
Atenolol Tablets 50 mg; 100's		1						
Ativan IV and PO, 2mh 10s		1						

Assignment	ACS	+ER	+SNF	+Ortho	+OB	+Pedi	+IC	+MH
Atropine Injection 0.1mg/mL; 10mL; 10s		1						
Azithromycin Syrup 200 mg/ 5 ml			1					
Azithromycin Tabs. 250 mg; 18's		1						
Bacitracin Ointment 15gm; 1's	1							
Baclofen Tablets 10 mg, 100's			1					
Bupivacaine (Marcaine) Injection, 0.5%, 30 ml, 25's				1				
Calamine Lotion, Phenolated, 6 ozs	1							
Carbamazepine Tablets, 200 mg; 100's		1						
Cefazolin Sod. Injection 1 Gm 10mL; 25's		1						
Cephalexin Oral Susp. 250 mg/5 ml; 200 ml		1						
Ciprofloxacin Injection 200mg/20mL; 10 vials		1						
Ciprofloxacin Tablets 250mg; 100's			1					
Clonidine HCl Tablets 0.1mg; 100's		1						
D50W (Dextrose 50%) Injection 50mL; 24s	5	5						
Dextrose 5% & Sodium Chloride 0.9% Inj. 500 ml, 24's	5	10						
Diaper Rash Ointment, 30Gm	2					10		
Digoxin Tablets 0.125mg; 100s			1					
Diphenhydramine Capsules 25mg; 100s	1	1						
Diphenhydramine Elixir 12.5mg/5mL; 120mL;		1				1		
Diphenhydramine Injection 50mg/mL; 1 ml 25 vial		1						
Dobutamine Hydrochloride Inj. 250 mg/20 ml, 10 vials		1						
Dopamine Injection 40mg/mL; 10mL; 25s vial		1						
Doxycycline Hyclate Tabs.,100 mg UD, 100's							1	
Epinephrine 1:1,000 (1mg/mL); 30 ml		1						
Epinephrine 1:10,000 (0.1mg/mL); 10mL; 10s		1						
Erythromycin Enteric Coated Tablets 250mg; 100s		1						
Famotidine Tablets 20mg; 100's		1						
Furosemide Injection 10 mg/ml 10 ml, 25's			1					

Assignment	ACS	+ER	+SNF	+Ortho	+OB	+Pedi	+IC	+MH
Furosemide Tablets 40mg; 100s		1						
Gamma Globulin Injection; 5mL; REFRIG		1						
Gentamicin Ophthalmic Solution 3mg/ml 5ml		1						
Glucagon for Injection 1mg w/ 1 ml		1						
Guaifenesin Syrup; 120mL						1		
Haloperidol Injection 5mg/mL; 10s								1
Heparin Lock Flush Kit, 100 units/ml , 25's	2	2						
Heparin Sodium Injection 1000 units/ml, 10 ml, 25's	1							
Humulin-NPH 100U/mL; 10mL		1	1					
Humulin-Regular 100U/mL; 10mL		1	1					
Hydrocortisone Cream 1%, 1 oz	1	2						
Ibuprofen Oral Suspension 100mg/5mL; 120mL 24s	1					1		
Ibuprofen Tablets 600 mg, 100's	1	1						
Ketorolac Injection 30mg/mL; 2mL 10s vial			1					
Lactated Ringers Injection 1000ml 12's	1	1			1			
Levothyroxine Sodium Tablets 0.1 mg; 100's			1					
Lidocaine 1% Injection 20mL; 25s		1		2				
Lidocaine 1% w/Epinephrine Injection; 30mL; 5		1						
Lidocaine 2% Viscous 100mL			1					
Lindane Lotion 1%; 60mL	1							
Lindane Shampoo 1%; 60mL	1							
Magnesium Sulfate Injection 500 mg/ml 10 ml, 10's		1		1				
Methylprednisolone Injection 125mg; 2mL 25s	1	1						
Methylprednisolone Tablets 4 mg; 21's						1		
Metoprolol 1mg/ml 5 ml; 12 amps		1						
Metoprolol Tablets 50mg; 100s			1					
Miconazole Cream 2% 30gm;					1			
Miconazole Vaginal Cream 45gm					1			

Assignment	ACS	+ER	+SNF	+Ortho	+OB	+Pedi	+IC	+MH
Naloxone Hydrochloride Injection 0.4 mg/ml, 1 ml, 10's		1				1		
Nitroglycerin Sublingual Tablets 0.4mg; 25 x 4s	1	1						
Nitroglycerine Transdermal System 0.2mg/hr, 30's		1						
Ophthalmic Irrigating Solution 4 fl ozs	1	10						
Oxytocin 10Units/mL; 25 amps					1			
Pedialyte Solution 8 fl oz; 24s						1		
Pediazole Oral Suspension; 200mL						10		
Penicillin G Sodium for Injection, 5 mill units, 10's		1						
Phenergan (injectable) 25mh, 25s		1						
Prednisone Tablets 5mg; 100s		1						
Promethazine Suppositories 50 mg, Adult, 12's		1						
Pseudoephedrine 30mg/Guaifenesin 100mg 4oz.						1		
Pseudoephedrine Tablets 30mg 24'S		1						
SMZ/TMP DS Tablets, 800/160mg; 100s							1	
Sodium Chloride 0.9%, 1000 ml, 12's		1			1			
Sodium Chloride Injection 0.9% 250ml 24's		1						
Tetanus and Diphtheria Toxoids Ads (peds); Syr						1		
Tetanus Immune Globulin, 250 units/syringe; 1s		1						
Triple Antibiotic Ointment; 15gm;	1							
Visine, Eye Drop (Tetrahydrazoline 0.05%)	10							

10.17 Appendix 17: SMOC Coordination Call Agenda Template

The coordination conference call intends to provide a virtual forum to collaborate with multiple stakeholders to accomplish ACS coordination elements. Participants and stakeholders may vary based on incident needs, threat progression, and size and scale of operations. The overall intent of the coordination conference call is to establish a common operating picture across the region when responding to a significant event.

SMOC Coordination Call Agenda Template	
Date	
Time	
Dial-In Information	
1. Introductions and Contact Information	
Lead/Facilitator	SMOC Representative: _____
Conference Call Attendees • Member Hospital _____ • Member Hospital _____ • Member Hospital _____	
Other Stakeholders • Local Emergency Management Agency _____ • STARRS • Illinois Emergency Management Agency (IEMA) • Missouri State Emergency Management Agency (SEMA) • Missouri Hospital Association • Illinois Regional Lead Hospital	
2. Event Details and Situational Awareness	
Lead/Facilitator	SMOC Representative: _____
SMOC Representative Situational Awareness Brief Out • Hazard/Event/Incident • Anticipated/Actual Incident Area of Impact • Threat Timeline/Anticipated Event Duration • Projected Patient Surge Numbers	

SMOC Coordination Call Agenda Template

3. ACS Operational Status and Operational Support Needs

Lead/Facilitator	SMOC Representative: _____

Status of ACS Operations

- ACS Site Selection
- Current Operational Timeline
- Estimated Time until ACS is Operational
- Projected ACS Capacity/Anticipated Demand
- Scope of ACS
- Limitations of ACS
- Anticipated Duration of ACS Operations

Resource Management

- Projected Personnel Resource Needs
- Projected Equipment Resource Needs
- Projected Supplies Resource Needs

Hospital	Resource Need(s)	Fulfilling Organization
XXXX		
XXXX		

Public Messaging Coordination

- Clear and Consistent Messaging

Message	
Public Information Officer (PIO) Contact Information	Name: _____ Jurisdiction: _____ Phone: _____ E-mail: _____
Disseminating Hospitals	• XXXX • XXXX • XXXX • XXXX
Press Conference Schedule	
Other	

SMOC Coordination Call Agenda Template

4. Regional Coordination (Where Applicable)

Lead/Facilitator	SMOC Representative

Summary of Regional Activities

- Regional Incident Status Brief Out
- Other Impacted Hospitals
- Other Regional ACS Sites
- Coordination Mechanisms
- Other

5. Other Discussion

Lead/Facilitator	(Round Robin)

- Discussion Items

6. Action Items

Lead/Facilitator	XXXX: _____

Conference Call Participant	Action Item

7. Next Coordination Conference Call

Lead/Facilitator	XXXX: _____

Date: _____
Time: _____

10.18 Appendix 19: Acronyms List

Acronym List	
AAR/IP	After Action Report/Improvement Plan
ABLS	Advanced Burn Life Support (ABLS)
ACLS	Advanced Cardiac Life Support (ACLS)
ACS	Alternate Care Site
ADA	Americans with Disabilities Act
ATLS	Advance Trauma Life Support (ATLS)
DMAT	Disaster Medical Assistance Team
ED	Emergency Department
EMA	Emergency Management Agency
EMAC	Emergency Medical Assistance Compact
EMS	Emergency Medical Services
EOC	Emergency Operations Center
ER	Emergency Room
ESAR-VHP	Emergency System for Advance Registration of Volunteer Health Professionals
ESF	Emergency Support Function
FEMA	Federal Emergency Management Agency
FMS	Federal Medical Station
HHS	[U.S. Department of] Health and Human Services
HICS	Hospital Incident Command System
HSEEP	Homeland Security Exercise Evaluation Program
IC	Infection Control
ICS	Incident Command System
IEMA	Illinois Emergency Management Agency
JAS	Job Action Sheets
LVN	Licensed Vocational Nurses
MOA	Memorandum of Agreement
MOU	Memorandum of Understanding
NALS	Neonatal Advance Life Support
NIMS	National Incident Management System
NP	Nurse Practitioner
OB	Obstetrics
PA	Physician's Assistant
RERC	Regional Emergency Resource Coordination [Plan]
RHCC	[Region 4] Regional Hospital Coordination Center
RHCP	Regional Healthcare Coordination Plan
RN	Registered Nurse
SEMA	Missouri State Emergency Management Agency
SMOC	St. Louis Medical Operations Center
SMSG	Shelter Medical Support Group
SNF	Skilled Nursing Facility

SOG	Standard Operating Guidelines
STARRS	St. Louis Area Regional Response System
VOAD	Voluntary Organizations Active in Disaster