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West Central Minnesota

Healthcare Preparedness Coalition

Organizational &

Emergency Operations Plan

(Readiness, Response, Recovery)

August 2024

# Approval and Implementation

#### Organizational and Emergency Operations Plan

[Insert plan approval language here]

# Record of Changes

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| --- | --- | --- | --- |
| **Date of Revision (Approval, if applicable)** | **Section** | **Change Made** | **Initials** |
| 7/11/2024 | Entire Plan | Plan development | SS |
| 8/5/2024 | New Member Toolkit | Changed language to reflect overall plan changes | SS |
| 8/14/2024 | Entire plan | Included more equity language | SS |
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# Introduction

This Organizational & Emergency Operations Plan outlines how the West Central Minnesota Healthcare Preparedness Coalition (WCMHPC) is organized and operates to effectively respond to and manage incidents impacting member facilities and organizations (i.e., healthcare). This plan documents WCMHPC's processes to prioritize needs and collaborate with local, regional, state, and federal stakeholders to develop and test response capabilities. Key focus areas include communication, information sharing, resource coordination, and response and recovery efforts.

By detailing the WCMHPC’s operations, information-sharing protocols, and resource management strategies, this plan ensures that all coalition members are aligned and prepared to respond collectively and efficiently to any healthcare crisis. This plan recognizes the importance of planning alongside communities most impacted by disasters and/or representatives of those communities. This plan details WCMHPC’s efforts to foster these relationships and center health equity in its core functions.

This plan and its associated annexes will promote the concepts outlined by the National Incident Management System (NIMS). They will commit to establishing a common set of goals, strategies, and terminology utilized in other regional plans. This plan and its associated annexes may be used as a supplement to local plans and will promote the coordination of a response with the local, regional, and State agencies involved in the response. This plan and its associated annexes outline the concept of coordination and operations for incidents wherein the complexity or duration requires regional coordination of information, resources, and/or response activities.

This plan does not replace or interfere with organizational emergency operations plans (EOP) or jurisdictional plans for official command and control authorized by state and local emergency management (EM) agencies. This plan is meant to provide guidance only and does not substitute for the experience of the personnel responsible for making decisions at the time of an incident.

# Section A: Readiness

## Introduction

The State of Minnesota is susceptible to natural as well as man-made disasters that could have a direct impact on the state’s healthcare resources. Situations could occur that create a surge of patients or may present patients that require specialized medical treatment that exceeds the existing facility's ability and/or resources (e.g., HazMat events, trauma surgery, burn treatment). Events could negatively impact the structure of the facility, requiring full or partial evacuation and disruption of services.

The U.S. Department of Health and Human Services (HHS) Administration for Strategic Preparedness and Response (ASPR) Hospital Preparedness Program (HPP) provides funding to support the development of coalitions to bring together health care facilities, local public health (LPH), emergency medical services (EMS), and EM. The funding is provided to the State of Minnesota Department of Health (MDH) Office of Emergency Preparedness and Response (EPR) and further disseminated amongst eight coalitions within the state. ASPR provides Health Care Preparedness and Response capabilities that will:

* Help patients receive the care they need at the right place, at the right time, and with the right resources during emergencies.
* Decrease deaths, injuries, and illnesses resulting from emergencies.
* Promote health care delivery system resilience in the aftermath of emergencies.

### Purpose

The WCMHPC Readiness Plan describes the organizational structure and processes of the Coalition. The plan identifies the goals and objectives the coalition utilizes to support its members and maintain a sustainable, response-ready coalition. *This plan provides health equity considerations to enhance the region’s capability and capacity to comprehensively plan and prepare for communities most impacted by disasters*.

### Scope

This plan is designed as a supporting tool and will work with the coalition response plan.

## Overview

### Introduction/Role/Purpose of Coalition

#### Coalition Definition

ASPR defines a Healthcare Coalition (HCC) as a formal collaboration among healthcare organizations and public and private-sector partners organized to prepare for and respond to an emergency, mass casualty, or catastrophic health event. The HCC can act as a multi-agency coordinating group that assists EM with activities related to healthcare organization disaster operations. Although the HCC does not hold a command-and-control function, the HCC does play a role in mitigation, preparedness, response, and recovery.

#### Mission Statement

The WCMHPC is a multi-disciplinary partnership of healthcare and supporting and responding agencies that collaborate to coordinate preparedness, response, and recovery activities as it pertains to routine and emergent events that could impact the region. The WCMHPC is dedicated to supporting the community, particularly those most impacted by disasters, by assisting in maintaining a coordinated healthcare response and developing strong partnerships.

#### Purpose of the Coalition

* Provide oversight and guidance for planning, implementation of strategies, guidance of financial resources, and the execution of respective roles and responsibilities of the WCMHPC. The West Central (WC) geographic boundaries are outlined in [A.2.2 - Coalition Boundaries](#_Coalition_Boundaries_(Preparedness).
* During a disaster, that may have regional implications, determine a strategy for ongoing coordination of planning, response, and recovery.
* Monitor, review, and implement improvements consistent with national and statewide capabilities and performance measures.
* Promote strategies to strengthen and sustain the HCC, including:
  + Develop and maintain guidelines, rules, and responsibilities of members within the WCMHPC
  + Plan for the sustainment of the Health Care Preparedness Coalition.
* Promote preparedness in the healthcare community through standardized practices and integration with other response partners.
* Foster communication, information, and resource sharing between local, regional, and state entities during emergency planning and response.
* Identify health care assets needed and available during a response.
* Recognize gaps in the healthcare community’s ability to effectively respond to an incident through exercises and training.
* Foster equitable community relationships within the region and promote comprehensive planning efforts that include all populations, especially communities most impacted by disasters.

See [A.5.1 Bylaws](#_Bylaws).

### Coalition Boundaries and Demographics

The WC Region is primarily an agriculture, industrial, lakes, and tourist area. The WCMHPC includes the following counties.

* Clay
* Douglas
* Grant
* Otter Tail
* Pope
* Stevens
* Traverse
* Wilkin

The State of Minnesota Department of Health conducted a comprehensive review to create a regional profile. The information shared in this profile will help the coalition make decisions when creating/updating plans, developing exercises and during response to ensure that we are addressing the needs of the community as a whole. All members are encouraged to utilize the tool in their local planning.

See [A.5.11 West Central Profile](#_West_Central_Profile).

See [A.5.7 Map and Demographics](#_Map_and_Demographics).

### Coalition Membership

Primary coalition members shall consist of a representative from each of the following entities:

* Hospitals
* Local EM
* EMS Regional Coordinator
* LPH

Other Coalition members may include representation from (Note: \*\*Indicates that there is currently representation within the coalition from this area):

* Behavioral Health \*\*
* Clinics \*\*
* Colleges
* Community-based healthcare (i.e., home health)\*\*
* Community health centers \*\*
* Communities most impacted by disasters and/or their representatives
* Faith communities
* Funeral homes/coroner
* Homeland Security/EM \*\*
* Laboratory services \*\*
* Law enforcement/Fire departments (awareness)
* Medical Advisor\*\*
* Mental health agencies \*\*
* MDH – Epidemiologist \*\*
* MDH – Public Health Preparedness Consultant (PHPC) \*\*
* Minnesota Mobile Medical Team (MN-MMT) \*\*
* Other volunteer organizations
* Outpatient facilities\*\*
* Private entities, such as hospital associations
* Private organizations active in disasters and other relevant partners
* Public works
* Public works/utilities (awareness)
* Skilled Nursing Facilities(SNFs)/LTC Facilities \*\*
* Specialty service providers such as dialysis units\*\*
* Stand-alone surgery centers and urgent care\*\*
* Tribal governments
* Volunteer Organizations Active in Disasters (VOADS) and other volunteer organizations
* WC Minnesota Responds Medical Reserve Corp (MRC) \*\*

*The WCMHPC is committed to engaging diverse organizations and agencies as partners in HCC core functions and activities. The engagement of these entities contributes to the mission of WCMHPC in supporting* eﬀective *and equitable health and medical response functions.*

Active membership in the coalition is evidenced by written documents such as the signed bylaw and memorandums of understanding (MOU). A list of signed members is maintained on the coalition website and by the Regional Health Care Preparedness Coordinator (RHPC).

The coalition has a New Member Toolkit which contains the Acknowledgement of Membership and discusses the roles and responsibilities of the members and the coalition staff.

The WCMHPC is also a part of the MNHCC. For more information on this collaborative, see [A.5.10 MNHCC Charter](#_MNHCC_Charter).

See [A.5.5 New Member Toolkit](#_New_Member_Toolkit)

See [A.5.8 Memorandum of Understanding](#_Memorandum_of_Understanding).

### Organizational Structure/Governance

#### Membership Roles and Responsibilities

Members of the Health Care Preparedness Coalition will:

* Work towards implementing emergency preparedness activities recommended by the HPP grant and the WCMHPC.
* Provide feedback to the Advisory Committee.
* Participate in education, training, and exercise opportunities.
* Share emergency preparedness information with the regional healthcare community.
* Respond to requests from regional staff. i.e., Surveys, MNTrac alerts, questions, etc.
* Serve on committees, workgroups, and other ad hoc groups.
* Attend meetings.
* Prepare for active participation in discussions and decision-making by reviewing meeting materials.
* Work with local public health partners and local emergency management as they identify and engage community partners that serve communities most impacted by disasters.
* Healthcare facilities will sign and retain a current copy of the coalition’s Mutual Aid MOU.
* Share information obtained from the coalition and membership within their organization and provide training and education at the facility level as it pertains to emergency preparedness.

##### Memorandum of Understanding

Healthcare facilities/providers within the coalition have developed an MOU that defines the roles and processes in place when sharing supplies, equipment, and staff. The MOU is also a supplement to the developing Coalition Patient Tracking process. Member healthcare facilities are requested to sign the acknowledgment of awareness document, which indicates membership in the coalition.

See [A.5.8 Memorandum of Understanding](#_Memorandum_of_Understanding).

##### Coalition Meeting Attendance and Frequency

The WCMHPC will meet face-to-face in April and October. All other meetings will be held virtually.

#### Advisory Committee Roles and Responsibilities

* The mission of the Advisory Committee shall be to assist in making decisions regarding regional Health care preparedness.
* The Advisory Committee is composed of a member of each of the coalition hospitals. Members such as public health, EMS, EM, and LTC can select one person from each entity to represent other similar entities in the coalition.
* The Advisory Committee may provide regional disaster response and support regional multi-agency coordination when activated.
* Will oversee that the grant duties are in accordance with the timelines established for completion.
* Provide recommendations on the allocation of grant funds.
* Provide feedback, updates, and final approval for all plans/appendices.
* May vote when decisions regarding asset management and distribution, programmatic processes, etc. are needed

##### Advisory Meeting Attendance and Frequency

The Advisory Committee will meet on an ad hoc basis based on the needs of the coalition.

##### Resignation

Members will submit a resignation to the RHPC, who will communicate the resignation to the Advisory Committee. If this is a hospital representative, an alternative representative from that hospital should be identified.

##### Coalition Policies and Procedures

The RHPC and any Advisory Committee member can propose changes to any response documents based on lessons learned, identified gaps, or changes identified in regulatory bodies. The RHPC, Committee members, or group of those individuals will be tasked with creating the changes necessary and they will be voted on by the Advisory Committee members.

##### Voting

Advisory committee members shall have voting rights.

* They must be signatory members of the coalition.
* Each hospital will have one vote. Members such as public health, EMS, EM, and LTC with representation on the advisory committee will have one vote per like entity.
  + Voting membership:
    - Each of the eight hospitals (8)
    - LPH (1)
    - EM (1)
    - EMS (1)
    - LTC (1)
    - Clinic (1)
  + Members such as public health, EMS, EM, and others can select one person from each entity to represent similar entities on the advisory committee and have voting rights.
* If the primary Advisory Committee member cannot be present to vote, their pre-determined alternate can vote.
* Voting members shall abstain from any vote that presents a conflict of interest.
* The RHPC will not vote, excluding a tiebreaker when the RHPC or their designee may cast a vote.
* Voting procedures:
  + A simple majority voting method is used.
  + The coalition/committee chair and one additional member will tally and report the vote results.
  + All voting results will be in meeting minutes distributed by the RHPC(s) or designee.
  + Motions pertaining to the general business of the coalition, including resolutions, statements of agreements, and other business, may be approved by the quorum of the Advisory Committee.
  + Voting may be conducted in “Face to Face” meetings, virtual meetings, or by email.
  + The presence of 51% of Advisory Committee members constitutes a quorum.

#### Grantee Roles and Responsibilities

The grantee for the WCMHPC is St. Cloud Hospital (SCH). Grantee responsibilities include:

* Accountable for the receiving and administering the funds received from ASPR through MDH
* Comply with all laws, rules, and regulations within the ASPR grant.
* Maintain records of all reimbursements and payments for services and grant activities performed.
* Process wages, social security benefit payments and deductions, tax payments and withholding, and W-2 forms for the coalition staff.
* Through the human resources department, the fiscal agent is responsible for hiring and dismissing any coalition staff.
  + When the coalition is hiring staff, members of the advisory committee will be asked to be a part of the interview process to ensure they have a voice in whom is hired.
  + If there are concerns regarding the coalition staff members, complaints or concerns can be vetted through the SCH human resources department.

The figure below outlines the organizational structure related to emergency preparedness and the WCMHPC and CMHPC collaborative with SCH.

Figure . St. Cloud, WCMHPC, and CMHPC Collaborative

#### Role of Leadership within the Coalition

##### Regional Healthcare Preparedness Coordinators

The RHPC(s) shall serve the coalition Advisory Committee and the coalition in the following capacities:

###### Planning and Coordination

The RHPCs support the Coalition’s planning and coordination mission. RHPCs will:

* Facilitate and organize planning, training, and exercises for the region. See [A.5.6 Integrated Preparedness Plan](#_Integrated_Preparedness_Plan).
  + Provide access to training opportunities. See [A.5.6 Integrated Preparedness Plan](#_Integrated_Preparedness_Plan).
  + Provide a process to assess risks and hazards within the region.   
    See [A.5.2 Hazard Vulnerability Analysis](#_HVA).
* Facilitate information sharing. See [Section B: Response.](#_Section_B:_Response)
* Promote efficient interface of the Coalition with jurisdictional authorities.
* Provide a platform for networking with preparedness and response partners across the state.
* Strategic planning to look at coalition needs annually. Using gaps identified in the annual HVA and in the After-Action Reports (AARs) from the exercises of the previous year will serve as a starting point for planning.

###### Response

Based on notification of an event from a Coalition member, partner, or other entity, the RHPC and/or designees can activate the WCMHPC Response Plan to support incident response.

Regional coordination activities can include:

* Promoting situational awareness and information sharing
* Coordinating incident response actions among healthcare organizations and supporting incident management policies and priorities
* Assisting with the coordination of Patient Transfers during a disaster
* Interfacing with other healthcare organizations and jurisdictional partners
* Supporting resource requests and receipt of assistance from local, Regional, State, and Federal authorities

###### Recovery

Recovery will begin at the same time as the response phase and continue until the event is over and systems and people return to normal. Assessment and evaluation of the residual effects of the event, the effectiveness of the response, and the need for ongoing monitoring and intervention may continue for weeks, months, or years, depending on the event. During the post-recovery phase, the response and recovery to the health and medical emergency will be evaluated and documented using an After Action Report (AAR) and Improvement Plan (IP). Lessons learned will result in modifications to plans and protocols. The RHPC will coordinate data collection to assist in the recovery phase.

### Risk

Recognizing that hazards and vulnerabilities are subject to change, the coalition conducts a hazard assessment annually. The coalition members provide insight into what they perceive to be areas of concern locally as well as regionally. The members then identify areas of priority so that the coalition can focus future trainings/exercises on these areas. The assessment process utilizes surveys as well as face-to-face discussions. The final document is created by the RHPC and approved by coalition members. The 2023 – 2024 HVA was discussed during the January 2023 Coalition meeting. The HVA is maintained by the RHPC, posted on the coalition website, and is linked in the [A.5 Readiness Appendices](#_Preparedness_Appendices).

Regional Risks identified include:

* Natural:
  + Weather (hot and cold)
* Man-Made:
  + Communications
  + Pandemic/Epidemics
  + Power outage
  + Lack of coordination between local/regional/state partners
  + Resource acquisition/sharing
  + Lack of funding to support the coalition and its activities
* Facility/Operations:
  + Staffing (numbers and skill)
  + Transportation
  + Rural/distance to a high level of care
  + Evacuation destination
  + Surge
  + Viability/success of the organization

The WCMHPC has conducted additional research on communities most impacted by disasters within the West Central region. Based on these assessments, certain communities in the West Central Region are more likely to be impacted by disasters.

1. Hispanic communities.
2. African American communities.
3. Rural communities.
4. Access and functional needs communities.
5. Homeless communities.

The WCMHPC participates with the Cross Border Diversity workgroup in Clay County to better understand ways in which these communities are impacted during disasters and identify ways that the coalition and its’ membership can support them. These communities are encouraged to become members of the coalition so that we can better learn from them.

### Gaps

During the HVA process discussed in [A.2.5 Risk](#_Risk), gaps were identified in local and regional processes. The gaps were grouped into six categories:

1. Staffing
2. Supplies
3. Emergency Coordination
4. Technology
5. Transportation/Patient Movement
6. Financial support of the coalition

During the discussion, several measures were identified to mediate the gaps. Several mediation measures can be accomplished during regional trainings and brought back to the facilities. The advisory committee recommended that the coalition focus on the grant workplan and indicated the importance of prioritizing the gaps identified by the region.

### Compliance Requirements/Legal Authorities

Some members of the WCMHPC are governed by federal statutory, regulatory, or national accreditation bodies. These regulatory agencies provide standards that are required during day-to-day operations as well as some special considerations that take place when planning for, responding to, and recovering from emergencies. These agencies include but are not limited to:

* Centers for Medicare & Medical Services (CMS)
* Clinical Laboratory Improvement Amendments (CLIA)
* Health Insurance Portability and Accountability Act (HIPAA)
* Emergency Medical Treatment & Labor Act (EMTALA)
* Occupational Safety and Health Administration (OSHA)
* The Joint Commission (TJC)
* Accreditation Commission for Health Care (ACHC)

The coalition will attempt to utilize these regulatory compliance requirements when developing policies and planning trainings/exercises. Coalition members will share any known requirements and changes to these requirements.

## Coalition Objectives

### Maintenance and Sustainability of the Coalition

Currently, the WCMHPC is supported financially through the HPP under ASPR. The HCC members recognize the value of the coalition activities and will continue to investigate how to sustain coalition activities should the funding from ASPR cease or diminish. A major component of the sustainability discussion includes the engagement of coalition partners, healthcare executives, clinicians, and community leaders. The coalition has developed tools to promote the mission and role of the coalition within the region. These tools are made available to coalition members for sharing with local community members who have a stake in the healthcare infrastructure. See [A.5.3 Coalition Flyer](#_Coalition_Flyer).

Sustainability includes the identification of ways to continue to provide training and exercises to support emergency preparedness efforts in the region. Some sustainability efforts currently in place within the region include the use of in-kind donations of storage services, information sharing, and resource management. Continued discussions include providing a fee-for-service program by providing services not currently under the HPP grant program.

See the [B.7 Continuity of Operations Plan](#_Continuity_of_Operations).

### Engagement of Partners and Stakeholders

The coalition is only as strong as the partners and stakeholders that it serves to unite. As identified in [A.2.3 Coalition Membership](#_Coalition_Membership), the coalition is comprised of a diverse group that all have a vested interest in the ability for healthcare services to continue during planned and unplanned events that have the potential for disruption. The RHPC maintains routine communications with the stakeholders via email and through the coalition website. This communication ensures that emergency preparedness activities are reviewed and allows for information sharing amongst its’ members. Networking amongst the partners and stakeholders allows for relationships where common practices and resources are shared.

#### Healthcare Executives

The coalition recognizes that the Healthcare Executives can promote buy-in with health care and community-based organizations. The coalition has identified a Healthcare Executive to spearhead the communications amongst the executive leaders and to speak for the coalition when conducting peer-to-peer meetings. The CEO leader will also advocate for coalition activities when working with the hospital association. To keep these executives knowledgeable about coalition activities, the coalition conducts an annual review virtual meeting with the executives. The meeting reviews the actions taken in the past year and discusses the goals for the next year. It allows the executives to provide feedback and recommendations going forward. This open dialogue will also promote the advancement of sustainability measures.

#### Clinicians

When planning and preparing for a response to emergencies, input from clinicians is essential to ensure that continued health care is provided. State led projects such as Burn Surge and Pediatric Surge have incorporated clinicians in its inception, development, and review of the processes. The WCMHPC has used clinicians as subject matter experts (SMEs) to support the Burn Surge project as well as the Crisis Standards of Care project. WCMHPC continues to engage clinicians by providing tools and resources that can be used during an event, including incident command training. Representatives from facilities are encouraged to continue dialogue with its clinicians in developing facility-level plans and encouraging participation in coalition-led and facility-led exercises. Additionally, clinicians engaged within WCMHPC share best practices related to medical care, as well as health equity, with other coalition members and partners.

#### Community Leaders

The WCMHPC recognizes that the response to an emergent event will have a direct impact on the communities within the region, with several communities being disproportionately impacted by disasters. The development of relationships with Community Leaders and representatives from communities most impacted by disasters will help ensure that there is recognition of the value of coalition participation by healthcare organizations and their partners. These relationships will also allow the WCMHPC and member organizations to better understand communities most impacted by disasters in the WC region and more comprehensively plan for these communities. Healthcare organizations are highly encouraged to participate in community-led preparedness efforts, including city and county emergency preparedness planning and exercising. The RHPC also participates in community-led events to ensure that the role of the coalition and its ability to assist in a response is known. Future discussions with community leaders about coalition sustainability is an option – this includes applying for local level grants and cost-sharing techniques.

**Communities Most Impacted by Disasters**

During a disaster some communities may be disproportionately impacted. The communities could include at-risk individuals, such as children, pregnant individuals, older adults, individuals with disabilities, or individuals with other access and functional needs. Additional communities may experience disproportionate risk due to other factors, such as structural inequities, historical marginalization, and/or geographic location (i.e., rural communities).

Additional considerations for at-risk individuals with disabilities or AFN have been developed, as considering the needs of these communities is vital towards inclusive planning for the whole community and have been mandated for inclusion in federal, state, territorial, tribal, and LPH emergency plans by the Public Health Service (PHS) Act. Such plans must also meet applicable requirements of the Americans with Disabilities Act (ADA). For more information on the emergency planning requirements of the ADA, refer to the [ADA Emergency Planning webpage](https://www.ada.gov/topics/emergency-planning/).

The WCMHPC assists coalition members by providing information and resources in the pre-planning, response, and recovery stages as needed to help lessen the impact, especially during response and recovery. Annual education occurs at the regional coalition meetings, and all exercises will include some component that is directly related to testing the ability of the healthcare organization to respond to and assist those with AFN.

### Health Equity and Access and Functional Needs

The WCMHPC utilizes the Centers for Disease Control and Prevention (CDC) definition of health equity, “Health equity is the state in which everyone has a fair and just opportunity to attain their highest level of health. Achieving this requires focused and ongoing societal efforts to address historical and contemporary injustices; overcome economic, social, and other obstacles to health and healthcare; and eliminate preventable health disparities (<https://www.cdc.gov/nchhstp/healthequity/index.html>).”

All coalition planning involves ensuring that all have equitable access to the appropriate care. Considerations are given to those communities most impacted by disasters, including individuals who require resources, such as those with language barriers, mobility issues, homelessness, communities of color, and the LGBTQIA2S+ population. Many healthcare facilities and LPH agencies within the coalition have staff available who may be able to assist with translating or have recommendations for language services.

All coalition members are encouraged to include health equity and AFN in their planning efforts.

As a rural HCC, our whole community is considered at risk. There is an overall lack of services due to geography and the limited availability of resources. One example is that the number of EMS agencies serving a large geographical area often leads to long wait times, long transportation times, and limited resources for higher acuity needs.

See [A.5.4 Health Equity and Access and Functional Needs Plan](#_Health_Equity_and_1).

## Workplan

### Committees and Work Groups

The following committees are developed as necessary throughout the year:

* Exercise Planning Committee:
  + Responsible for creating the Integrated Preparedness Plan, developing exercises and trainings, and reviewing those trainings by creating the AAR.
  + See [A.5.6 Integrated Preparedness Plan](#_Integrated_Preparedness_Plan).
* Budget Work Group
  + Responsible for reviewing the current work plan, IPP, and creating a budget that financially supports the coalition and its activities
  + Refer to the WCMHPC Current HPP Grant Budget and Narrative for more information. This document can be requested through the RHPC for WCMHPC.
* Coalition Plan Development and Review Work Group
  + When activated, this group is responsible for reviewing coalition-level and local-level plans to ensure they are complete and operational.
* Sustainability Work Group
  + This group is tasked with investigating funding sources to ensure the sustainability of the coalition.

Activation of these work groups is based on need. As the coalition identifies and works towards the deliverables outlined in the workplan, the need to utilize work groups may become necessary. The coalition Advisory Committee has a strong presence in the work groups.

Any plans, policies, and procedures created by these work groups will need the Advisory Committee's approval prior to acceptance.

## Readiness Appendices

### Bylaws



### Hazard Vulnerability Analysis



### Coalition Flyer



### Health Equity and Access and Functional Needs Plan



### New Member Toolkit



### Integrated Preparedness Plan



### Map and Demographics



### Memorandum of Understanding



### HPP Performance Measures

[2019 – 2023 HPP Performance Measures Implementation Guidance](https://aspr.hhs.gov/HealthCareReadiness/guidance/Documents/Updated-2019-2023-HPP-PMI-Guidance-6Jul2023-508.pdf)

### MNHCC Charter



### West Central Profile





## Readiness Assessments

# Section B: Response

## Introduction

### Purpose

The purpose of the WCMHPC Response Plan is to guide the operations of the West Central MN Health Multi-Agency Coordination Center (WCHMAC) member organizations during an incident that exceeds the capacity and capability of a member organization, or other neighboring healthcare facilities that may impact the WC region. The plan identifies how the coalition will address the impact and respond with its resources. The plan will also provide general guidance for preparing, responding, and recovery from all hazard events that can have a direct impact on the healthcare system within the coalition.

### Scope

The Response Plan and its associated annexes and appendices apply to all member organizations of the WCMHPC when an incident is beyond the individual facility’s ability to manage and that facility requires mutual aid and support from other coalition member organizations. The section is limited to the agreements signed by the coalition members, the coalition Bylaws, and the coalition MOU. See the [A.5 Readiness Appendices](#_Preparedness_Appendices) section for these documents.

This plan and its associated annexes and appendices do not replace or interfere with organizational EOP or jurisdictional plans for official command and control authorized by state and local EM agencies.

### Situation and Assumptions

An emergent situation may impact a single facility, multiple facilities, or regions. The WCMHPC is developed to support healthcare facilities in planning for, preparing for, and responding to any hazard.

See [A.2.5 Risk](#_Risk) regarding the identification of hazards and risks within the region. The Coalition Readiness plan also identifies the geography and membership of the coalition.

The following assumptions were used to develop this plan:

* All events should be managed at the most local level possible. Local resources will be used first. Facilities will communicate their medical needs to the coalition and non-medical needs to the jurisdictional emergency operations center (EOC)/emergency manager.
* Healthcare organizations will take internal steps to increase patient capacity and implement surge plans before requesting outside assistance.
* Planning and response should be flexible, scalable, and adaptable.
* This plan does not cover isolation or quarantine. These are public health containment measures used to combat communicable diseases that may occur in single, cluster, or larger patient quantities.
* This document supplements each Coalition Member’s or Partner’s EOP. Coalition members should develop an internal EOP that includes the principles of the NIMS. Impacted facilities will have activated their EOP and staffing of their facility operations center.
* Coalition member hospitals are expected to maintain the capability to manage emergencies, independent of support from the Coalition.
* Resource sharing amongst Coalition members and partners during a response will be managed in accordance with existing operating agreements, mutual aid agreements, and other agreements.
* The word “patient” is interchangeable and applies to patients, residents, and clients in healthcare facilities.

## Concept of Operations

### Introduction

This section outlines the functions of the WCMHPC in a response and the potential for activation of the Healthcare Multi-Agency Coordination (HMAC). The Region Medical Operations Coordination Cells (RMOCC) is a component of the HMAC. The primary goal of the RMOCC is load-balancing patients across healthcare facilities and systems to ensure that the highest level of care is available to all patients who need that care prior to engaging in a crisis standards of care situation. The WCMHPC provides logistical support for WC Region hospitals and healthcare facilities unable to coordinate among themselves, and to integrate with local EM, LPH departments, police, EMS, and the MDH during the response. Activation of the HMAC is event-driven. Minor events may only require a regional response that can be managed by coalition staff, the RHPC(s), and the PHPC. Larger-scale incidents may require more support and complete activation of the HMAC process. This document discusses both the regional response, HMAC operations, and RMOCC operations and priorities.

### Role of the Coalition in Events

A regional response performs the same role as the HMAC activation. When the situation exceeds the capacity or capability of the coalition staff, the RHPC and/or the PHPC the full HMAC may be activated. The HMAC is a multi-disciplinary coordination center that allows WCMHPC members and partners a means to obtain additional support during a response. The HMAC performs a “clearing house” function by collecting, processing, and disseminating data and information. The HMAC does not serve a command-and-control function for the region; however, it can support functions to improve a coordinated response, including:

* Facilitating information sharing and situational awareness among the Coalition by using coalition resources such as MNTrac and the coalition website
* Facilitating resource support and resource sharing among Coalition members, including supporting the request and receipt of assistance from local, State, and Federal authorities
* Facilitating patient transfers via assisting with patient tracking and information sharing
* Supporting Evacuation activities and Shelter-in-Place activities.
* Supporting incident management policies and priorities.

The HMAC helps improve response coordination by ensuring Coalition partners have the information they need to adequately respond to events. This information exchange builds consistency in response activities. It also allows healthcare partners from across the region to better interface with non-medical responders at the jurisdiction level by providing timely and accurate “snapshots,” or composite updates of local healthcare facilities' operations and capabilities, including:

* Facility infrastructure status,
* Bed availability,
* Service availability,
* Resource availability
  + Personnel
  + Supplies
  + Equipment
  + Pharmaceuticals
  + Organizational and Regional

For extended incidents with health and medical impact, other disciplines may be involved with HMAC activities, including, but not limited to:

* Unaffected Healthcare providers (hospitals, clinics, LTC)
* EM
* Public Health/Epidemiology
* EMS
* Behavioral Health
* Various SMEs (legal, ethical, structural experts)

#### Regional Medical Operations Coordination Cell (RMOCC)

The RMOCC makes data and stakeholder-informed recommendations to balance patient load and ensure high-quality care. RMOCC recommendations direct the movement of patients and resources from one facility to another or re-direct referrals that would usually go to an overwhelmed facility or system to one with capacity.

The priorities/needs of the RMOCC include the following activities:

* Collecting, analyzing, and disseminating hospital capacity information.
* Establish a collaborative work group of all hospitals to establish protocols and triggers to support the decision-making process regarding patient level loading.
* Act as a mediator and establish a meeting process where affected facilities can collaborate to share appropriate information to appropriately level load patient care within the region and, if necessary, work with other regions to bring in additional support.
* Identifying a physician lead to oversee and support clinical decision making.
* Identify an administrative lead/coordinator to track and report activities.
* May need to establish a phone bank to take calls regarding emergent placements.

See [B.8 Medical Surge Coordination Plan](#_Medical_Surge_Coordination_1) for a more in-depth discussion about the RMOCC utilization within the region.

#### Member Roles and Responsibilities in Response

During a coalition response to an event, whether it be a Regional Response or full activation of the HMAC, it is essential that the coalition members understand their roles in response:

* Hospitals
  + All facilities will respond to any requests made by the coalition in a timely manner or as outlined by the coalition.
  + Provide continuous situational awareness.
  + Track any response activities at the local level and be prepared to share this information with the coalition.
  + Hospitals may be asked to have representation in the HMAC, either physically or virtually.
  + Notify the coalition of any situation that may impact the facility's ability to provide care – this may be for situational awareness or as a precursor to a potential need for assistance.
  + Respond to MNTrac alerts and announcements, including participating in the MNTrac Command Center if activated/requested.
  + Respond to any request for data, including\*:
    1. Personal Protective Equipment (PPE) capacity/inventories
    2. Bed capacity and surge capacity
    3. Staffing levels
    4. Patient care response

\*This data collected may be shared with local, state, and federal partners.

* Regional EMS Representative (WCEMS)
  + Log activities on the Operational Log
  + Notify local EMS of HMAC activation. Determine EMS asset needs.
  + Assess available EMS assets/Obtain EMS Essential Elements of Information (EEI).
  + Coordinate emergency transportation asset support.
  + Coordinate/activate an EMS Strike team.
  + Notify Statewide EMS MACC if necessary and request a conference call through MRCC.
  + Report to WCHMAC, local EOC, and/or State EOC.
  + Provide EMS staging and communications information.
  + Support patient tracking activities. Patient information sharing during tracking/transport will occur in accordance with HIPAA information security/privacy requirements.
  + Support EMS requests for assistance obtaining appropriate PPE for response.
  + Support EMS training needs for response.
  + Coordinate with public health, if applicable.
  + Participate in the MNTrac Command Center if activated by the RHPC/Coalition.
  + Encourage EMS participation in MNTrac activities.
* LPH
  + Respond to all requests by the PHPC in a timely manner
  + Participate in MNTrac Command Center communications with the coalition or the room designated by the PHPC.
* LTC Facilities
  + Fulfill data requests from the HMAC
  + Understand the process for EMS transport to hospitals and the potential for receiving patients from hospitals as a means to off-load lower acuity patients.
  + Understand and agree to maximize any additional surge capacity for low-acuity patients or residents.

More detailed roles and responsibilities are identified in [B.8 Medical Surge Coordination Plan](#_Medical_Surge_Coordination_1) and its associated annexes.

#### Coalition Response Organizational Structure

The HMAC will be run on the principles of the Incident Command System (ICS), and the primary responding entities will operate within a unified command structure. When activated, the HMAC will staff according to this structure (see [B.13.6 HMAC Job Aids and Position Descriptions](#_HMAC_Job_Aids)).

##### HMAC Command Staff

* **HMAC Command:** responsible for coordinating agencies within the HMAC.
* **Liaison/Information Officer:** responsible for collecting information and disseminating communications.
* **Operations:** responsible for coordinating information about all health and medical operations in support of an incident response.
* **Planning:** responsible for collecting and evaluating data and plan development to support regional partners. Planning is also responsible for creating/collecting situational reports and maintaining all HMAC documentation.
* **Logistics:** responsible for receiving and facilitating the fulfillment of resource requests, including services, personnel, equipment, and materials.
* Partner agencies may be asked, by phone or by email, upon activation, to provide staff to play a role (either physically or virtually) in the HMAC.

### Response Operations

This section and subsequent sections address the actions taken by the coalition and its members before and during an event. The information provided will be utilized by the members to support their facility-based processes and serve as a resource when planning and responding to a local healthcare event.

#### Stages of Incident Response

The stages of incident response are dependent upon the type of incident and the potential resources needed or anticipated. The following table briefly describes the stage as an operating level as well as a brief description of the incident and response activities for each level.

Table . Coalition Operating Levels, Threat Levels, and RHPC/PHPC Activities

| **Operating Level** | **Threat Level** | **RHPC/PHPC Associated Activities** |
| --- | --- | --- |
| **Awareness / Alert** | Incident potential exists:   * Flood watch/warning * tornado watch/warning * Increased incidence of disease, CDC/WHO Pandemic Status | * RHPC/PHPC notifies the Coalition of the potential activation of the HMAC. |
| **Monitoring** | * An incident that can be managed at the organizational level or local level occurs; * An incident that has the POTENTIAL for needing HMAC support | * RHPC/PHPC is notified of an event by an affected Coalition member or partner. * RHPC will conference call with the affected organization. * RHPC/PHPC contacts PHPC, Regional EMS, and Regional EM. * RHPC/PHPC determines if HMAC needs to be activated (see the next level) and/or if there is a need for information sharing. * RHPC/PHPC determines if an MNTrac Alert should be sent to Coalition members or if an MNTrac Coordination Room should be established. |
| **Activation and Operations** | * A request to activate the HMAC is made for an incident that is acute in nature and impacts EMS, hospital, or long-term care facility operations. (e.g., mass casualty incident)   See [B.2.3 Response Operations](#_Response_Operations). | * The RHPC will notify Coalition members, other RHPCs, MN State Duty Officer, and MDH that the HMAC has been activated. * The PHPC will notify LPH and the PH Liaison/supervisor at MDH. * RHPC sends an MNTrac Alert to Coalition members. Determine if an MNTrac Coordination Room should be established. * HMAC will support information management, situational awareness, resource requests, and patient transfer requests in accordance with operational agreements and regional guidelines. |
| **Deactivation** | * Post-event: organizations/ communities no longer require HMAC assistance.   See [Section C: Recovery](#_Section_C:_Recovery) for more definition/detail on the deactivation process. | * RHPC notifies Coalition partners, other RHPCs, and MDH of HMAC deactivation. * The PHPC will notify LPH and the PH Liaison/supervisor at MDH. * Finalize documentation and initiate after action review process. |

#### Incident Recognition

Any impacted medical or healthcare entity may request activation of the HMAC by contacting the RHPC. In the event of a public health event, such as a pandemic, the HMAC may be activated by a request from the LPH to the PHPC.

Potential triggers for HMAC activation may include, but are not limited to:

* + - * A request by a Coalition member or partner agency, facility, or jurisdictional representative where resource requests exceed, or will soon exceed, available critical resources.
      * A request to open by MDH
      * Multi-jurisdictional incident or outbreak
      * An incident in an area with few resources, such as a low-population county.
      * An incident large enough to require resource sharing, including:
        + Strategic National Stockpile deployment
        + Epidemiologic investigation
        + Facility Evacuation
        + Any substantive Health Alert Network (HAN) message requiring action from public health and/or healthcare. Possible examples:
      * A natural disaster (e.g., widespread tornado or flooding)
      * A biological attack (e.g., anthrax dispersion)
      * A chemical attack or spill (e.g., a train derailment that forces a community evacuation)
      * A biological disease outbreak (e.g., pandemic influenza)
      * When there is an obvious regional interagency need to coordinate health-related policies and procedures.

#### Activation

The activation processes are dependent upon whether there is a local EOC open. The coalition response is primarily focused on supporting the local EOC. In some situations, there is no EOC activation.

##### Activation WITHOUT Local EOC Open

In this type of activation, the incident is sufficient to require additional support from other healthcare organizations but does not require local EOC activation. The HMAC will interface directly with organizations to ascertain specific needs and assist with the response. It is essential that even if the local EOC is not open, the local emergency manager be notified of the situation.

The figure below represents the activation process without a local EOC open/active.

Figure . Activation WITHOUT Local EOC Activation

##### Activation WITH Local EOC Open

In this type of activation, the incident requires additional support from other healthcare organizations and the activation of one or more jurisdictional EOCs. In this situation, the HMAC supports one or more local EOCs by supporting pre-hospital and hospital response operations and/or LPH response.

While the EOC is responsible for coordinating the overall response, the HMAC can be used as a support function of Medical Operations under the Operations Section. Through the EOC, the HMAC has access to multiple agencies to support response operations if necessary. During large-scale responses that include multiple coalition involvement, the length of the response is extended, and federal assets are involved, the Statewide Health Care Coordination Center may be activated to help coordinate the communications between the State and regional coalitions.

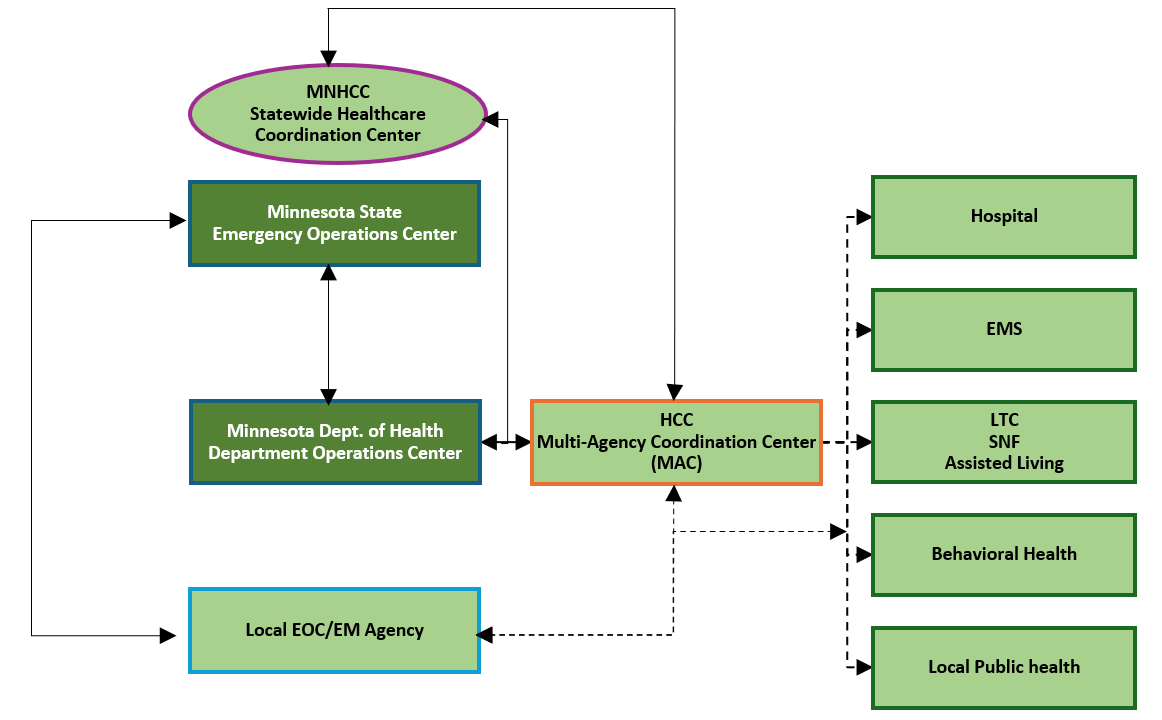
The figure below represents the activation process with a local EOC active.

Figure . Activation With Local EOC Activation

The figure below represents a multi-county/regional response.******

Figure . Multi-County/Regional Response Model

The figure below represents the activation process of the WCMHMAC.

A diagram of a company

Description automatically generated

Figure . WCMHMAC Activation Process

#### Notifications

If the HMAC is activated, the following entities will be contacted and advised of HMAC activation and be provided contact information.

* All hospitals in the region
* All LPH agencies in the region
* EM in the affected area
* The Central MN Health Preparedness Coalition (CMHPC) will be notified of HMAC activation due to the partnership between the two coalitions.

Additional notifications may be made to the following partners:

* + MDH-EPR
  + Neighboring LPH agencies
* Neighboring coalitions (if the situation has the potential for escalation outside of regional borders or if additional resources or assistance is needed)
  + Minnesota Healthcare Coalition Collaborative members
  + Local healthcare organizations/providers
  + Local EMS
  + Cross-border healthcare partners and public health
  + CDC/ASPR

The RHPC and/or PHPC shall be the primary parties responsible for notifying the coalition members of the activation of the HMAC. Working together, the RHPC will communicate with all healthcare partners and emergency managers, and the PHPC will communicate with LPH.

* The HMAC will utilize MNTrac as the primary communication tool. Additional communication methods are outlined in the [B.3 Communications](#_Demobilization_(Response_2.3.1.6)) of this plan.
* When the HMAC is activated, the initial communication to regional partners and MDH will include HMAC contact information (including but not limited to the phone number and email address).

The HMAC will use a pre-designed electronic survey to gather a Situation Report from Coalition members. If this cannot be completed by electronic survey, the information will be gathered by phone or email.

#### Mobilization

Upon activation or the decision to activate, the actual mobilization of the HMAC is purely event-driven. The HMAC can be done in person or virtually.

##### Virtual Activation

The HMAC can be “virtual” as needed. Participants can engage through various virtual platforms. See [B.3 Communications](#_Demobilization_(Response_2.3.1.6)) for a description of communication resources available.

##### In-Person Activation

If the HMAC personnel need to be located together, there is one primary location for the WC Region. As a backup, the HMAC could be activated at a healthcare facility, a public health location, or a local EOC.

**WC Region Primary HMAC location:**   
MDH District Office  
1505 Pebble Lake Road. Suite 300  
Fergus Falls, MN 56537  
Phone to be established upon activation.

**WC Region Secondary HMAC location:**  
9840 State Highway 114 SW  
Alexandria, MN 56308

#### Incident Operations

When activated, either in-person or virtually, the HMAC will follow the ICS structure, including the Planning P. Roles and responsibilities will be assigned by the RHPC and/or PHPC as necessary. See [B.13.6 HMAC Job Aids and Position Descriptions](#_HMAC_Job_Aids).

##### Initial Coalition Actions

Each HMAC position will implement the following procedures to fulfill their functions:

* Briefings:
  + Identify where and when briefings are held, either by phone or in person.
  + Gather information and provide current situation updates and probable future situation reports.
  + Describe current issues.
  + Introduce new issues.
  + Address questions and offer clarification.
* Decisions:
  + Review criteria to establish priorities.
  + Prioritize incidents, if necessary.
  + Allocate Central and WC Region resources, if necessary.
  + Assure representation of involved agencies and facilities at the Joint Information Center if one is opened in the region.
  + Consider implementation strategies.
  + Identify and determine the operational period.
* HMAC Documentation:
  + Develop an Incident Action Plan for each operational period.
  + Decisions/priorities are determined and communicated to affected parties.
  + Plan for implementation identified.
  + Meeting notes and decisions will be recorded and communicated to appropriate staff and external partners.
  + Decisions requiring financial commitments (including staff time) will be recorded.
  + Situational reports will be compiled as requested.
  + ICS Forms will be used as needed.
    - See [B.13.6 HMAC Job Aids and Position Descriptions](#_HMAC_Job_Aids) and [B.13.5 HICS Forms](#_Interregional_Communications_Recomm).

##### Ongoing Coalition Actions

During the incident response, the HMAC will continue to gain situational awareness and respond to requests for support. If the HMAC is open for an extended period, the RHPC may request the support of non-impacted coalition members to fulfill roles within the HMAC. This request would be made utilizing the Resource request process. See the [B.4 Resource Request Plan](#_Resource_Request_Plan).

If the response includes multiple coalitions, State and Federal partners, the SHCC may be activated to support the efforts of the regional and local response.

## Communications

This section aims to establish communications guidelines for WCMHPC that align with the Minnesota Statewide Interoperable Communication Plan. Coordination of relevant regional healthcare information will be performed by the Region. The coordination of state, regional, and local partners is depicted in the figure below.

A diagram of a medical organization

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Figure . Communication Pathway Diagram

### Information Sharing

#### Data Use and Release

Hospital data use will occur as outlined in the Hospital Disaster Preparedness & Response Compact, MDH MNTrac Agreement, and WC Regional Hospitals. Refer to the agreements for further details.

Sharing of nonpublic data obtained by the HMAC via MNTrac is limited to MDH. Sharing of other nonpublic data, including EEI, obtained by the HMAC is limited to HMAC representatives, the organization “owning” the data, and HICS as necessary to support disaster response operations.

#### Public Information Sharing

Before, during, and after an incident, prioritizing equity, inclusivity, and accessibility in communications is essential. The HCC encourages all members to consider this when working with facility public information officers. The coalition does not communicate with the public. HMAC members will not directly release operational or patient information to the public. If the local EOC is activated, all communication will be directed through the local EOC or joint information center (if activated). All requests for information concerning patients will be directed to the affected hospital. Patient information released to the public will be shared in accordance with Hospital Policy. The HMAC will support information sharing by disseminating situational updates, reports from partners, and State or National resources as necessary. The coalition will provide Public Information Officer (PIO) training to its members as requested to ensure facilities are trained and able to implement the PIO role in the response to an event.

#### Information Validation

Information validation actions will be taken when inconsistencies with established reporting mechanisms or inconsistent/missing data have been identified.

### Essential Elements of Information (EEI)

EEI contains situational awareness information that is critical to the initial response, ongoing response, and recovery operational periods. Specific elements stated here may not apply in every event, may not be all-inclusive, and should be modified to obtain the maximum benefit. EEIs should be added or deleted for each operational period depending on the specific circumstances and phase of response. Sharing this information among regional partners is important to the coordination of the response.

The following will be determined by the incident:

* Frequency of sharing
* Authority to receive and disseminate shared information
* Use and release shared information

Information and data deemed to be sensitive or confidential will receive protection in accordance with impacted facilities’/agencies’ policies and procedures as directed by MDH. The legal, statutory, privacy, and intellectual property considerations will be honored and protected to the extent possible during any real-world response.

Types of information that could be shared as EEI are outlined below. Other information may be shared as applicable or determined through coordination.

**Initial Response (Immediate)**

* What is the scope of the incident and the response?
* How will it affect service delivery?
* Where are the impacted communities?
* What population is impacted?
* What is the anticipated medical surge?
* Determine communication means
* Evaluate healthcare organization, staff, and supplies
  + Healthcare facility status, including structural integrity
  + Consider healthcare facility incident command status
* Determine health department status
* Identify who needs to know
* Identify resources to be deployed
* Consider healthcare facility decompression initiatives
* Status of evacuations/shelter-in-place operations

**Ongoing Response**

* Projections for healthcare organization, staff, and supplies:
  + Identify additional resources
  + Responder safety and health
  + Identify capabilities by specialties
  + Prioritize routine health services
* Forecast duration of the incident
* Update response partners
* Status of critical medical services (i.e., hospitals, urgent care, EMS, LTC, LPH department, behavioral health)
  + EMS status (e.g., patient transport, tracking, and availability)
* Status of critical infrastructure (CI) (e.g., electric, water, sanitation, heating, ventilation, and air conditioning)
* Status of critical healthcare delivery (e.g., surge status, bed status, deaths, medical and pharmaceutical supplies, and medical equipment)
* Status of interoperable communication systems

**Recovery**

* Prioritize essential functions
* Identify support resource systems
  + Human resources
  + Infrastructure resources
* Identify documentation
* Address regulatory requirements for reimbursements
* Assess functional staff (i.e., physical, mental screening, vaccinations)

See [B.13.2 Essential Elements of Information](#_HMAC_Coordination_Job) and [B.13.3 Essential Elements of Information Template](#_Essential_Elements_of_1).

### Interoperable Communication Systems

#### State Systems

##### Health Alert Network

The HAN is a statewide system for the rapid and broad dissemination of information on a developing condition, event, or other crucial health information. After receiving a HAN message from MDH, each public health agency forwards the message to appropriate local contacts, including behavioral health contacts. Hospitals also receive Health Alerts. All appropriate contacts should receive the health alert within one hour and health advisories within 24 hours. Local HANs are tested to determine the rapidity with which partners can receive messages and respond. The goal is for 100% response within 2 hours.

##### MDH SharePoint

The MDH SharePoint is a password-protected Web portal for information, technology tools, messaging capabilities, and sensitive document posting. MDH and its partners use SharePoint for three functions: messaging, data collection, report generation, and secure storage of sensitive documents that need to be shared with MDH staff and partners.

##### MDH REDCap

The MDH SharePoint site is password-protected and available to invited partners. The use of RedCap is to provide a secure site for HCCs to track deliverables and complete tasks identified by MDH EPR.

##### [Minnesota System for Tracking Resources, Alerts, and Communication (MNTrac)](https://www.mntrac.org/)\*

MNTrac is a database-driven web application intended as a statewide communication solution. MNTrac can track beds, pharmaceuticals, and resource availability from all designated facilities within the state, as well as provide for the allocation of these resources to support surge capacity needs. Hospital bed diversion status, emergency event planning, emergency chat, and alert notifications are possible in real-time. Information submitted by healthcare facilities can be imported to other systems and agencies to improve communications and share pertinent information. Standard and ad hoc reports can turn data into useful information.

\*This system is also available regionally and may be used independently of MDH activation. Alerts and coordination rooms can be activated by the RHPC or HMAC personnel.

##### Satellite Phones

The MDH District Office located in Fergus Falls maintains a satellite phone, which is used by the regional PHPC and/or district office staff.

##### Microsoft Teams\*

The State of Minnesota uses virtual meeting platforms (i.e., Microsoft Teams) to provide on-demand collaboration, online meetings, web conferencing, and videoconferencing applications. This system may be used during an event or healthcare response to disseminate information to the eight HPP healthcare regions as well as other coalition partners.

\*This resource is also available regionally.

#### Regional and Local Systems

##### Voice Communications

###### Cellular Telephone

The WC Region’s RHPCs and staff have cellular telephones from several different cellular providers, which allows for better statewide coverage in the case of an event or response.

###### 24/7 Emergency Contact

The 24/7 Emergency contact phone is housed at Saint Cloud Hospital and is answered 24 hours a day. The number is (320) 654-2720. The callers will request one of the Regional Coordinators, and if that person is unavailable, the call center has a list of Regional Staff numbers to call as an alternate.

###### Conference Call

The WC Region maintains a conference call line through Teams audio conference solutions. The audio conference system is available 24/7 and is accessible from any location with a phone.

###### Government Emergency Telecommunications Service (GETS)

GETS can be accessed if there is a dial tone. GETS can be for long-distance calls or during times of local system congestion and damage. All regional coalition partners are encouraged to obtain a GETS card.

###### Wireless Priority Service (WPS)

WPS is the wireless complement to GETS. Calls are queued for the next available radio channel by calling \*272. Currently, WPS is available in Minnesota through Cingular, Nextel, Sprint, T-Mobile, and Verizon. All regional coalition partners are encouraged to sign up for a WPS with their wireless provider.

###### Plain Old Telephone System (POTS)

POTS telephones remain a crucial communications portal. POTS are fixed numbers that can be forwarded to cellular devices which allows staff to be mobile but using a fixed telephone number. WC RHPCs maintain a current list of coalition partner POTS telephone numbers.

##### Two-Way Radio Systems

###### “ARMER” 800 MHz Radio System

The Allied Radio Matrix for Emergency Response (ARMER) is used as Minnesota’s strategy for public safety communication interoperability. The ARMER plan provides all public safety/service entities a shared platform to provide for interoperability.

* All WC Hospitals have both a base station as well as several handhelds.
* The WC HPP Region maintains a cache of 800 MHz Radios and a dedicated WC Region Talk Group.
* The WC Program Manager has a radio to support communications.

###### Ham Radios

HAM radio can serve multiple purposes within a hospital or health department. The most obvious function is for HAM radio to be used to communicate with emergency responders outside the hospital. The WC Regions’ Ham operators link county EOCs, hospitals, and public health agencies in the WC region. To access local Ham operators, the coalition will work with the local EM in the county.

###### VHF Radio System

The WC Region currently has a bank of 20 handheld radios that utilize six channels with an estimated 2–5-mile range. These assets are to be distributed to WC Coalition Partners as an independent system available when all other radio systems are down.

##### Electronic

###### Fax

FAX Transmission Systems are included in most copier/scanner/fax systems. The WC Region has access to three portable systems which allows for portable as well as redundant backup for document/information transmittal.

###### Email

The WC Region RHPCs maintain individual and group e-mail lists of all coalition partners who will allow for timely dissemination of information in daily operations as well as during an event and/or response.

###### Electronic Document Portability

Document Scanner Systems are included in most copier/scanner/fax systems. The WC Region has access to three portable systems, which allows for portable as well as redundant backup for document/information transmittal via e-mail attachments as well as document storage and uploads to cloud or server-based storage sites.

###### [Regional Website](https://www.cwchealthcarecoalitions.org/)

The coalition website provides the public access to resources and templates as well as a schedule of our coalition activities. Members of our coalition who are registered with the website have complete access to our website, which includes access to meeting minutes, coalition-specific documents, training opportunities, contact information, and a web-based chat room. This chat room will serve as a backup to MNTrac and can be used to share real-time information.

###### Virtual Private Network (VPN)

The WC Region’s RHPCs and all regional staff have VPN to SCH which is the Regional Healthcare Resource Center for the WC and Central HPP Regions as well as the MN-MMT. Additionally, several of the WC Region’s Coalition partners have VPN access to their agencies, which can be used during an event or response.

###### Wireless Cellular Internet Systems

The WC Region has access to three Wireless Cellular Internet Systems to provide for wireless internet systems in the Alternate Care Sites (ACS), Region offices, and other essential areas of operation where critical electronic information transmission and reception is needed.

###### Microsoft Forms

The WC Region has created a Microsoft Forms survey to gather information easily and electronically from the WCMHPC members. This survey could be replaced by a phone call or email to gather information.

###### WCMHPC SharePoint

All current regional files will be housed on the WCMHPC SharePoint site. Files include all regional plans, budgets, and contact lists.

###### Non-Web-based File Storage

The program manager has an external hard drive that has all the coalition documents loaded on it if web/internet options are not available. This hard drive is updated quarterly.

### Cross-State Communications

Dependent upon the incident, coordination and communication may be required across state lines, particularly with North Dakota, due to the geographic location of the region. The figure below outlines how WCMHPC will utilize MNTrac to communicate with North Dakota partners.

A diagram of a company

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Figure . Regional and North Dakota Partner MNTrac Communications

The RHPCs for the WC and Northwest regions will serve as the regional point of contact when communicating with North Dakota Partners. See the [Key Contacts](#_Key_Contacts) for these individuals’ contact information.

See [B.13.6 HMAC Job Aids and Position Descriptions](#_HMAC_Job_Aids).

###### Resource Coordination

See the [B.4 Resource Request Plan](#_Resource_Request_Plan) and the [B.13.14 Resource Request, Receipt and Promissory Agreement](#_Resource_Request_Receipt) – Resource Request Form for the process the coalition will use to coordinate the sharing or acquisition of resources before and during a response.

For more information on regional healthcare resources, see [B.13.1 Assets and Essential Services](#_Assets_and_Essential).

## Resource Request Plan

### Purpose

During times of scarce resources, medical surge, and/or evacuation measures, there may be situations where resource sharing/acquisitions may be coordinated through the coalition. This plan identifies the process in place to facilitate such sharing. The WCMHPC maintains a regional cache of healthcare supplies that may be needed to supplement the resources available for Coalition members. The WCMHPC is responsible for maintaining, monitoring, allocation, and distribution control of all the inventory items in the cache, as well as the acquisition and disposal of equipment.

### Objectives

A centralized cache of supplies supports the response of the WCMHPC in times of medical surge, pandemic, and other unexpected events. Coalition members can rely on Regional Healthcare Preparedness Coordinators (RHPC) for their assistance and consultation regarding supplies as well as product availability and costs. Individual healthcare organizations are expected to utilize their primary vendor suppliers and other regular means of acquiring resources before requesting assistance through the Coalition. This includes their affiliated organization (enterprise/parent) and mutual aid agreements first. As members of the coalition, healthcare partners have signed the MOU, which states that when available, members agree to assist in resource sharing and acquisition. The resources include durable medical equipment, health care supplies, and personnel.

RHPCs will:

* Manage and coordinate requests for supplies.
* Assist in arranging for distribution of supplies in a safe, timely, and efficient manner.
* Maintain the regional cache by reusing, recycling, and disposing of expired surplus cache supplies safely and economically.
* Share resource acquisition information with coalition partners where group buying will allow for decreased costs to coalition members.

### Resource Request

#### From the Cache

A WCMHPC Member or Partner may request products from the regional cache when the following terms are met:

* The facility has utilized its own resources/suppliers, and the supplies are unavailable within the time frame needed.
* The facility has contacted outside vendors/suppliers to request the product and the product is unavailable.
* The facility has contacted the RHPC with a specific need.
* The facility has completed a requisition form with the following:
* The product needed and the amount needed.
* The anticipated date that the facility will be replacing the product used
* The transportation means requested and the time the product is needed by.
* A signature from the receiving facility and a signed copy returned to the RHPC.
* The region may not fulfill the entire requested amount due to availability, other requests, and/or the State of Minnesota requirements.

#### From Fellow Coalition Members/Partners

The coalition member may contact coalition partners directly or request assistance from the RHPC to borrow or purchase supplies/resources from fellow members. The resource request form will be utilized in this case. Copies of the request will be maintained by the borrower, lender, and the RHPC.

#### Specific Resource Request Requirements

As per the [WCMHPC MOU](#_Memorandum_of_Understanding), requests for resources need to be specific. The following identifies specific requirements:

##### Medical Supplies/Pharmaceuticals

* All requests for medical supplies and pharmaceuticals will specify:
  + Amount of material needed.
  + Size/dosage of material needed.
  + When the materials are needed.
  + Arrangements for the exchange of such supplies.
  + Reimbursement or restocking of materials.
  + The requesting facility will use the requisition forms/paperwork of the agency supplying the materials.
  + The recipient facility will reimburse the donor facility for all the donor facility's costs determined by the donor facility’s regular rate.
  + It is recommended that reimbursement be made within 90 days following receipt of the invoice or otherwise negotiated facility to facility. This can include replacing items or reimbursing for the cost of items.

##### Loaned Equipment

* All requests for loaned equipment will specify:
  + Amount/quantify of equipment being requested.
  + An estimate of how quickly the requested equipment is needed.
  + Estimated length of time the equipment will be needed.
  + Identify how the equipment will be picked up and returned.
  + Identify where the equipment will be used.
  + If any equipment is damaged, the receiving facility will agree to repair or replace the equipment within 30 days or as otherwise agreed to.
  + Documentation should detail the items involved in the transaction, the condition of the material prior to the loan (if applicable), and the party responsible for the material.
  + The donor facility is responsible for ensuring that the equipment provided is safe to use and operational.
  + The recipient facility is responsible for using the equipment provided in accordance with the manufacturer’s guidelines.
  + If parts or all of the equipment loaned are consumable or for one-time use, the recipient facility will reimburse for the actual cost or replacement of the equipment – as agreed upon by both parties.

##### Staff

* All requests for staffing will specify:
  + The type and number of requested personnel
  + An estimate of how quickly the request is needed.
  + The location where they are to report.
  + An estimate of how long the personnel will be needed.
  + The recipient facility will have supervisory direction over the donor facility’s staff.
  + The recipient facility will assume all legal responsibility for the personnel from the donor facility during the time the personnel are at the recipient facility.
  + The recipient facility will reimburse the donor facility for the salaries of the donated personnel at the donated personnel's rate, as established by the donor facility unless other arrangements are made between the facilities.
  + The donor facility is responsible for the appropriate credentialing of personnel.
  + The recipient facility is responsible for verifying the credentials of personnel being received.
  + The senior administrator (or designee) and/or medical director, in conjunction with the directors of the affected services, will decide whether medical staff and other personnel from another facility will be required at the impacted facility to assist in patient care activities.

##### Limitations on Loaned and Volunteer Staff Instructions

* Personnel offered by donor facilities should be limited to staff that are fully accredited or credentialed in the donor institution.
* The recipient facility's senior administrator or designee (the health care facility or public health agency command center) identifies where and to whom the donated personnel are to report.
* Professional staff of the recipient facility will provide supervision to the donated personnel.
* The supervisor or designee will provide direction regarding point of entry, parking, length of shift, clothing requirements, and other pertinent information to perform the assigned job.
* The supervisor or designee will provide donated staff a briefing and orientation as pertinent to the position.
* The recipient facility will provide all PPE necessary to perform the duties as assigned unless otherwise negotiated between facilities that PPE will come with. If the receiving facility requires PPE that requires fit testing, the recipient facility will fit test the personnel.

##### Allocation

During times of scarce resources, RHPCs will initiate an emergency voting process with the WCMHPC advisory committee. If this cannot be accomplished, the HMAC members will determine the allocation and distribution process.

##### Distribution

* Regional assets can be deployed within four (4) hours of the request.
* The requesting facility will pick up the items or arrange pick up with a courier of their choice (as indicated on the Request Form).
* RHPC may be able to assist in transporting the products in extreme cases. The RHPC will coordinate the distribution of all regional cache items.
* Items in the cache may not be the same model as requested – this may require additional training at the requesting facility. Any additional training and/or fit testing is the responsibility of the requesting facility.
* During large-scale or multi-location events, the regional cache will be disseminated based on coalition needs and may be impacted by guidance from MDH. The items contained within the cache are purchased using federal funds and are subject to recall through State or Federal mandate.

##### Maintenance of the Regional Cache

* Items in the cache are in a clean, dry, and secure environment. Access to the cache is available 24/7 through the RHPC.
* RHPCs review the regional cache supplies, maintain an inventory log, and update and maintain the inventory on MNTrac at least annually.
* Any items that are outdated or expired past the manufacture’s recommendations will be stored for future consideration of distribution and use in a supply-crisis or pandemic. (For example, Recent guidance (3/11/20) by the CDC has indicated that, in recognition of the supply-crisis currently being experienced globally due to the COVID-19 Pandemic, certain expired N95 masks may be used to protect healthcare workers.)
* Equipment and supplies will be maintained per manufacturer guidelines or to the best of the host facility's capabilities.
* Ebola supplies purchased with Ebola funding will be maintained and housed with the regional cache. These items are kept separate from the main regional cache and will be available for distribution regionally or as requested by the State of Minnesota. All Ebola supplies will be kept universal throughout the region.

See the [B.13.14 Resource Request, Receipt, and Promissory Agreement](#_Resource_Request_Receipt).

## Regional Patient Tracking Plan

### Introduction

CMS issued a rule to establish consistent emergency preparedness requirements for healthcare providers participating in Medicare and Medicaid to increase patient safety during emergencies and establish a more coordinated response to natural and man-made disasters. This rule went into effect in November 2017. A component of the Emergency Preparedness Rule requires facilities to identify the location of their patients during day-to-day operations, re-locations, evacuations, and mass casualty incidents.

Lessons learned in past events have identified there are gaps in the ability to track patients at the facility, local, regional, and state levels. The inability to track patients may:

* Delay or inhibit the efficient provision of patient care.
* Increase the psychological impact of the event on patients and their loved ones.
* Delay the reunification between the patients/residents/clients and their loved ones.
* Diminish the capability of healthcare providers to identify resource needs.
* Inhibit the ability of law enforcement partners to gather evidence and investigate the event.
* Create gaps in documentation that are essential for future legal action or the potential for reimbursement from federal agencies.
* Limit the capability of affected facilities to be reimbursed for costs incurred when providing treatment.

### Purpose

The purpose of the WCMHPC Regional Patient Tracking Plan is to provide the tools and resources for healthcare providers within the region to assist with patient/resident/client tracking. This plan allows all healthcare providers to utilize the same processes that will ensure continuity of patient/resident/client tracking within the region. The objectives for the WCMHPC’s Regional Patient Tracking Plan are:

* To determine and document the identity of the patient.
* To determine and document the patient’s location.
* To identify the modes of transportation utilized.
* To utilize the START Triage patient tracking identifiers to indicate the basic status of the condition of the patient and facilitate the continuity of care.
* To create a database of patients and their locations to aid the local emergency manager and law enforcement in their investigation process.
* To create a database of patients and their locations to assist the Local EM and/or HHS family reunification process.
* Utilize the MNTrac Patient Tracking program to compile data collected and work within the MNTrac Command Center for confidential information sharing capabilities.
* To create a redundant means of compiling data when MNTrac is unavailable.

### Scope

The Regional Patient Tracking Plan is divided into two sections:

* **Section I** is the processes involved in day-to-day patient tracking involving the use of the EMTALA form as the conduit of information sharing.
* **Section II** is for mass casualty patient tracking and includes regional multi-agency coordination and information sharing amongst all emergency preparedness partners.

### Planning Assumptions

* Patient tracking is the responsibility of the affected facility and the personnel managing the transportation assets.
* Not all information about the patient will be available at the beginning of patient tracking. As patient care and time allows, more information about the patient will be gathered and documented.
* Based on the incident, patient tracking may continue for an extended period.
* The Regional Patient Tracking plan is designed to support family reunification efforts; however, it does not address the actual processes or the operations of the family reunification center (FRC).
* The Patient Tracking Plan can be used with the MNTrac Patient Tracking platform, or it can be a stand-alone plan. Utilization of the MNTrac Patient Tracking application can be initiated after the immediate on slot of patients.

Much of the information gathered for patient tracking is considered Protected Health Information (PHI) and is subject to HIPAA. All information shared must take into consideration HIPAA.

### Responsibilities

Implementation of a successful patient tracking process will be dependent on coordination among numerous entities. The following are roles and responsibilities related to patient tracking for key emergency response partners. Individual roles may vary depending on the circumstances of the incident.

Table . Regional Patient Tracking Plan - Partner Roles and Responsibilities

| **Partner Type** | **Responsibilities** |
| --- | --- |
| **EMS** | * Activates internal patient tracking; may request activation of regional patient tracking as needed. * Initiates minimum patient tracking in the field via a unique identifier, on a wristband or triage tag if available, for each patient requiring transportation to definitive care. * Follows agency protocol regarding patient distribution. * Requests transportation assistance via mutual aid agreements with partner agencies. * If the event is over an extended period, EMS will work with the regional WC EMS coordinator to facilitate requests for additional resources. * Shares unique identifier (and any other patient information captured) with hospital/ACF/receiving health care facility. |
| **WCMHPC** | * Monitoring health care system and population impacts. * Identifying and anticipating resource needs. * Activating and coordinating centralized patient tracking information via MNTrac. * Activates patient tracking as needed. Activate patient tracking in the centralized database (MNTrac) if available. * Notifies all regional partners of patient tracking activation. * Support WC EMS with coordinating patient distribution if requested. * Monitors impact on the healthcare system and assists in coordinating medical resource support. * Serving as the single point of contact for patient tracking, if requested. This includes compiling data from facilities and uploading that data into MNTrac (if available). The coalition staff can be used to share allowable information with law enforcement, LPH, and EM. * Participate in the JIC on behalf of patient tracking if activated and requested. * Supports local, county, regional, and state agencies in response activities. |
| **Hospitals, Alternate Care Facilities, and Other Healthcare Organizations** | * Activates internal patient tracking; may request activation of regional patient tracking as needed. * Establishes a process for documenting patient tracking information provided by EMS and coordinating this information with patient registration/medical records. * Initiates patient tracking for patients received at the facility. * Documents minimum patient tracking information via a spreadsheet (see the [B.13.8 Master Patient Tracking Form](#_Master_Patient_Tracking) and [B.13.5 HICS Forms](#_Interregional_Communications_Recomm) for HICS 254 MNTrac Master Patient Tracking form) or directly in the MNTrac patient tracking database, if available. * Provide Regional HICS 254 patient tracking lists to WCMHPC if not using a database. * Facilitates family reunification for patients within the facility in coordination with local partners (Red Cross, Family Assistance Center (FAC), Call Center). |
| **LPH/Local HHS** | * Coordinate with the WCMHPC and local healthcare organizations. * Monitors impact on the healthcare system and assists in coordinating medical resource support. * Support local EM by assisting with the coordination of a FAC. * May support EM with public messaging related to health and medical system impacts, including information about patient tracking and related family reunification efforts. |
| **MDH** | * Activates patient tracking as needed. Activate patient tracking in the centralized database (MNTrac) if available. * Notifies WCMHPC and all regional partners of patient tracking activation. * Provides support for coordinating patient tracking information during incidents that cross multiple jurisdictions. * Coordinates with regional coalition coordinators to obtain patient tracking information from their jurisdiction, as needed. * Serves as a conduit for sharing patient tracking information with federal agencies as needed. * Provides coordination with state-level FAC or call center if established. * Monitors the impact on the healthcare system and assists in coordinating medical resource support as applicable. * Serves as the lead agency at the state level for public messaging related to health and medical system impacts, including information about patient tracking and related family reunification efforts. |
| **Local EM** | * Support resource needs for coordination of a FAC and/or call center. * Serves as a conduit with State EM for coordination of resources as applicable. * Supports coordinated public information and messaging in partnership with health care facilities, the coalition, and LPH/HHS through a Joint Information Center, if established. |
| **Law Enforcement** | * Responsible for coordinating missing persons' information. * Assists with the identification of unidentified patients. * Assists with family reunification for missing persons as applicable. |
| **Other Partners** | * County Medical Examiner – access patient information through the partnership of local EM, public health/HHS, health care, and the MNTrac database for victim identification. * Non-Governmental Organizations (i.e., Red Cross) – work with local EM, LPH /HHS, and response partners to facilitate family reunification/notification. |

### Concept of Operations

#### Operations Overview

In an MCI, it is essential that, at a minimum, the patient tracking process be initiated as soon as the patient begins receiving health care services. This may occur when patients are transported from the field to a point of definitive care or following arrival at a point of definitive care via self-referral (e.g., hospital, alternate care facility, clinic). The patient’s whereabouts and condition should be tracked throughout the incident until the patient is accepted at another facility for continued care or discharged to home.

In a mass casualty incident, especially in the more rural areas, the ability of EMS providers to document patient identification is limited. As such, the priority for EMS should be to begin initial patient treatment and prioritize the patients utilizing the triage protocol (assigning a red, yellow, green, or black identifier). EMS is tasked with identifying the appropriate receiving facilities and providing early notification to those receiving facilities. The collection of patient-identifying information will be prioritized once the patient arrives at a point of definitive care.

Healthcare facility patient tracking should end when:

* Patient is discharged home (with or without home health/care services).
* Patient is discharged to a long-term care facility.
* The patient is deceased, and the County Medical Examiner has taken control of the human remains.
* Patient has been transferred to another healthcare facility, and they have assumed care.

Patient tracking is one aspect of a larger victim accounting and family assistance process. The overall purpose of the FAC is to assist with victim identification and family reunification with the missing and deceased. Patient tracking information supports the identification of individuals associated with an incident, along with information on the deceased, missing persons, and uninjured persons. Patient tracking is only meant to track living patients with the understanding that some patients may become deceased as the incident progresses. The FAC is primarily initiated by Local EM and is supported by their local/regional/state and federal partners. This section of the plan does not discuss operationalizing the FAC.

#### Patient Tracking Activation

Patient tracking will be activated to support a mass casualty incident (MCI) as well as be used in day-to-day operations. From this point forward, the plan will identify the processes involved within each of the components of patient tracking.

The two components are:

1. Day-to-day operations
2. MCI

Patient tracking is highly recommended for Day-to-Day operations and is required if/when a facility evacuates. The Patient tracking plan should be incorporated or referenced in the facility’s Evacuation plan (See [B.10 Evacuation and Shelter-in-Place Planning](#_Evacuation_and_Shelter-in-Place)). The decision to activate patient tracking during a mass casualty incident will usually be made by the Emergency Room/Triage staff who receive notification from EMS about the incident or if/when there is a surge of patients from a single event. Facilities will utilize their communications plan and notify all staff of the activation. The earlier the plan is activated, the more data is collected.

#### Patient Tracking Data Elements

Core to the patient tracking process is the need to know what data elements will be required during an incident. It is important to recognize that early in the event, limited information about the patient’s identity may be available. EMS and health care providers will prioritize patient care over collecting patient-identifying information. Efforts to collect more comprehensive information about a patient’s identity will be made as resources become available.

The minimum data that should be collected for patient encounters and tracking are:

* Patient Name
* Date of Birth
* Triage Color
* Patient number or unique identifier
* Method of arrival
* Date/time of arrival
* Location within facility
* Gender

It is important to keep in mind that much of the information gathered for patient tracking is considered PHI and is subject to HIPAA.

There are circumstances during an MCI when the identity of a patient may not be easily or quickly determined (e.g., the patient is unconscious or unable to communicate and does not have personal identification with him/her). Under these circumstances, healthcare organizations should document as many identifying characteristics about the patient as possible and provide this information to law enforcement and/or the FAC if one is established. Information will be used by the authorities to assist with the coordination of missing persons’ information and reconciled with data being provided about individuals who are unaccounted for to assist in determining the patient’s identification.

Utilization of the [HICS 254 Master Patient Tracking Form](#_HICS_Forms) during a Mass Casualty event will allow facilities to start the initial patient tracking process and gather the minimal data elements into one spreadsheet. The Master Patient Tracking form has been slightly altered to allow for alignment with the MNTrac program. Facilities are encouraged to save an electronic version of this form so that it is available and ready to be used when the plan is activated. See the [B.13.8 Master Patient Tracking Form](#_Master_Patient_Tracking).

#### Patient Tracking Triggers and Procedures

##### Section I. Day-to-Day Patient Tracking

CMS requires healthcare facilities to track the locations of their patients while under their care. During day-to-day operations, patients may be transferred to a different facility to receive care. It is imperative that the transferring facility have a system in place that identifies the receiving facility has accepted the patient and the patient has been received at that facility. Since this activity occurs daily within health care, there is no actual activation of this plan as it is a daily process already adopted by the health care facility.

This plan does not address a system for monitoring temporary patient movement, such as when the patient is required to go to another facility for a procedure or test that does not require an overnight stay. It is recommended that facilities have a process that identifies when the patient has been received at the other facility and when they are returning to the initial facility. This may be simply done via communication between the facilities or between the transferring facility and the EMS agency or transportation asset. All this information needs to be documented in the patient’s chart.

LTC and SNFs are required to track patient movement as well. When a patient/resident is transferred to another facility for continued care, it is essential that the confirmation of transfer be documented in the patient’s chart. If it is a discharge to another facility or a temporary transfer for continued care, the facility needs to communicate with the receiving facility to ensure that the patient arrived and is now under their care. The coalition developed a Resident Transfer form that contains the recommended information to be used when transferring patients to another facility/agency. When patients are being transferred to another facility for continued care, the transfer form must be completed. Facilities are not required to utilize the Regional Transfer form; however, any form they use should contain the same information for continuity of care.

See the [B.13.13 Resident Transfer Form](#_Resident_Transfer_Form).

The following process is recommended to ensure that facilities have a system in place to track the day-to-day patient tracking. If healthcare facilities choose not to follow this process, they are strongly encouraged to develop an internal process of their own. (See algorithm below)

1. When patients are being transferred to another facility for continued care, the Hospital EMTALA form or Resident Transfer form should be completed.
2. Ensure that the transferring facility’s name and fax number are listed in the appropriate section.
3. During the Nurse-to-Nurse report out, the Transferring facility’s nurse will advise the receiving facility that the Hospital EMTALA form/Resident Transfer form will be sent with the patient and request that the bottom section of the form, identifying receipt of the patient, be completed and faxed back to the transferring facility within four (4) hours of arrival at the receiving facility.
4. Three copies of the form are made and distributed as below:
   1. One copy to the patient.
   2. One copy to the receiving facility (advise the transportation agency to give the Hospital EMTALA form/Resident Transfer form to the receiving facility upon arrival).
   3. One copy will be maintained by the transferring facility.
5. The nurse documents in the patient’s chart the time that the patient left the facility as well as the information about the agency that is providing transportation.
6. A copy of the Hospital EMTALA form/Transfer form will be held at the transferring facility. It is suggested that this be held at the nurse’s station until the receiving facility faxes back their copy with the accepting information completed. This will ensure there is a system in place so that if the information is not received from the receiving facility a call can be placed to obtain the necessary information. If the Hospital EMTALA form/Transfer Form is not received within 2-4 hours of transfer – a station clerk/receptionist will contact the receiving facility and request the form to be faxed.
7. The acceptance information will be noted in the patient’s chart, and the final completed Hospital EMTALA form/Transfer form will be scanned and placed into the patient’s medical record. The copy that is incomplete can then be destroyed.

##### Section II. Mass Casualty Incident Patient Tracking

Patient tracking should be initiated when one or more of the following applies:

* More than one facility will be receiving patients.
* Patients may arrive at a treatment facility (e.g., hospital, alternate care facility) by multiple methods, including EMS and self-transport.
* A field treatment site is established.
* There are multiple incident locations.
* The incident is determined to be a mass fatality (based on a local threshold).
* Circumstances warrant the activation of a Family Reunification and/or FAC.

To ensure that the WCMHPC is activated, facilities receiving patients from a mass casualty event should notify the regional health care coordinator as soon as possible upon learning about the event. This notification is essential to ensure that the coalition’s HMAC can be activated. Any coalition partner can contact the coalition to request activation of the regional patient tracking plan.

MCI Patient Tracking will look like the following:

1. Incident Occurs
2. EMS will arrive on the scene and begin triaging patients according to institutional protocols.
3. When possible, EMS personnel will document the unique identifier that is attached to the patient (via a wristband, triage tags if available). Unique identifiers should remain on/with the patient the entire time they are active in the incident. If time allows, EMS may document some additional information and enter the information onto the patient’s run sheet. If a manual patient tracking process is being used, the coalition will receive tracking information from hospitals in step #5.
4. The patient is transported from the scene to the receiving site (i.e., hospital).
5. Upon arrival at a hospital/ACF or another healthcare facility, intake staff will begin to collect the minimum data elements outlined in the [Patient Tracking Data Elements section](#_Patient_Tracking_Data). Not all information may be collected immediately, but the intake staff will begin the process by creating a record for the patient and taking note of the unique identifier begun by EMS (on the wristband or triage tag if available). If a unique identifier has not been assigned, the facility will assign one. The facility may assign a temporary “disaster” patient number due to the deluge of patient flow and decreased amount of time to fully register the patient. The information should be merged with a more permanent patient identifier as soon as patient flow allows. This information will then be recorded into a HICS 254 patient tracking form. Before entering any data into the electronic medical record system, healthcare staff should search the database to ensure they are not duplicating profiles. Hospitals should also record the unique identifier in the patient’s electronic medical record file. Hospitals are the primary source of patient tracking information for the coalition.
6. Once the coalition has been notified of the incident, the coalition staff will immediately create a Patient Tracking event and a Command Center in MNTrac and send an alert to the appropriate partners within MNTrac (other healthcare facilities, local EM, and neighboring regional coordinators, etc.).
7. Healthcare facilities will upload their HICS 254 into the Patient Tracking event, or coalition staff can assist healthcare facilities by uploading the HICS 254 forms and verifying that the data has been uploaded correctly. Healthcare facilities can upload their forms to the MNTrac Command Center.
8. Any patients received after the Patient Tracking event has been opened will have their basic data elements loaded directly into the MNTrac Patient tracking event, and the hospital will suspend utilization of the HICS 254 form and use the Patient Tracking event within MNTrac for any additional patients received.
9. If a patient is being transferred out to another facility, ensure the patient maintains their unique identifier, record in their file and profile on the MNTrac patient tracking event describing when and where they are being sent. The transferring facility will ensure the receiving facility is provided with the appropriate information and a unique identifier.
10. Upon receipt of a transferred patient, intake the patient as you would above. If a profile has already been created in the MNTrac patient tracking database, update that information with all relevant information. Coalition staff will invite receiving facilities to the Patient Tracking event within MNTrac as necessary.
11. If a patient is being discharged, ensure that their file and profile are updated appropriately.
12. Regional patient tracking will end when all patients have been accounted for and are receiving care or are discharged to home.

See the figure below for more information and see [B.13.8 Master Patient Tracking Form](#_Master_Patient_Tracking).

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Figure . Mass Casualty Patient Tracking Process

#### Distribution of Patient Tracking Information

During a response, patient tracking information will be needed by multiple agencies to support a variety of activities. These may include providing patient care, patient/victim identification, family reunification efforts, resource tracking, public information, and/or criminal/legal investigations. The following table reflects primary entities that may need patient tracking information and examples of the potential purposes for which it will be needed. The WCMHPC will coordinate with partner agencies to develop and deliver accurate and timely information on patient tracking. The stakeholders listed below may need and receive detailed patient tracking information (including identifying information); all other stakeholders may only receive summary reports.

##### HIPAA

HIPAA Privacy Rule 45 CFR 164.510(b)(1)(ii) allows for disclosure of patient information during emergent situations in certain situations. According to the HHS, the HIPAA Privacy Rule permits a covered doctor or hospital to disclose PHI to a person or entity that will assist in notifying a patient’s family member of the patient’s location, general condition, or death. [US DHHS HIPAA Privacy Rule statement](https://www.hhs.gov/hipaa/for-professionals/faq/491/may-a-doctor-disclose-information-to-a-person-that-can-notify-a-patients-family/index.html)

Table . Stakeholders and Roles/Responsibilities in the Distribution of Patient Tracking Information

| **Stakeholders** | **Purpose** |
| --- | --- |
| **Hospitals/other health care organizations/ACFs** | * Document involvement in the incident. * Maintain situational awareness. * Document and ensure continuity of patient care. * Identification of the patient. * Assistance with family reunification. * Media/Public Information. * Documentation to assist with financial reimbursement. * Accountability |
| **WCMHPC** | * Maintain situational awareness * Monitor health care system and population impacts. * Identify/anticipate resource needs. * Coordination with Public Health concerning health care and patient tracking * Coordination of MNTrac for patient tracking operations * Coordination of the completion of all patient tracking information (closing the loop on outstanding patients) * Coordinate with local law enforcement/EM to facilitate family reunification or incident investigations. * Media/Public Information * Accountability |
| **Public Health/HHS** | * Situational awareness * Monitor health care system and population impacts. * Identify/anticipate resource needs. * Call Center operations/public information to assist with family reunification. * FAC operations/assist with victim accounting * Coordination with regional partners (EMS, EM, Law Enforcement) concerning patient tracking. * Media/Public Information * Accountability |
| **MDH** | * Situational awareness * Monitor health care system and population impacts. * Identify/anticipate resource needs. * To monitor patient movement across regions/out-of-state * Call Center operations/public information to assist with family reunification (if this is coordinated at a state level) * FAC operations/assist with victim identification (if this is coordinated at a state level) * Media/Public Information * Accountability |
| **EMS** | * Document involvement in the incident * Situational awareness * Document and ensure continuity of patient care. * Identification of the patient * To provide information to the PIO * Documentation to assist with financial reimbursement. * Media/Public Information * Accountability |
| **County Medical Examiner** | * Victim Identification * Determining cause/manner of death * Assist with family reunification. * Accountability |
| **EM** | * FAC and assist with reunification efforts. * Documentation to assist with financial reimbursement via FEMA. * Media/Public Information * Situational Awareness * Assist with victim location/identification |
| **Law Enforcement** | * Criminal investigations (evidence/witness information) * Suspect identification/location * Assist with Family reunification. * Identification of missing persons |
| **Red Cross/Volunteer Organizations** | * Family reunification/FAC support |

#### Coordinating Patient Tracking Information

Mechanisms for documenting and sharing patient tracking information will vary depending on the conditions of the incident, resources available, and patient tracking processes or systems established prior to a disaster occurring. Depending on the scale and complexity of the incident, patient tracking information may flow through normal channels, with response agencies communicating directly with each other. In larger or more complex incidents, it may be necessary to centralize patient tracking information in a centralized database (MNTrac) or through a manual process. Even when patient tracking information is centralized, there will still be a need for individual response agencies to communicate directly with each other for information. It is important to centralize information to:

* Ensure organizations receive up-to-date and appropriate information.
* Decrease the burden on health care, EMS, law enforcement, and other response partners to continually provide information.
* Create a centralized source of patient tracking information that can be accessed for the purposes of family reunification and victim identification.

If a centralized database (MNTrac) is not available, the WCMHPC and its’ healthcare care partners use FAX, phone, radio, or other methods to collect patient tracking information; the method of collecting information should, at minimum, include the minimum data elements identified in [B.3.2 Essential Elements of Information (EEI).](#_Essential_Elements_of)

* If a health care system is already centralizing patient tracking information, the coalition will coordinate with the health care system to collect system-wide patient tracking information. If a manual process is used, the timeframe for gathering and sharing patient tracking information will likely be extended.

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Figure . Patient Tracking Information Flow

Roll-up information shared concerning patient tracking may include but is not limited to:

* # of patients transported by EMS
* # of patients treated at health care facilities following an incident
* Types and severity of injuries are being seen at local healthcare facilities.

Detailed information for the purposes of family reunification/identification will be provided to some of the above agencies on a case-by-case basis; not all agencies may receive the same level of detailed information. Information may include but is not limited to:

* Patient name, date of birth, location
* Identifying information, marks, scars
* General information on the condition
* More detailed information for the purposes of identification

## WC Regional Hospital Diversion Process

### Purpose

To provide guidelines to hospitals and ambulance services in the WC region to identify facility status changes that may impact the ability to provide patient care. The policy is created to outline the appropriate utilization of the MNTrac facility status platform and to limit the impact on such diversions, which can include extended transport times or delays in ambulance availability in the community due to diversions to distant hospitals.

### Hospital Status Available within the WC Region

Hospitals indicate one status listed below:

* Open
* Closed to ED Only
* Closed to OB Only
* Closed to Trauma Only
* Closed to ED & OB
* Closed to ED & Trauma
* Closed to ED, Trauma & OB
* Closed to Trauma & OB
* Closed to Mental Health (Behavioral Health)
* Closed to Mental Health and OB
* Closed to Med/Surg – Non-Metro
* Closed to Mental Health and Trauma
* Closed to ICU (Intensive Care Unit) – Non-Metro
* Closed to Admissions – Non-Metro
* Closed to ICU and Med/Surg – Non-Metro
* Full Closed
* Diverting Stroke and Trauma
* Diverting Stroke only
* Making a facility-based announcement – check email

### Timing and Requirements of Closed/Divert Status Options

#### Closed Statuses (ED, Closed to Trauma, Closed to ED and Trauma, Medical Surge, OB, ICU)

* Limited to a maximum of 120 minutes (2 hours).
* Designed to allow time for the facility to relocate patients or increase capacity by enacting the facility surge plan (increase bed numbers/increase staffing)
* RHPC may reach out to facilities to request that they re-open after two hours if the facility does not do it on their own.

#### Divert to Stroke and Trauma/Stroke Only

* Requires a maximum diversion of patients for 240 minutes (4 hours)
* This diversion status may be renewed after 4 hours for an additional 4-hour period.
* Equipment failures are to be noted in the MNTrac Availability Section in the Diversion Comments field.
  + Examples of equipment failure are - the CT scanner is down, the MRI machine is down, Interventional Radiology is down, Catheter Lab is unavailable.

#### Full Closed

* Closure due to physical plant or critical equipment failure for an extended period
* Full closed indicates that you are unable to provide ANY patient care – you may be in the process of evacuation/physical plant issues, creating a critical situation where patient care is unavailable. This status is a last resort status.
* Closed to all ambulance transports and transfers (closed to all patients arriving by ambulance for 8 hours; option to renew the closure after 8 hours, as needed)
* This closure may be continued as needed until the situation has been resolved.
* RHPC will not automatically open a hospital that is Full Closed after 8 hours. The facility should remain in contact with the RHPC to ensure regional situational awareness.

### Important Consideration/Processes

* The hospital-authorized designee will enter the closed/diversion status into MNTrac. In the event of MNTrac failure, the hospital designee shall call the RHPC at (320) 760-3513. The RHPC will reach out to affiliated facilities and notify them of the closure/diversion.
* The closed-to-ED and/or Trauma status does not prevent paramedics from taking a patient to the closed hospital or stand-alone ED for immediate interventions if the patient's condition is felt to be life-threatening.
* Any ambulance transporting a patient, regardless of acuity, at the time a Closed to ED and/or Trauma Status is declared may continue transport to the closed hospital or stand-alone ED.
* A hospital closed to ED and/or Trauma agrees to care for any patient when the ambulance provider determines that it is the most appropriate transport destination. (EMTALA)

## Continuity of Operations Plan

The primary purpose of the continuity of operations plan (COOP) is to enable the coalition to recover from a disaster as soon as possible so that it can continue its mission. In times of disaster, that mission might additionally include support and assistance to the various healthcare agencies, other public safety organizations, their personnel, and the public to help them recover from disaster. The exact form of assistance may vary depending on the disaster, but this plan identifies the essential steps the Coalition will take to support the healthcare community and others who will depend on that support.

The ability of the coalition to support its members in a response relies on the availability of coalition staff as well as the involvement of members supporting the coalition’s activities. Processes in place to support the coalition HMAC include:

* Coalition Response Team (CRT)
* Redundant communications
* Coalition to coalition relationships
* Administrative and financial support
* Alignment between coalition and individual facility plans

If, at any time, the WC RHPC is unavailable to perform their duties, coalition members are to contact the HPP Program Manager and/or Director of Emergency Preparedness for assistance and guidance. During planned absences, the WC RHPC will notify coalition members in advance of any changes to coalition contacts. If any members have any concerns about the operations of the coalition, they can reach out to the Director of Emergency Preparedness at CentraCare or the MDH EPR.

See the [Key Contact list](#_Key_Contacts) for contact information for these individuals.

### Coalition Response Team (CRT)

Depending upon the scope of the incident and the required response by the coalition, it may be necessary to request unaffected health care facilities to provide representation at the HMAC. The coalition has provided in-depth incident command training to its membership to develop a core group of individuals who can help with coalition response activities. The training included training on the roles and responsibilities of the coalition in response efforts. The CRT includes individuals from both the Central and WC HCCs. This diverse group allows the coalitions to reach out to unaffected areas for support. To activate the team, the RHPC or PHPC will send out a resource request via MNTrac, which would include a description of the required role, the amount of time needed, and the location where to respond. Any facility that can provide support with then be provided a contact name and number to finalize arrangements. The CRT is part of the mutual aid agreement among coalition members.

### Coalition to Coalition Relationship

The WC region works closely with its’ Central region partners. This relationship allows for sharing of resources, personnel, and information. In a response, if the WC HMAC is activated, the RHPC will immediately notify the Central RHPC of the activation and request any support needed. A secondary backup to the Central region is the NW regional RHPC.

Working relationships with other coalitions ensure that in a response, if the incident exceeds the capacity of the coalition or if it has the potential to impact any other region, the RHPC can reach out to his/her peers in other regions. This includes asking the peer to, at a minimum, be a liaison between coalitions, support MNTrac use, and communicate with MDH. Coalition peers have access to the WC regional MNTrac contacts, which would help facilitate the availability of the peer RHPC to support the region in a response.

The WCMHPC is also a part of the MNHCC. For more information on this collaborative, see [B.13.10 MNHCC All-Hazards ConOps](#_MNHCC_All-Hazards_ConOps) and [B.13.9 MDH Inter-Regional Communications](#_MDH_Interregional_Communications).

### Alignment Between Coalition and Individual Facility-Level Plans

The coalition advisory committee approves all coalition plans. This process allows for facility-level plans to align with the coalition plans to ensure a smoother response and greater awareness of the roles and responsibilities of all entities.

### Order of Succession/Delegation of Authority

During or after a disaster or any other event that can impact the operations of the coalition, in the long-term absence or inability of the RHPC to perform executive functions, the following are authorized to act on behalf of the RHPC in the order of succession listed until his/her return or until the replacement is named:

1. Program Manager
2. Central RHPC or Northwest RHPC
3. Central and WC Exercise and Training Coordinator
4. Delegate from the Hospital Advisory team membership

In the absence of the Program Manager – the West Central RHPC will work with the Director of Emergency Preparedness to fulfill the roles previously held by the Program Manager.

### Continuity Systems

Table . Continuity Systems

|  |  |
| --- | --- |
| **System** | **Function/Action** |
| **Microsoft Outlook** | * The WC RHPC will ensure that all contact lists are shared and accessible to the succession list via SharePoint. * The WC RHPC will share his/her calendar with the Central Region RHPC and the Exercise and Training Coordinator. * The WC RHPC will enable the Central Region RHPC to have access to the WC emails. * The WC Coalition will use a standardized email ([cwchealth carecoalitions@centracare.com](mailto:cwchealthcarecoalitions@centracare.com)) that is not tied to one specific individual to allow access to the succession list at any time. |
| **Essential Files** | * The Coalition requires all work-related electronic files to be saved on the SCH/CentraCare Health System network server, which is accessible to the Central RHPC and Exercise and Training Coordinator. Backup files may be restored by IT support as needed. * Coalition files are also maintained on the Coalition SharePoint site and website. * Coalition files are maintained on an external hard drive if internet-based access is limited. These files are updated quarterly. The external hard drive is stored in a fireproof safe at the alternate WC HMAC site. * Laptops should be configured to automatically save to a default network file location. * 24/7 IT support is available by calling the SCH at (320) 251-2700 and request extension 54540. * Laptops are required to be password protected and those passwords are automatically set to update every 60 days per CentraCare policy. * All RHPC’s have a mobile hotspot device to ensure connectivity to the internet if facility-based internet is not available. |
| **Website** | * The WC and Central RHPC, Program Manager, as well as the Training and Exercise Coordinator, have administrative access to the coalition website. * The website is maintained on the Vye, Inc. Emergency contact with Vye can be made by calling (320) 230-1223. * Website account information can be found on the Bioterrorism shared drive under the folder titled Website. |
| **Communication Sources** | * See [B.3 Communications](#_Demobilization_(Response_2.3.1.6)). * Bi-annual radio tests will ensure proficient use of the 800 MHz radios amongst coalition partners. * Bi-annual communications exercises will ensure that all members understand the forms of redundant communications in place. * In the absence of the MNTrac Command Center, the coalition will utilize the chat room on the coalition website for non-patient-related information sharing. |
| **Coalition Office** | * The main office for the coalition is located at:   + CentraCare Northway Clinic 1555 Northway, St. Cloud, Minnesota * The alternate office location is:   + 9840 State Highway 114 SW, Alexandria, Minnesota * Minimal office requirements:   + Electricity/water/sewer   + Access to the internet – either directly or indirectly   + Copier/Scanner   + Communications – Telephone, Cellular, and 800 MHz * Coalition staff will practice safe workplace practices by being aware of weather conditions and other situations that could impact safety in their workplace. * All smoke detectors and carbon monoxide detectors are to be in working order. * Coalition staff are to follow safe zone recommendations – i.e., shelter-in-place and evacuation zones established by the CentraCare Emergency Preparedness policies. * Most of the coalition staff are set up to work remotely. If the CentraCare clinic site is not usable – CentraCare will utilize their COOP plans and re-locate affected staff to temporary locations within their facilities – to include coalition staff. * The financial department of the grantee is in the South Point/CentraCare building and has several staff who work remotely. The accounting department has redundant staffing in place to ensure continuity of operations. The primary account manager for the coalition grants is Michael Stutsman, and his email address is [Michael.stutsman@centracare.com](mailto:Michael.stutsman@centracare.com). * The grantee provides health insurance and worker's compensation insurance for staff employed greater than 80%. * Coalition staff are required to maintain their automobile insurance per CentraCare policy:   + Required to have insurance with liability limits of a minimum of $300,000 combined single limit or 250/500/50 split limits.   + Have a valid driver’s license.   + The CentraCare Motor Vehicle Driving program policy is located on the CentraNet or can be obtained through the CentraCare human resources department.   + The coalition does not carry insurance and is not covered by another entity. |

### Healthcare Continuity – Essential Functions

A diagram of a health care service delivery

Description automatically generatedThe following functions are considered essential to ensure the coalition can successfully commit to its mission:

* Healthcare Workforce
* CI
* Supply Chain Integrity
* Transportation
* Information Technology/Communications
* Administrative/financial support

All coalition members are encouraged to develop their continuity of operations plan to ensure that these essential functions are always accessible. The HCC will support its membership in providing these essential functions.

The coalition conducts a HVA annually which includes all coalition member’s feedback/input. The HVA is available on the coalition website as well as the shared drive. The identified risks/hazards to coalition operation include:

* Lack of funding
* Lack of staff
* Technology failure
* Lack of resources

During or after a disaster or any event that has the potential to disrupt the ability of the coalition to fulfill its mission, the coalition will:

* Collect situational assessment data from coalition members on their ability to provide patient care.
* Aggregate individual facility data to generate coalition healthcare service delivery situational reports.
* Disseminate healthcare service delivery data to local and state authorities.
* Assist local HCC partners in obtaining/securing resources as available.
* Assist coalition partners in returning to full operational status.

#### Access to Healthcare Workforce

Defined: Access to healthcare workforce is the ability to deploy a credentialed health workforce to provide patient care to support healthcare service delivery in all environments.

The coalition shall support its’ partners by:

* Conducting a health workforce shortage assessment within coalition boundaries in collaboration with local partners .
* Coordinating with healthcare organizations to maximize medical & non-medical personnel support
  + This may include activating the Regional MOU.
* Working with LPH in identifying resources to support the local need – including Minnesota Responds.
* Disseminating reports of regional staffing shortages to local EM/EOC and MDH, if applicable.

#### Community/Facility Critical Infrastructure

Defined: To be fully operational, critical community/facility infrastructure, including power, water, sanitation, etc., is necessary to support patient care environments.

The coalition shall support its’ partners by:

* Determining local/region-wide disruption of CI that affects the healthcare system.
* Aggregating reports of CI disruption.
* Disseminating reports to Coalition partners, as appropriate.

#### Healthcare Supply Chain

Defined: Supply Chain integrity is full access to healthcare supplies, including medical & non-medical supplies, pharmaceuticals, blood products, industrial fuels and medical gases, food, etc.

The coalition shall support its’ partners by:

* Monitoring region-wide disruption of the healthcare supply chain.
* Determining the specific medical and non-medical supply needs of healthcare partners.
* Facilitating disaster medical resource support for healthcare organizations with local EM agency/EOC and MDH, as applicable.
* Assisting with coordinating private sector vendors on distribution and resumption of normal supply delivery.
* Disseminating healthcare supply chain disruption situation reports to local EM agency/EOC MDH, as applicable.
* Activating the coalition MOU and coordinating the sharing of resources amongst coalition members and, if necessary, accessing the limited coalition cache. See [B.4 Resource Request Plan](#_Resource_Request_Plan).

#### Access to Transportation

Defined: A fully functional medical and non-medical transportation system that can meet the operational needs of the healthcare sector during the response and continuity phases of an event.

The coalition shall support its’ partners by:

* Collecting medical transportation needs of healthcare organizations during response and continuity operations.
* Working with the WC EMS representative or alternate, coordinate with EMS agencies to close gaps in medical transportation needs.
* Advocate for coalition partners’ medical transportation assistance.

#### Information Technology/Communications

Defined: Fully functional information technology and communications infrastructure that supports high availability of the healthcare sector’s data management and information sharing capability.

The coalition shall support its’ partners by:

* Determining the extent of disruption of communication/information technology capabilities within coalition boundaries.
* Activate redundant communication capabilities if necessary – to include monitoring the regional 800 MHz talk group, opening up a Command Center in MNTrac, and utilizing the chat room on the coalition website.
* Work with local EM to identify alternative sources of communication, such as HAM radio and Cellular support services.
* Coordinate with state health authorities to disseminate critical response and continuity operations information.

#### Administrative/Financial

Defined: Fully operational administrative and financial capability, including maintaining & updating patient records, adapting to disaster recovery program requirements, payroll continuity, supply chain financing, claims submission, losses covered by insurance, and legal issues.

The coalition shall support its’ partners by:

* Collecting disaster response data to be used in AARs.
* Informing coalition partners about any available disaster assistance from federal, state, and local authorities.
* Providing incident command support either by utilizing the regional MOU or sharing staff and SMEs to support the facility operations center.

The WC region has an agreement with SCH to act as the fiscal agent for the coalition. This agreement ensures that response efforts are not limited by immediate access to coalition funds. By being fiscal agents, the SCH human resources department provides direct support to coalition staff, including ensuring wages/benefits are provided to coalition staff. The human resources department also provides support to coalition members by being the point of contact if there are any concerns or complaints about coalition staff.

## Medical Surge Coordination Plan

This section outlines the support role that the coalition plays during a medical surge event at a WCMHPC member facility. This plan will integrate region-wide medical, health, and community resources before, during, and after an emergency that exceeds the ability of the healthcare system.

A major component of the Medical Surge Plan is the RMOCC. The RMOCC's primary goal is to work towards patient level loading between facilities. In rural areas and due to limited resources, the utilization of an RMOCC will be limited and will rely heavily on state or federal coordination. If those services/resources are not available, the RMOCC will operate as outlined in this surge document to support the needs of the coalition and the healthcare members.

### Assumptions

* To manage the medical surge, only the most acutely injured or ill should be treated at hospitals. Clinics and other medical facilities (i.e., surgery centers) will be requested to assist if needed as they are able to assist with people experiencing sub-acute injuries or illness.
* The WCMHPC HMAC may be activated to assist with surge capacity, patient transportation issues, patient tracking assistance, staffing issues, resource sharing and requests, and communications. Regional staff will work in cooperation with the appropriate Hospital Command Centers and Local or State EOCs. This may include the activation of the RMOCC.
* Facility level Crisis Standards of Care plans may need to be implemented with the Medical Surge Plan to address shortages of equipment, supplies, pharmaceuticals, beds, personnel, and sources of transportation.
* WC Region Hospitals have EOPs that address medical surge capacity and capabilities and activation and operation of ACS. The HMAC can support medical surge or ACS plans as needed.
* This section does not cover isolation or quarantine because isolation and quarantine are not medical surge conditions; they are public health containment measures used to control the spread of communicable diseases which may occur in single, cluster or larger patient quantities.
* Healthcare providers should plan for an influx of family members requesting updates on loved ones. This influx should be addressed in facility-level plans and include local law enforcement, LPH, and EM.

### Definitions

Table . Medical Surge Definitions

| **Surge Level** | **Definition** |
| --- | --- |
| **Conventional capacity:** | The spaces, staff, and supplies used are consistent with daily practices within the institution. These resources are used during a major mass casualty incident that triggers activation of the facility EOP. Healthcare institutions will maintain conventional standards as long as possible. |
| **Contingency capacity:** | The spaces, staff, and supplies used are not consistent with daily practices but provide care to a standard that is functionally equivalent to usual patient care practices. These contingency resources may be used temporarily during a major mass casualty incident or on a more sustained basis during a disaster (when the demands of the incident exceed community resources). The duration of contingency resource use will be dependent on the scope of the situation. |
| **Crisis capacity:** | Adaptive spaces, staffing, and supplies are not consistent with usual standards of care but provide sufficiency of care in the setting of a catastrophic disaster (i.e., provide the best possible care to patients given the circumstances and resources available). Crisis capacity activation constitutes a significant adjustment to standards of care. This category of care will be limited in duration as soon as additional resources become available contingency or conventional practices should resume. |

*\*\*\* Patient Care Resources for Scarce Resource Situations, MDH and Institute of Medicine 2012 – Crisis Standards of Care*

### Planning for Medical Surge

The intent of the WCMHPC Medical Surge Plan is to add specific Medical Surge tenets to be used by the HMAC to coordinate the response to a medical surge event.

* Immediate Bed Availability (IBA)
* IBA is a means to provide appropriate levels of care to all patients during a disaster by availing 20% of staffed beds to higher acuity patients within four (4) hours of a disaster and identifying and providing the appropriate care for lower acuity patients. Each hospital in the WCMHPC will adjust its facility Medical Surge Plans to accommodate the 20% increase by off-loading patients, early discharges, increasing staff, etc.
* The WCMHPC will be asked to demonstrate the capability of all the hospitals in the region to deliver appropriate levels of care to all patients as well as to provide no less than 20% immediate availability of staffed beds within a few hours of notification of the event.

The table below shows the standard bed availability for each hospital within the region. Real-time data and capacity will be assessed as needed by MNTrac alerts or other notification from coalition (email etc.).

See [B.13.2 Essential Elements of Information](#_HMAC_Coordination_Job) and [B.13.3 Essential Elements of Information Template](#_Essential_Elements_of_1).

Table . Bed Availability for Regional Hospitals

| **Agency Name** | **Bed Type** | **Bed Totals** |
| --- | --- | --- |
| **Alomere Health** | Adult Ventilator | 4 |
| Surge Ventilators | 17 |
| Medical and Surgical | 47 |
| Operating Rooms | 7 |
| Pediatric Ventilator | 0 |
| Emergency Room | 14 |
| Adult ICU | 7 |
| Pediatrics | 2 |
| **Glacial Ridge Hospital - Glenwood** | Operating Rooms | 2 |
| Adult Ventilator | 1 |
| Surge Ventilators | 3 |
| Medical and Surgical | 25 |
| Pediatrics | 0 |
| Emergency Room | 5 |
| Pediatric Ventilator | 0 |
| Adult ICU | 2 |
| **Lake Region Healthcare - Fergus Falls** | Adult ICU | 5 |
| Medical and Surgical | 30 |
| Operating Rooms | 5 |
| Emergency Room | 12 |
| Pediatrics | 8 |
| Psychiatric | 12 |
| Pediatric Ventilator | 0 |
| Adult Ventilator | 5 |
| Surge Ventilators | 13 |
| **Perham Health** | Medical and Surgical | 25 |
| Pediatric Ventilator | 0 |
| Adult ICU | 0 |
| Pediatrics | 0 |
| Emergency Room | 8 |
| Adult Ventilator | 0 |
| Surge Ventilators | 5 |
| Operating Rooms | 2 |
| **Prairie Ridge Hospital** | Pediatric Ventilator | 0 |
| Operating Rooms | 1 |
| Pediatrics | 0 |
| Adult Ventilator | 0 |
| Surge Ventilators | 0 |
| Emergency Room | 2 |
| Adult ICU | 0 |
| Medical and Surgical | 10 |
| **Sanford Wheaton Medical Center** | Pediatrics | 0 |
| Adult ICU | 0 |
| Operating Rooms | 1 |
| Medical and Surgical | 12 |
| Emergency Room | 4 |
| Adult Ventilator | 0 |
| Surge Ventilators | 4 |
| Pediatric Ventilator | 0 |
| **St. Francis Medical Center - Breckenridge** | Pediatric Ventilator | 0 |
| Pediatrics | 0 |
| Operating Rooms | 2 |
| Adult Ventilator | 2 |
| Surge Ventilators | 3 |
| Emergency Room | 6 |
| Medical and Surgical | 22 |
| Adult ICU | 3 |
| **Stevens Community Medical Center** | Adult ICU | 3 |
| Pediatrics | 0 |
| Pediatric Ventilator | 0 |
| Operating Rooms | 2 |
| Adult Ventilator | 2 |
| Surge Ventilators | 3 |
| Emergency Room | 4 |
| Medical and Surgical | 22 |

* Patient Tracking
  + Utilizing the MNTrac System, the regional coordinator will activate the regional patient tracking plan upon notification from a healthcare entity of a surge event. See [B.5 Regional Patient Tracking Plan](#_Regional_Patient_Tracking).
* EMS
  + The WCMHPC includes the WC Regional EMS Coordinator to streamline planning efforts. EMS would also be included in the HMAC upon activation. EMS agencies within the WC Region are encouraged to plan and train with other coalition members. They are invited to participate in training and exercises.

### Notifications

Following notification of an MCI, Pediatric Surge, or chemical, Biological, Radiological, Nuclear, and high yield Explosives (CBRNE)/Hazardous Materials (HazMat) Event, the RHPC and HMAC will identify appropriate partners to notify, such as:

* Neighboring LPH agencies
* Local healthcare organizations/providers
* Local EMS
* Local EM
* West Central Minnesota HCC
* MNHCC members
* Cross-border healthcare partners and public health
* MDH (Preparedness and Communicable Disease)
* CDC/ASPR
* Other health partners as necessary

### Roles and Responsibilities

#### WCMHPC

To support a coordinated healthcare response, the RHPC, alongside the PHPC, can consider activation of the HMAC to:

* Disseminate information from MDH to the members.
* Coordinate with local, regional, and state agencies
* Establish periodic briefings to assess the impact on Coalition, including:
  + Current capacities and needs.
  + Assess the status of staffing and patient load at coalition hospitals.
* Anticipate needs for the upcoming period.
* Gather and share information on bed availability within the region and with neighboring regions.
* Aide in Patient tracking
* Assist with resource requests and allocation
* Establish Situational awareness
* Refer facilities to their MCI/Medical Surge Plans as requested.

The RHPC can:

* Assist with communications and information sharing under the direction of local and state agencies.
  + If the situation is widespread and the MNHCC SHCC is activated, the RHPC will be an active member of such activation. See [A.5.10 MNHCC Charter](#_MNHCC_Charter) the [B.13.10 MNHCC All-Hazards ConOps](#_MNHCC_All-Hazards_ConOps).
* Assist with resource requests for coalition members.
* Provide general support for Coalition members as requested.
* In the event of an evacuation:
  + Activate the patient tracking plan
  + Coordinate with the Regional EMS representative
  + Note: The Coalition does have a cache of evacuation tags/tools for utilization if requested.
  + See [B.10 Evacuation and Shelter-in-Place Planning](#_Evacuation_and_Shelter-in-Place)

The information below outlines possible roles and responsibilities of member and partner facilities/organizations during medical surge.

#### EMS/Pre-Hospital Providers

* Provide knowledge, assessment data, requests, and other needs during an incident.
* Lead local agency for first response, treatment, and patient transport
* Interface with local hospitals and EOC to share information/status.
* Maintain appropriate staff in county EOC to receive and monitor notifications.
* Monitor the MNTrac system for any alerts related to diversions and patient movement.

#### Frontline Healthcare Facilities

* Provide initial treatment and stabilization of any victim/patient transferred or presenting to their facility.
* Follow normal organizational referral procedures and transport procedures.
* Identify the need for additional resources.
* Ensure that individuals with access and function needs and those disproportionately impacted by an incident have access to appropriate medical care and support services.
* Determine the appropriate distribution of patients-injured, infected, and psychologically impacted.
* Initiate internal EOPs and call staff back to work as needed.
* Analyze the facility's capabilities to accept and treat patients over a protracted period.
* Track disaster/incident-related expenditures and coordinate with local, state, and federal organizations for reimbursement activities, if applicable.
* Follow state or federal guidelines during situations of scarce resources.
* Consider activation of Continuity of Operations Plans.

#### County EM

* Provide knowledge, assessment data, requests, and other needs during an incident.
* Lead local agency for incident coordination, including activation and coordination of jurisdictional EOC as needed
* Serve as point of contact for local resource requests and request resources that exceed local capabilities from the State.
* Request state declaration of emergency if needed.
* Disseminate public information via designated PIO.
* Coordinate volunteer and donation management.
* Work with local healthcare and LPC to set up a Community Reception Center.
* Coordinate distribution of supplies from the coalition or other partners.
* Coordinate or facilitate meetings inclusive of county healthcare, public health, and other agencies as needed.
* Act as liaison between local, regional, state, and federal assets responding to the incident.

#### LPH Department

* Establish and monitor surveillance systems as needed.
* Investigate unusual occurrences of diseases, bioterrorist agents, chemical agents, and radiation to identify possible public health threats.
* Contain disease outbreaks by implementing control measures such as community outreach and education, provision of MCM, isolation, social distancing, and/or quarantine.
* Work with local EM to establish a reunification center or reception center, if applicable.
* Disseminate appropriate messaging to community members.
* Ensure those disproportionately impacted by an incident, those with access and functional needs, and those who have limited language proficiencies have access to appropriate medical care and support services.
* Provide staffing support to impacted LPH departments.
* Follow local procedures and policies on tracking disaster/incident-related expenditures.
* Maintain appropriate personnel in the county EOC to receive and monitor notifications.
* Work with MDH and share information with partners.

#### MDH

* Lead state agency for health-related issues – works closely with MN Homeland Security EM for incident coordination.
* Consider activation of the State EOC.
* Request state disaster or public health emergency declarations and governor’s emergency orders, as required to support response.
* Request CMS 1135 waivers as required during response to allow patient billing when usual conditions cannot be met.
* Request specific emergency orders by the Governor’s office as needed.
* Provide health-related guidance and recommendations to partners and practitioners.

#### Minnesota Homeland Security and Emergency Management

* Lead state agency for incident coordination
* State point of contact for resource requests
* Request State declaration of emergency, if needed
* Liaison between state and federal response partners

The WCMHPC has established hazard-specific medical surge annexes for [pediatric](#_Pediatric_Surge_Annex_1), [burn](#_Burn_Surge_Annex_1), [infectious disease](#_Infectious_Disease_Surge_1), and [radiation](#_Radiation_Emergency_Surge) events. These annexes contain information specific to these hazards and additional roles and responsibilities for WCMHPC staff, members, and partners.

### Patient Movement Coordination

There are four levels of Patient Movement:

* **Local Level**
  + Utilization of Mutual Aid agreements and partnerships with local EMS to handle most of the patient movement.
* **Regional Level**
  + Utilization of the HCC Regional plans/processes to coordinate patient movement to include:
  + Activation of Regional Mutual Aid agreements
* **Cross-border/cross-regional cooperation**
  + Utilization of the MNTrac program to identify locations with bed availability, including sending out regional bed availability alerts.
  + Activation of the MNHCC SHCC
* **State Level**
  + When local and regional activities are overwhelmed, or more resources are required, the State may consider:
    1. The MDH Department Operations Center (DOC)
    2. Activation of the State EOC
    3. Activation of the EM Assistance Compact (EMAC) to enlist the assistance of neighboring states.
    4. Request Federal assistance
* **Federal Level**
  + When all local, regional, and state assets are overwhelmed, or the State identifies that resources are exhausted, the State may reach out to the federal partners for assistance.

#### Patient Movement Assumptions

* During mass casualty incidents, local jurisdictions will follow existing comprehensive EM plans and healthcare facilities’ existing surge and evacuation plans.
* Patient movement decisions will be made at the local level in conjunction with the receiving facilities.
* Patient Coordination refers to conducting situational assessment and coordinating the placement of patients in an appropriate facility based on their level of acuity and needs.
* As with any response, the patient movement process should start at the local level. If local-level facilities are unable to find a facility to accept patients, then they can reach out to the region for guidance.
* All healthcare facilities will do what is best to maximize their care and determine their triggers based on capability. (e.g.)
  + Unexpected or overwhelming number of patients present in emergency rooms and clinics
  + Significant increase in patients due to health threat
  + Shortage of equipment, supplies, pharmaceuticals, beds
  + Shortage of personnel
  + Disruption of transportation affecting the ability to move patients
* There are potentially significant differences in the policies and procedures among partner agencies. These differences will require flexibility during an escalated incident where inter‐agency collaboration is necessary.

#### Surge Planning

Six key components of surge planning for healthcare delivery systems include:

1. Bed Capacity
2. Staffing
3. Communications
4. Continuation of Essential Healthcare Services/Crisis Standards of Care
5. Alternate Care
6. Transportation

##### Bed Capacity

It will be important to track the types and numbers of beds available to provide coordination of available assets to ensure a streamlined process for patient transfers. Hospital bed reporting (for the type and availability) may be event-specific and may include the following categories:

* Adult
* Pediatric
* Medical/Surgical
* Orthopedic
* Telemetry
* Cardiac
* Critical Care
* Surgical/Trauma
* Maternity/(OB/GYN)
* Burn
* Swing

In certain medical surge events, it may be necessary for the hospitals to report the number of patients they are able to accept related to patient triage. Utilizing the MNTrac system and the MCI Patient Capacity widget – hospitals can be asked to report the number of red, yellow, and green patients they are able to accept. An alert from the RHPC/HMAC will be generated and hospitals are asked to respond within the requested time.

Table . Bed Capacity Roles and Responsibilities

| **Entity/Organization** | **Roles/Responsibilities** |
| --- | --- |
| **Healthcare Facilities and Systems** | * Activate individual healthcare organization’s internal surge plans. * Update bed availability through MNTrac and with a pre-established reporting structure. * Update MCI Patient Capacity through MNTrac. * Communicate directly with receiving hospitals to triage patients to appropriate available beds (critical care, burn pediatric, behavioral health, etc.) * Increase bed availability within the healthcare facility based on facility surge planning prior to requesting additional capabilities. * Implement additional plans, such as rapid discharge, early discharge with appropriate follow-up, transfer of appropriate patients to corresponding hospitals and long-term care facilities, and forward movement of patients to transfer in-patients to other hospitals to make additional beds available nearer the incident.   + Consider transferring patients back to their community healthcare facilities for recovery.   + Develop discussion points to use when communicating with patients – it is essential that the patients and their families are comfortable with the decision for relocation. * Work with EMS to ensure the availability of resources to accommodate the transfer process. * Ensure that accurate reporting of bed availability is in the MNTrac system. * Utilize the MNTrac Availability Status report to identify available beds. * Facilities that are not surging may need to keep patients and use resources such as telehealth and support from the larger systems to maintain and provide care. |
| **Regional HCC** | * Determine and track regional bed availability by type. * Coordinate the communication of regional bed availability among hospitals and other applicable healthcare organizations. * Assist with information gathering and sharing among hospitals and healthcare organizations. * Utilize the MNTrac system to obtain updated bed availability by issuing a regional bed alert. * Utilize the MNTrac system to obtain the MCI Patient Capacity. |

##### Staffing

During a medical surge event, additional staff will be needed to handle the influx of patients to hospitals and healthcare organizations for an acute period or over an extended period. Staffing refers to all staff, including clinical and nonclinical personnel.

Table . Staffing Roles and Responsibilities

|  |  |
| --- | --- |
| **Entity/Organization** | **Roles/Responsibilities** |
| Healthcare Facilities and Systems | * Activate the hospital’s surge staffing plan. This may involve staff recall and changes in shift scheduling (e.g., 8-hour shifts become 12-hour shifts). This may also result in the reassignment of staff from non‐patient care, administrative, or elective care areas into primary care roles. * Physicians, physician assistants, nurse practitioners, nurses, pharmacists, respiratory therapists, paramedics, EMTs, communications specialists, support personnel, administrative roles, and others who may fill clinical roles will need to be considered on an ongoing basis in order to ensure adequate staffing. * Request additional medical professional staffing. |
| Regional HCC | * Assist with communicating and disseminating the status of staffing needs and requests of hospitals and other healthcare organizations to appropriate supporting agencies such as other healthcare providers or public health agencies. |

If additional assistance is needed with staffing beyond what local healthcare and regional coordination can provide, staffing assistance may be available through coordination with the Statewide Coordination Center.

##### Communications

Communication challenges often coincide with coordination activities within and among organizations. In efficient emergency operations, most communications have occurred before the incident. Goals and tasks are often determined by tradition and are formalized in statutes, contracts, charters, mutual aid agreements, and standard operating procedures. These are especially important if CI has been compromised because a medical surge has occurred.

| **Entity/Organization** | **Roles/Responsibilities** |
| --- | --- |
| **Healthcare Facilities and Systems** | * Notify the regional coalition of the potential medical surge situation. * Maintain and monitor situational information. * Maintain ongoing communications with local/county EM. * Maintain ongoing communications with the LPH. |
| **Regional HCC** | * Support health facilities and systems to maintain and monitor real‐time information through designated communications systems. * Maintain ongoing communication with healthcare facilities and systems. * Provide any updates to relevant health and medical information to the health and medical community (single hospital or healthcare facility/systems, EMS, etc.). |

If the response includes more than one coalition or region, working with the MDH and the SHCC to assist with communications may become necessary.

##### Continuation of Essential Healthcare Services/Crisis Standards of Care

Crisis care reflects local / facility conditions of severe overload. These may occur at any time and should result in rapid engagement of the HCC to load-balance or otherwise mitigate the situation back to contingency or conventional through patient transfers or resource movement. Usually, these situations can be reversed within hours to days. If crisis care conditions are affecting most facilities or coalitions and are expected to last for days to weeks, more formal crisis standards of care may be needed. In this case, the State of Minnesota provides guidance and regulatory support for the coalition and facility regarding actions that need to be taken to best address the resource shortfalls consistently.

Refer to:

* [The MDH Crisis Standards of Care Plan](https://www.health.state.mn.us/communities/ep/surge/crisis/index.html)
* [Patient Care Strategies for Scarce Resource Situations](https://www.health.state.mn.us/communities/ep/surge/crisis/standards.pdf)

##### Alternate Care Site

An ACS is a facility that is temporarily converted for healthcare use during a public health emergency to reduce the burden on hospitals and established medical facilities. Conceptually, these sites are a last-stand strategy and will only be utilized after all other load balancing options have been exhausted. These would only be viable once the state has entered Crisis Standards of Care.

There are two types of ACS sites:

* Hospital based alternate care site (HACS) – the hospital has identified, equipped, and staffed additional areas within their facility/footprint for patient care.
* Community based alternate care site (CACS) – Located near a hospital but not within the hospital, which can include hotels, dorms, etc.
  + Work with Local EM and the HCC to establish the CACS.
  + This may include working with State partners in activating the State identified ACS.

Table . ACS Roles and Responsibilities

| **Entity/Organization** | **Roles/Responsibilities** |
| --- | --- |
| **Healthcare Facilities and Systems** | * Identify the need to activate an ACS. If unable to open a HACS then:   + In collaboration with the SHCC/SEOC, county/local EM, and local/county public health departments, make the decision to activate alternate care facilities, based on the current surge situation.   + In collaboration with SHCC and local/county public health departments, determine the scope of care to be delivered within the alternate care facility. * An ACS may also be needed for emergent needs – such as hospital evacuation. All hospitals are required to have ACS plans to support this type of need. This plan should include pre-determined locations and agreements with those locations, as well as MOUs with transportation. * Assist county EM in determining staffing needs within the alternate care facilities that have been or may be activated. |
| **Regional HCC** | * Support information sharing and activation tracking for ACS between hospitals, EMS, local/county public health departments, and local/county EM. * Fulfill the regional operational roles identified by the current Minnesota ACS ConOps. |
| **EMS** | * Maintain communications with healthcare facilities and the Regional EMS coordinator regarding any modifications in triage and transfer protocols. * Coordinate with local dispatch any changes in patient transport destinations in accordance with regional and state guidance. |

##### Transportation

Incident command on-scene should coordinate with the responding transportation agencies as appropriate for transportation considerations. This may include EMS, bus transport, non-emergent medical transport agencies as well as private vehicles. Additional transportation capabilities will be required to support multiple aspects of medical surge. Transportation of the patients to, from, and between treatment facilities will be required. EMS may be forced to transport patients longer distances for higher levels of care. They may also need to transport patients from higher-acuity facilities to lower-acuity facilities to increase the capacity of the higher-level facilities. The process of level loading involves moving patients from lower to higher-level care centers and moving patients from facilities that are full to those that have capacity. This may include utilizing alternate means of transportation with companies in which MOUs or MOAs (Memorandums of Agreement) have been established. Vehicles for use by the Patient Transportation System may be drawn from the EMS task force, local transportation authorities, military transportation units, taxi companies, bus companies, and other sources. These transportation resources may include:

* Those equipped to carry a single recumbent patient (such as an ambulance)
* Those that can carry 30 non‐recumbent patients (such as a bus)
* Non‐recumbent wheelchair‐accessible vehicles (such as wheelchair‐accessible vans)

The best vehicles for patient transportation should be those vehicles that have the characteristics and capabilities most closely associated with the patient’s needs (e.g., Advanced Life Support (ALS)/Basic Life Support (BLS) ambulances).

Ambulance Strike Teams could be requested for transport assistance through local EM to the State EOC or the Minnesota State Duty Officer.

Transportation processes in use during a surge incident should adhere to the appropriate regulatory guidance, including EMTALA and HIPAA, as well as other medical and legal guides to transporting patients and transferring care. Hospitals would use their normal referral processes and locations.

Table . Transportation Roles and Responsibilities

| **Entity/Organization** | **Roles/Responsibilities** |
| --- | --- |
| **Healthcare Facilities and Systems** | * Identify the primary EMS agency that responds to and transfers from your facility.   + Assess the resources available within the primary EMS agency. * Identify a secondary/alternate EMS agency that would be contacted if/when the primary agency is unable to fulfill the transfer/patient movement request. * Reach out to the HCC for information sharing and coordination assistance. |
| **Regional HCC** | * Working with the Regional EMS representative:   + Coordinate the communication of available transportation resources among county EM, hospitals, and other applicable healthcare organizations.   + Assist with transportation and transportation route availability among hospitals and healthcare organizations, county EM, and SHCC. |
| **EMS** | * Support the movement of patients between hospitals, other healthcare facilities, and ACSs, as needed. * Request additional capabilities through internal protocols as needed. * EMSRB (Emergency Medical Service Regulatory Board)/EMS MACC activation would only occur in the following situations.   + All local resources were exhausted.   + High-volume patient movement required a higher level of coordination. * Mutual aid agreements are in place with some services. |

##### Regional Medical Operations Coordination Cell

As introduced in the [Response plan](#_Regional_Medical_Operations), the RMOCC makes data and stakeholder-informed recommendations to balance patient load and ensure high-quality care. RMOCC recommendations direct the movement of patients and resources from one facility to another or re-direct referrals that would usually go to an overwhelmed facility or system to one with capacity. The State and Federal MOCCs have more authority – the regional coalition does not have the authority to direct where patients can go; however, with collaborations between membership/partners decisions can be made to help level load patients. The role of the coalition is to facilitate the discussions and to bring the right people together to ensure that the conversations are occurring. Lessons learned during COVID-19 showed how collaborations between healthcare helped increase the ability to level load and assist in patient care. Scheduled huddle calls allowed facilities to exchange situational updates and bed availability and to indicate critical needs. During COVID-19, the State created the C-4 to assist with Bed availability – this was used in a scarce situation – (see [B.8.14 Resources for Medical Surge](#_Resources_for_Medical)) – the goal of the RMOCC is to start the level loading process prior to the point where beds are completely unavailable.

The priorities/needs of the RMOCC include the following activities:

1. Collecting, analyzing, and disseminating hospital capacity information.
2. Establish a collaborative work group of all hospitals to establish protocols and triggers that will support the decision-making process regarding patient level loading.
3. Act as a mediator and establish a meeting process where affected facilities can collaborate to share appropriate information to appropriately level load patient care within the region and, if necessary, work with other regions to bring in additional support.
4. Identifying physician leads to oversee and support clinical decision-making.
5. Identify administrative leads/coordinators to track and report activities.
6. May need to establish a phone bank to take calls regarding emergent placements.
7. May bring one or more coalitions together to increase the ability to bring high level of care providers into the mix to ensure a better ability to level load patients.
8. Healthcare members will need to ensure that they respond to all requests for information from the RMOCC and participate in all calls and/or meetings as necessary to ensure open communication.
9. The coalition will bring together senior executive leaders to identify any issues and discuss process changes/concerns.

Patient movement considerations need to be made during the level loading process.

The WCMHPC works with surrounding regions to discuss and identify alternative transfer patterns necessary to ensure that appropriate patient care is available. Collaboration with the Central Region and SCH allows for the back-and-forth movement of patients from the WC Region to SCH and reverse. Level loading occurs with the North Dakota partners by transferring patients that require a lower level of care to the critical access hospitals, allowing for increased capacity at the higher acuity facilities. The regional process includes:

* An assessment or awareness of the capabilities of the hospitals/healthcare facilities in the region/state:
  + Identifying which facilities can care for higher acuity (level of care) patients.
  + Identifying the resources available at facilities to ensure that the patients can receive the appropriate level of care.
* Continuous awareness of the healthcare facility's current patient census and the type of care needed for the patients within the facility.
  + Identifying if there are patients that can be moved out of ICU to a medical surgical unit within the facility or if they can be transferred to another hospital to receive the appropriate level of care.
  + Identifying if a patient can be discharged to a SNF, assisted living, or home with services.
* As with routine patient transfers – the decisions must be mutual amongst the facilities involved, with the end goal being that the patients are placed in facilities that can provide the appropriate level of care and still fall within the CMS standards of care

During COVID-19, the HCCs created a Patient Movement Decompression Guidebook as well as a directory of all the hospitals to support the decision-making process for patient transport:

### Patient Exchange

* In a surge setting, if a facility needs to transfer a patient to a facility that can provide a higher level of care, they may need to take a lower acuity patient (requiring fewer services) in exchange. Example: Level 3 trauma center transfers a patient to a Level 1 trauma center, and the Level 1 trauma center transfers a medical surgical patient to Level 3 for continued care.
  + This includes the involvement of EMS doing reverse (two-way) transfers (drop off and pick up). It is important that the EMS agencies are involved in the decision-making process to ensure that the resources are available for this type of activity.
* The patient exchange will allow for the receiving hospital to decompress to accept a new higher acuity patient.

### Hospital Decompression Planning

* A group of hospitals or systems working together to identify variances to typical transfer patterns that will allow for a healthcare facility to remain free of infectious disease (i.e., COVID-19).
  + One or more hospitals agree to treat these highly infectious and high acuity patients; however, the other hospitals need to agree to take on more lower acuity patients.
  + Patients who present to the low acuity hospital with infectious symptoms are immediately transferred to the higher acuity facility.
  + Patients at the high acuity facilities that require less care are pre-emptively transferred for continued care to the lower acuity facilities – to allow for increased capacity at the higher acuity care centers.
    1. Options for continued care can include increased telemetry/consultation between the transferring facilities.

The following map identifies the patient movement options available within the region and surrounding partners (this was used during the COVID-19 response; however, this can be adapted to fit any Medical Surge situation):

***A map with red lines and arrows

Description automatically generated***

Figure . WCMHPC COVID-19 Transfer Patterns

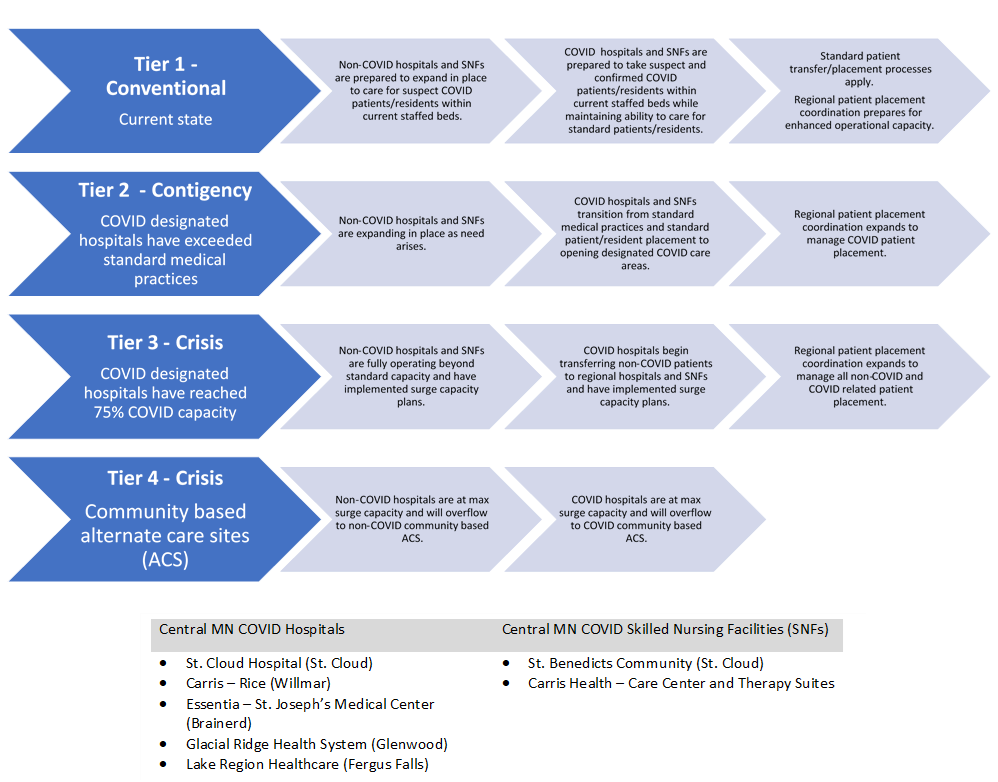
The CentraCare System has also identified a process/decision tree to help facilitate some of the patient movement processes. 

Figure . Central MN Hospital and SNF Surge Framework

### Burn Surge Annex

#### Introduction

##### Purpose

In the event of a medical surge burn incident, the MN State Burn Surge Plan calls on each regional Healthcare facility to initially treat and stabilize burn victims for up to 72 hours when transportation to MN Burn Centers is not feasible. This burn surge annex provides a regional framework to support and supplement the MN Statewide Burn Surge plan. This annex identifies the WC healthcare preparedness coalition’s response to a medical surge event involving severe or life-threatening burns.

##### Scope

The Burn Surge Annex is part of the regional Response plan.

##### Overview/Background of HCC and Situation

The State of Minnesota currently has two Burn Centers acknowledged by the American Burn Association (ABA), which are Hennepin County Medical Center (HCMC) and Regions Hospital. Neither of these two facilities are in the WC region. During a burn surge incident, the initial receiving facility will collaborate and communicate with the burn centers. If, at some point, the MN Burn Centers are unable to accept the number of patients referred to them, the statewide Burn Surge plan will be activated. Normal day-to-day operations are the goal of this annex, this annex will only be activated when local resources are exhausted, and the MN Burn Centers are unable to provide immediate care for burn patients.

The WC region is based around the I-94 highway system and has several rail lines that run both north/south and east/west. Even though rail transportation of hazardous materials is recognized to be the safest method of moving large quantities of chemicals over long distances, there is still the risk of derailment or accidental release of hazardous materials that could result in a burn incident. The I-94 interstate highway is a major thoroughfare through the upper United States and is utilized by heavy goods vehicles carrying a variety of hazardous materials. The transportation of hazardous materials through the region is not the only risk of mass burn potential. The region also has an increased risk of fire from wildfire, pipeline disruption, and industrial business compromise.

In rural communities, a single burn patient may need to be transferred several hours away to a burn facility. When those systems are overwhelmed, the local facilities and burn surge facilities may need to be activated.

The WC healthcare preparedness coalition has identified three burn surge facilities (BSFs) to be utilized in a surge event. In coordination with the ABA Burn Center, patients may be transferred from the initial receiving hospital to the BSF, which will provide treatment until more definitive care options are available. The BSFs will be responsible for caring for the burn patients in the event of a statewide surge. This responsibility can last up to 72 hours. The ABA Burn Center will work with state partners to coordinate the care and transportation of burn patients according to the MN State Burn Surge plan.

The three burn surge hospitals for WC Minnesota are:

* **SCH**  
  1406 6th Avenue North  
  St. Cloud, MN 56303   
  Transfer: 888-387-2862
* **Sanford Medical Center**   
  801 Broadway  
  Fargo, ND 58122  
  701-234-2000
* **Essentia Health**  
  3902 13th Ave S.   
  Fargo, ND 58103  
  701-364-6600

##### Assumptions

* All hospitals within the region may receive burn patients and should be prepared to provide initial assessment and stabilize the patient.
* EMS will be responsible for providing the initial triage of the burn patients and will be critical in deciding the appropriate location for patient transfer. This may be the closest burn center, burn surge facility, or local healthcare facility.
* The ideal location for the care of a burn patient is the burn center or a level I or II trauma center.
* Care of a critical burn patient is resource-intensive and requires specialized staff.
* Burn patients often become clinically unstable within 24 hours of injury; therefore, transferring the patient to the appropriate care facility in a timely manner is imperative.
* Burn patients may have co-existent traumatic injuries such as inhalation injuries and penetrating trauma.

#### Concept of Operations

##### Activation

The initial recognition of a burn surge event will typically occur on the scene and involve the responding local EMS agency. The earliest that there is a communication from the scene to the local healthcare facility the earliest that the burn surge plan can be activated. As in any emergent situation, activation of local plans occurs first.

Assessment of the situation will include:

* Identify the nature and location of the incident
* Obtain the projected or actual number of patients
* Estimate time related to distance away from a care center

##### Notifications

A diagram of a medical procedure

Description automatically generated with medium confidence

Figure . Burn Surge Event Notification Pathway

##### Roles and Responsibilities

Refer to the [State of Minnesota Burn Surge Plan](https://www.health.state.mn.us/communities/ep/surge/burn/burnsurgeplan.pdf) Table 4 for a more in-depth review of the roles and responsibilities during a burn response.

###### Initial Receiving Hospital(s)

* The initial receiving hospital will provide initial stabilization and treatment to burned patients, as directed by their medical director or through advisors at one of the MN Burn Centers. Although burn patients should be transferred to the appropriate burn center as soon as possible, the extent of the incident and the availability of burn bed resources may exceed the capacity of the burn center. If this occurs, patients may be transferred to an alternative location, such as a Burn Surge Facility.
* The initial receiving hospital may be required to care for the burn victim until a higher level of care is available, either at the Burn Center or a Burn Surge facility. Working with the Burn Center and utilizing telehealth options will ensure that the appropriate patient care is being provided.
* Transportation arrangements should be coordinated by the initial hospital and the receiving facility, utilizing agreements with their EMS partners.
* Refer to the State of MN Burn Surge Plan for referral criteria.

###### Burn Center

* Either HCMC or Regions Burn Center – whoever is contacted first – will take the lead in the surge event.
* The medical director of that facility will determine which facility would be the most appropriate for the burn patient by reviewing their injuries and the treatment needed.
* Will act as the point of contact for healthcare facilities currently caring for a burn victim – may provide support via telemedicine when available.

###### Burn Surge Facility

* Will maintain situational awareness when activated and prepare to receive a burn patient.
* Will activate surge plans to increase capacity to care for a burn patient – this may include level loading patients or discharge patients if appropriate.
* Will work with the Burn Center to determine the best treatment course for the burn patient.

###### RHPCs

* During a burn surge event, the RHPCs in the state will be notified of the activation of the MN Burn Surge plan by the Metro Regional Healthcare Resource Center (RHRC).

##### Logistics

A burn patient requires specific treatment protocols that are resource-intensive. The region may be asked to assist in obtaining the resources for facilities that are caring for a burn patient and waiting for transportation to a higher level of care.

###### Staff

If a local healthcare facility is caring for a burn patient for an extended amount of time and has limited staff, the facility can reach out to the coalition, which will reach out to neighboring facilities to request assistance. This assistance would be requested via the Regional MOU.

See the [B.4 Resource Request Plan](#_Resource_Request_Plan)

###### Supplies

The coalition does not have the supplies to care for a burn patient; however, by utilizing the Regional MOU and the Regional Resource Allocation Plan, facilities can request assistance in obtaining supplies by reaching out to the coalition, who in turn can reach out to coalition members for support. The state plan outlines supply recommendations for facilities to maintain for either outpatient or inpatient burn victims (Refer to pg. 10-12, [State of MN Burn Surge Plan](https://www.health.state.mn.us/communities/ep/surge/burn/burnsurgeplan.pdf)).

##### Special Considerations

###### Behavioral Health

As with any traumatic event, burn patients require the support of behavioral health professionals throughout their care. Behavioral health support should be available for the families of the patient as well as to the staff providing care.

###### Pediatric Burn Patients

Pediatric burn patients require specific considerations related to their treatment and recovery. Refer to the [MDH - Pediatric Surge Toolkit](https://www.health.state.mn.us/communities/ep/surge/burn/pedsorders.pdf)

###### Combined Injury

Combined injury (burns with trauma or other injuries) increases mortality. These patients are often better treated at a trauma center. Initial triage by EMS should focus on the traditional trauma guidelines and then address the burn injury. Refer to [Guidelines for Burn Care Under Austere Conditions.](https://ameriburn.org/wp-content/uploads/2017/05/guidelines_for_burn_care_under_austere_conditions_.68.pdf)

##### Operations

###### Triage

The initial triage of a burn patient happens on scene by EMS. EMS agencies should have a triage plan in place. Refer to the [EMS Triage and Destination Plan](https://www.ncems.org/pdf/TraumaTriageTemplate.pdf).

When the burn patient is brought to a healthcare facility – the facility will contact the burn center to discuss treatment needs and identify the appropriate care facility.

###### Treatment

The [Minnesota Burn Surge](https://www.health.state.mn.us/communities/ep/surge/burn/index.html) site has two resources that discuss the recommendations for treatment. Healthcare facilities should familiarize themselves with these resources.

###### Transportation

[The Minnesota Burn Surge Plan – Appendix B](https://www.health.state.mn.us/communities/ep/surge/burn/burnsurgeplan.pdf) identifies the breakdown of resources available statewide for burn transport. The hospital will determine and coordinate the appropriate transportation to a higher level of care. This determination will include a conversation with the Burn Center to identify the appropriate transport resource.

###### Patient Tracking

See [B.5 Regional Patient Tracking Plan](#_Regional_Patient_Tracking).

###### Rehabilitation and Outpatient Follow Up

Burn rehabilitation and follow-up are extensive and are typically offered by the Burn Centers. Several regional hospitals offer Wound Care nursing services that may be able to support the rehabilitation of a burn patient.

#### Burn Surge Resources and References

[MDH - Minnesota Burn Surge State Plan and References](https://www.health.state.mn.us/communities/ep/surge/burn/index.html)

##### Training and Exercise Recommendations

It is important that first responders, EMS personnel, and first-receiving hospitals have appropriate education and training to increase their knowledge, skills and abilities for the initial treatment and supportive care for burn-injured patients. The WCMHPC will make all attempts to assist in coordinating training opportunities. Each hospital within the WC coalition was provided with one Advanced Burn Life Support (ABLS) Handbook. All efforts to facilitate or notify facilities of training opportunities will be provided by the RHPCs.

* All providers are provided links to the Educational Curriculum for Medical Providers Responding to a Mass Casualty Burn Surge Incident:
  + [Burn Surge Videos](https://www.health.state.mn.us/communities/ep/surge/burn/video.html)
  + [Determining Burn Depth](https://www.health.state.mn.us/communities/ep/surge/burn/burndepth.html)
  + [Determining Total Body Surface Area](https://www.health.state.mn.us/communities/ep/surge/burn/tbsa.html)
  + [Burn Triage](https://www.health.state.mn.us/communities/ep/surge/burn/triageburns.html)

### Pediatric Surge Annex

#### Introduction

##### Purpose

This annex applies to a mass casualty event with many pediatric patients. It is designed to support the WCMHPC [Response Plan](#_Section_B:_Response) and [B.8 Medical Surge Coordination Plan](#_Medical_Surge_Coordination) by addressing the specific needs of children and the medical care of a pediatric patient. This annex does not replace any existing facility policies or plans; however, it is designed to support the facility-level plans by providing pediatric-specific resources and information.

##### Scope

The Regional Pediatric Surge Plan is designed to provide the communication processes and the procedure for inter-regional and interstate transfer as related to pediatric patients. This pediatric surge annex provides a regional framework to support and supplement the MN Statewide Pediatric Surge plan. The Plan is designed to:

1. Support safe pediatric transfer decision-making
2. Discuss and identify standardized care guidelines available for facilities
3. Provide tools to ensure regional communication processes are in place
4. Support the tracking of pediatric patients throughout the incident
5. Identify the pediatric tertiary care centers/specialty care centers
6. Assist with the decompression from pediatric tertiary care centers/specialty care centers in order to make additional critical care beds available for acutely ill/injured pediatric patients.

##### Overview/Risks

The total population in the WC region is approximately 197,164, of which 6.5% are under the age of 5 and 22% are under the age of 18 (See [Section A: Readiness](#_Section_A:_Readiness_1)). In 2021, there were 61 crashes resulting in one fatality and 26 injuries in which a school bus was indirectly involved. ([www.dps.mn.gov](http://www.dps.mn.gov)). In rural WC Minnesota, many students rely on bus transportation to get to and from school in addition to school events. The WC Minnesota region has eight (8) hospitals within the region. An event that impacts the region’s pediatric population would have a major impact on the ability of healthcare services to provide care. With just over 55,000 pediatrics in the region and the limited amount of healthcare resources, the region’s facilities will be very reliant upon the neighboring healthcare facilities as well as the pediatric specialty facilities in the state. These resources are between 1.5 and 4 hours away from hospitals within the WC region.

The table below identifies the number of pediatric-specific resources available at each facility:

Table . Pediatric Resources at Regional Facilities

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name of Facility | # Pediatric Beds | # PICU Beds | # NICU Beds | Pediatricians on staff |
| Alomere Health | 6 | 0 | 0 | Yes |
| Lake Region Health | 4 | 0 | 0 | Yes |
| CHI St Francis, Glacial Ridge Health, Prairie Ridge Health, Sanford Wheaton, and Stevens Community Medical do not have Pediatric beds or Pediatricians on staff. | | | | |

The WC region has ten pediatric beds. This indicates the reliance upon neighboring facilities as well as specialized pediatric facilities to support an event within the region. The region will use the North Dakota Pediatric facilities and SCH as needed. There are no Pediatric Trauma Centers located within our coalition. The WC regional assets do not include Pediatric specialized EMS.

The below shows available resources in regions surrounding the WC region:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name of Facility | Region | # Pediatric Beds | # PICU Beds | # NICU Beds |
| Sanford Fargo  (701) 417-2000 | North Dakota | 24 | 12 | 40 |
| Essentia Health – Fargo  701-364-8000 | North Dakota | 3 | 0 | 10 |
| SCH  (320) 251-2700 | Central | 20 | 5 | 30 |

Table . Pediatric Resources at Hospitals in Surrounding Regions

The following table identifies specialized pediatric centers within the State of Minnesota:

|  |  |  |
| --- | --- | --- |
| **Trauma Designation** | **Hospital** | **HCC Contact** |
| Level I | Children’s of Minnesota, Minneapolis | Metro Health & Medical Preparedness Coalition  612-873-9911 |
| Level I | Hennepin County Medical Children’s Hospital |
| Level I | Regions Hospital/Gillette Children’s Specialty Healthcare |
| Level I | Mayo Clinic Hospital Eugenio Litta Children’s Hospital | Southeast Minnesota Disaster Health Coalition  855-606-5458  507-255-2808 |
| Level I | Essentia Health St. Mary’s Medical Center | Northeast Healthcare Preparedness Coalition  Jo Thompson 218-269-7781  Adam Shadiow 218-428-3610 |
| Level II | North Memorial Health Hospital | Metro Health & Medical Preparedness Coalition  612-873-9911 |

Table . MN Specialized Pediatric Centers

The table below indicates the estimated disabilities amongst the pediatric population in WC Minnesota.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | All Disabilities | Hearing difficulty < 17 years | Vision Difficulty < 17 years | Cognitive Difficulty < 18 years | Ambulatory Difficulty <18 years | Self-Care difficulty <18 years |
| Clay | 429 | 9 | 75 | 434 | 32 | 105 |
| Douglas | 284 | 66 | 57 | 193 | 9 | 31 |
| Grant | 83 | 19 | 24 | 45 | 5 | 4 |
| Otter Tail | 534 | 54 | 43 | 466 | 61 | 117 |
| Pope | 137 | 17 | 25 | 103 | 26 | 30 |
| Stevens | 38 | 6 | 4 | 34 | 2 | 2 |
| Traverse | 40 | 15 | 4 | 26 | 3 | 6 |
| Wilkin | 76 | 19 | 13 | 36 | 9 | 9 |
| **Totals** | **1621** | **205** | **245** | **1337** | **147** | **304** |

Table . Estimated Disabilities Among WC Pediatric Populations

*Data collected from:* [***http://w20.education.state.mn.us/MDEAnalytics/Data.jsp***](http://w20.education.state.mn.us/MDEAnalytics/Data.jsp)

*Information obtained 08/30/2019*

See the [A.3.3 Health Equity and Access and Functional Needs](#_Health_Equity_and) for AFN considerations.

See the [Pediatric Resources](#_Pediatric_Resources) section for a list of resources available for planning and response considerations.

#### Concept of Operations

##### Activation

When an incident occurs, resulting in pediatric victims, the initial response should follow local surge plans. Local hospitals and EMS agencies should assess:

* Scope and magnitude of the incident,
* Estimate the influx of patients and the real or potential impact on the local healthcare system,
* Any special response needs (e.g., infectious disease, hazardous materials, etc.), and
* Internal response plan activation(s).
* Facility normal referral patterns and availability of these resources

The local hospitals will notify the pediatric trauma center and advise them of the situation. If the designated pediatric trauma center activates their internal surge plan, they are responsible for requesting activation of the Minnesota Pediatric Surge Plan by contacting their HCC as delineated in their regional activation and notification plan(s). The pediatric trauma center will assume the role of the State Coordinating Pediatric Trauma Center (SCPC).

Activation of the statewide [Minnesota Pediatric Surge Plan](https://www.health.state.mn.us/communities/ep/surge/pediatric/pedsurgeplan.pdf) is done as outlined in the Concept of Operations of that plan.

##### Roles and Responsibilities

###### Initial Receiving Hospital/Healthcare Facility

It is expected that all hospitals providing emergency care will maintain a standardized basic level of preparedness and ability to deal with traumatic injury. Per the Minnesota Pediatric Surge Plan, the SCPC may provide telephone/telemedicine expertise to assist in stabilizing hospitals caring for victims.

###### Designated Pediatric Trauma Center

* Assess the situation and, if deemed necessary, activate their facility’s surge plan.
* Provide guidance to the initial facility regarding the stabilization of patients.
* Notify the HCC of the need to activate the state Pediatric Surge plan.

##### Logistics

###### Supplies

The Coalition does not provide a cache of pediatric supplies in the event of a pediatric incident. The Coalition would contact MDH – CEPR for additional resources.

See the [B.4 Resource Request Plan](#_Resource_Request_Plan).

##### Special Considerations

Reference materials are available in the [Pediatric Surge Toolkit](https://www.health.state.mn.us/communities/ep/surge/pediatric/index.html). Within the Toolkit, the [Pediatric Surge Videos](https://www.health.state.mn.us/communities/ep/surge/pediatric/video.html) cover special consideration topics, as does the [Pediatric Primer](https://www.health.state.mn.us/communities/ep/surge/pediatric/primer.pdf).

###### Behavioral Health

The HMAC will support any requests for assistance with behavioral health needs by working with local HHS and may reach out to the Minnesota Behavioral Health Response team within MN Responds.

Behavioral Health Homepage: <https://www.health.state.mn.us/communities/ep/behavioral/index.html>

Pediatric Surge Toolkit Handouts: [PFA](https://www.health.state.mn.us/communities/ep/surge/pediatric/pfa.pdfhttps:/www.health.state.mn.us/communities/ep/surge/pediatric/pfa.pdf), [Disaster Mental Health for Children](https://www.health.state.mn.us/communities/ep/surge/pediatric/mental.pdf), [Guide for Parents & Caregivers](https://www.health.state.mn.us/communities/ep/surge/pediatric/disaster.pdf)

###### Decontamination

Special considerations need to be considered when decontaminating a pediatric patient. Facilities are encouraged to access the [Pediatric toolkit](https://www.health.state.mn.us/communities/ep/surge/pediatric/index.html) to obtain guidance on planning for the decontamination of a pediatric patient.

###### Evacuation

Any pediatric special equipment will be requested amongst members and then to the local emergency manager to assist in locating the supplies. i.e., car seats.

###### Pediatric Infection Control

Children are more likely to become dehydrated from vomiting or diarrhea because they have less body fluid reserve than adults, and this increases their risk for rapid dehydration. Children also have smaller circulating blood volumes than adults, so without rapid intervention, relatively small amounts of blood loss can become dangerous more quickly. Isolation precautions with a pediatric patient are unique as they are often accompanied by a parent. Healthcare facilities are encouraged to utilize the resources contained within the [Pediatric toolkit](https://www.health.state.mn.us/communities/ep/surge/pediatric/index.html) to plan for infection control for pediatric patients.

See [B.13.7 Infection Control Plan](#_Infection_Control_Plan).

###### Security

Each hospital should outline its security procedures and differences for pediatric patients. They can use the following sources to help plan for security:

* [Pediatric Primer](https://www.health.state.mn.us/communities/ep/surge/pediatric/primer.pdf) pg. 12
* Pediatric Surge Toolkit Reference: Pediatric Safe Area [Checklist](https://www.health.state.mn.us/communities/ep/surge/pediatric/checklist.pdf), [Registry](https://www.health.state.mn.us/communities/ep/surge/pediatric/registry.pdf), [Unaccompanied Minor Registration](https://www.health.state.mn.us/communities/ep/surge/pediatric/minors.pdf).

##### Operations – Medical Care

###### Triage and Treatment

Per the Minnesota Pediatric Surge Plan, EMS will triage patients in the field according to their standard of care. It is the responsibility of all hospitals to perform secondary triage to determine the best setting for a patient to receive definitive care. The SCPC will maintain the lead on definitive care guidance for patient placement.

MDH-CEPR provides a [Quick Reference for Assessment, Stabilization and Transfer of Pediatric Patients](https://www.health.state.mn.us/communities/ep/surge/pediatric/priorities.pdf) online. Additionally, [Patient Care Strategies for Scarce Resource Situations](https://www.health.state.mn.us/communities/ep/surge/crisis/standards.pdf) is another online resource for providers and includes Pediatric Resource and Pediatric Triage cards.

##### Transportation

The region is limited in pediatric/neonatal specialty transport assets. This region has access to medical transport options, which include helicopter and fixed-wing resources (Sanford Air Med, Life Link III, and North Ambulance), ground ambulance services, and a few private businesses (MediVan, Peoples Express, Rainbow Rider) for transporting patients. Sanford Fargo EMS has a transport bus located in Fargo, ND, that could be requested directly through Sanford Fargo EMS. Family members may be asked to transport if able. Several long-term care facilities have vans with some wheelchair tie-downs that could be used for transport. Local school buses and handicap-accessible buses may be requested through local EM. The HMAC, along with local EM, will assist with procuring the necessary transportation assets if requested.

##### Minnesota Pediatric Surge Plan Maintenance

The Minnesota Pediatric Surge Plan is maintained by MDH-CEPR and is reviewed at a minimum annually or after an exercise or activation, as warranted.

##### Pediatric Resources

* Bridge to Benefits (<http://mn.bridgetobenefits.org/Disability_Services2>)
* Children’s Minnesota (<https://www.childrensmn.org/>)
* PACER Center (<https://www.pacer.org/>)
* Vision Loss Resources (<http://visionlossresources.org/>)
* Autism Society (<https://www.ausm.org/>)

### Infectious Disease Surge Annex

#### Introduction

In an increasingly internationalized world, the ability for infectious diseases to be transmitted globally has increased. International travel increased the ability of citizens of Minnesota, and more specifically WC Minnesota, to be easily exposed to infectious diseases such as Coronaviruses, Ebola, and other unknown emerging infectious diseases, as well as outbreaks of established diseases such as measles.

An “infectious disease response” is a response to any new, emerging, or severe infectious disease situation that goes above and beyond routine infectious disease investigation, coordination, and response and likely requires a significant multi-agency response.

##### Purpose

The WCMHPC Infectious Disease Surge Plan Annex will define the roles and responsibilities of regional coalition members and partners in an infectious disease response. This will include coordination of healthcare, LPH agencies, and other regional and State partners. The annex will serve as a template and guide toward response and will be considered a flexible document as infectious diseases evolve and change over time.

The purpose of this annex is to provide a concept of operations for a coordinated regional response related to an infectious disease outbreak. The purpose of the plan is to:

* Describe the decision-making structure to be used to determine healthcare response actions and priorities and how they will integrate with LPH.
* Describe procedures to consider for patient placement, movement, and care. The plan is considered a guide; however, it will not provide specific patient care treatment guidance/guidelines.
* Outline the coalitions’ role and procedures for sharing and/or prioritizing scarce resources, as well as how those activities will relate to cross-regional and statewide efforts.
* Discuss the roles and responsibilities of healthcare, public health, local response agencies, EM, community, non-governmental, and local, state, federal, and tribal partners in an infectious disease response in the region.
* Review the coalition's process for communications and coordination among public health, healthcare partners, and other local partners during a response.
* Describe procedures for the coordination of local healthcare planning and response efforts.

##### Scope

The Infectious Disease Surge Annex is part of the WCMHPC Response Plan and is applicable for any incident in which an individual or community is impacted by a suspected or confirmed infectious disease that is beyond the scope of a local response. This annex outlines the concept of coordination and operations for incidents wherein the complexity or duration requires regional coordination of information, resources, and/or response activities.

This annex will promote the concepts outlined by the NIMS and will commit to the establishment of a common set of goals, strategies as well as terminology utilized in other regional plans. This annex may be used as a supplement to local plans and will promote the coordination of a response with the local, regional, and State agencies involved in the response.

#### Overview of HCC and Situation

##### Description of Disease

Diseases are illnesses caused by the presence and actions of one or more pathogenic agents, including viruses, bacteria, fungi, protozoa, multicellular parasites, and abnormal proteins called prions. A disease may be classified as “emerging” or “re-emerging.”

According to the National Institute of Allergy and Infectious Diseases, emerging infectious diseases are commonly defined as:

* Outbreaks of previously unknown diseases
* Known diseases that are rapidly increasing in incidence or geographic range in the last two decades
* Persistence of infectious diseases that cannot be controlled.

Emerging diseases include HIV infections, SARS, Lyme disease, Escherichia coli O157:H7 (E. coli), hantavirus, dengue fever, West Nile virus, and the Zika virus.

Reemerging diseases are diseases that reappear after they have been on a significant decline. Reemergence may happen because of a breakdown in public health measures for diseases that were once under control. They can also happen when new strains of known disease-causing organisms appear. Human behavior affects reemergence. For example, overuse of antibiotics has led to disease-causing organisms that are resistant to medicines. It has allowed the return of diseases that once were treatable and controllable. Reemerging diseases include malaria, tuberculosis, cholera, pertussis, influenza, pneumococcal disease, and gonorrhea.

The transmission of diseases can occur through a variety of modes, including:

* Inhalation of airborne particles
* Inhalation of droplet particles
* Contact with infectious surfaces

The National Institute of Allergy and Infectious Diseases identifies three categories of pathogens:

Category A pathogens are those organisms/biological agents that pose the highest risk to national security and public health because they:

* Can be easily disseminated or transmitted from person to person.
* Result in high mortality rates and has the potential for major public health impact.
* Might cause public panic and social disruption.
* Require special action for public health preparedness.
* Examples: Anthrax, botulism, plague, and Ebola

Category B pathogens are the second highest priority organisms/biological agents. They are moderately easy to disseminate and:

* Result in moderate morbidity rates and low mortality rates.
* Require specific enhancements for diagnostic capacity and enhanced disease surveillance.
* Examples: Ricin, Staphylococcus, Food and waterborne pathogens, and mosquito borne viruses

Category C pathogens are the third highest priority and include emerging pathogens that could be engineered for mass dissemination in the future because of

* Availability
* Ease of production and dissemination
* Potential for high morbidity and mortality rates and major health impact
* Examples: Hantaviruses, tickborne viruses, tuberculosis, influenza, human coronaviruses.

See [Infectious Disease Surge Resources and References](#_Infectious_Disease_Surge) for links to the National Institute of Allergy and Infectious Disease.

##### Coalition Infectious Disease Surge Resources

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Facility Type** | **Hospital** | | **Address** | **Phone Number** |
| Highly Infectious Disease Treatment Facility | | Mayo Clinic | 200 First St. SW Rochester, MN 55905 | (507)229-3401 |
| Highly Infectious Disease Treatment Facility | | M Health Fairview University of Minnesota Medical Center – West Bank | 2450 Riverside Ave., Minneapolis, MN 55454 | (612) 273-3000 |
| Infectious Disease Assessment Facility | | Allina Unity Hospital | 550 Osborne Rd NE, Fridley, MN 55432 | (763) 236-5000 |
| Pediatric Infectious Disease Specialists | | Children’s Hospital | 345 Smith Ave N, Saint Paul, MN 55102 | (651) 220-6000 |

Table . MN Infectious Disease Facilities/Specialists

Table . Out of State Support Facilities with Infectious Disease Specialties

| **Facility Type** | **State** | **Hospital** | **Address** | **Phone Number** |
| --- | --- | --- | --- | --- |
| Regional Biocontainment Center | Nebraska | Nebraska Medicine | 4350 Dewey Ave. Omaha, NE | (800) 922-0000 |
|  | North Dakota | Sanford Health | 736 Broadway N. Fargo, North Dakota 58102 |  |
|  | South Dakota | Sanford Infectious Disease Clinic | 1205 S. Grange Ave. Suite 401 Sioux Falls, South Dakota 57105 |  |

Table . Coalition Frontline hospitals

| **Trauma Designation** | **Hospital** | **Address** | **County** | **Phone** | **Website** |
| --- | --- | --- | --- | --- | --- |
| Level III | Alomere Health | [111 17th Ave E, Alexandria, MN 56308](https://www.bing.com/local?lid=YN873x15006471809990872322&id=YN873x15006471809990872322&q=Alomere+Health&name=Alomere+Health&cp=45.87384796142578%7e-95.37608337402344&ppois=45.87384796142578_-95.37608337402344_Alomere+Health) | Douglas | (320) 762-1511 | <https://alomerehealth.com/> |
| Level III | Lake Region | [2311 W Lincoln Ave, Fergus Falls, MN 56537](https://www.bing.com/local?lid=YN873x116389110&id=YN873x116389110&q=Lake+Region+Healthcare&name=Lake+Region+Healthcare&cp=46.288787841796875%7e-96.11359405517578&ppois=46.288787841796875_-96.11359405517578_Lake+Region+Healthcare) | Otter Tail | [(218) 739-6800](tel:2187396800) | <https://www.lrhc.org/> |
| Level IV | Prairie Ridge Health | [1411 Highway 79 E, Elbow Lake, MN 56531](https://www.bing.com/local?lid=YN873x2460824518512697105&id=YN873x2460824518512697105&q=Prairie+Ridge+Hospital+%26+Health+Services&name=Prairie+Ridge+Hospital+%26+Health+Services&cp=45.99063491821289%7e-95.95817565917969&ppois=45.99063491821289_-95.95817565917969_Prairie+Ridge+Hospital+%26+Health+Services) | Grant | [(218) 685-7300](tel:2186857300) | <https://www.prairiehealth.org/> |
| Level IV | Perham Health | 1000 Coney Street West  Perham, MN 56573 | Otter Tail | (218) 347-4500 | <https://www.perhamhealth.org/> |
| Level IV | Glacial Ridge | 10 4th Ave SE, Glenwood, MN 56334 | Pope | [(320) 634-4521](tel:3206344521) | <https://glacialridge.org> |
| Level IV | Stevens Community Medical Center | [400 E 1st St, Morris, MN 56267](https://www.bing.com/local?lid=YN873x8794785356260166973&id=YN873x8794785356260166973&q=SCMC&name=SCMC&cp=45.585025787353516%7e-95.9049072265625&ppois=45.585025787353516_-95.9049072265625_SCMC) | Stevens | (320) 589-1313 | <https://www.scmcinc.org/> |
| Level IV | Sanford Wheaton Health | 401 12th Street North  Wheaton, MN 56296 | Traverse | [(320) 563-8226](tel:3205638226) | <https://www.sanfordhealth.org/locations/sanford-wheaton-medical-center> |
| Level IV | St. Francis Medical Center | 2400 St. Francis Drive  Breckenridge, MN 56520 | Wilkin | [(218) 643-3000](tel:2186433000) | <https://www.sfcare.org/> |

##### Planning Assumptions

Planning assumptions for this annex include:

* This annex is meant to provide an overview of the regional response to an infectious disease outbreak and the coordination with other relevant regional plans and health partners.
* Infectious disease outbreaks may be anticipated and provide the ability to plan, or there may be no notice and require an immediate response.
* Patients with an infectious disease could present to healthcare organizations in the region through two modes:
  + A patient presents with symptoms with or without a history of exposure and no advance notification to the healthcare facility.
  + A patient being monitored or treated for a disease/exposure is directed to a healthcare facility for evaluation or treatment in the region.
* Not all healthcare facilities in the coalition may be able to care for all infectious disease patients.
* All healthcare facilities must be able to maintain a base level of preparedness to safely screen (in-person or remotely), stabilize, isolate if necessary, and arrange for the transport of a possible infectious disease patient.
* Resources such as personnel, equipment, and PPE may be in short supply throughout the region, state, country, or the globe, depending on the severity and nature of the infectious disease.
* The objectives of public health and hospitals may differ in an infectious disease response:
  + Public health is primarily concerned with community disease control.
  + Healthcare facilities are focused on the clinical care of patients.
* This annex does not apply to routine disease responses such as tuberculosis, measles, STD, and foodborne illness cases or outbreaks unless the response requires coordination above and beyond normal operational procedures.
* LPH agencies maintain plans for pandemic/avian influenza as well as isolation and quarantine. This annex is meant to complement other local planning efforts.
* Responses to large-scale infectious disease response may require coordination with other regional, state, and federal partners.
* Local Board of Health and MDH have the authority to change or implement procedures to protect the public’s health, including isolation and quarantine.
* Healthcare organizations and systems throughout the region will commit their own resources to address internal challenges prior to releasing resources to other healthcare organizations.
* Pediatric, obstetric, and other specialty care patients, including those who are critically ill, may present to ANY healthcare facility during an infectious disease response.
* Healthcare organizations will rely on existing contracts with medical suppliers and pharmaceutical vendors to the maximum extent possible.
* Hospitals and healthcare systems are expected to have their own plans for an infectious disease response. This annex is not designed to replace the facility-level planning effort.
* An infectious disease outbreak can cause a surge of patients – this annex will work along with [B.8 Medical Surge Coordination](#_Medical_Surge_Coordination_1) as well as [B.9 Crisis Standards of Care](#_Crisis_Standards_of).

#### Concept of Operations

##### Activation

This annex may be activated during any infectious disease scenario that requires coordination between healthcare organizations and coalition partners when the existing resources and plans are limited and inhibit the ability to adequately respond to the infectious disease.

Potential triggers to activate the Infectious Disease Annex include:

* Regional coordination is required to assist with monitoring, laboratory testing, patient care, patient movement, etc.
* Multiple counties are affected by an infectious disease, requiring a coordinated response.
* Regional coordination is required for risk communication, public information, and/or media response.
* Public health response to a new/novel communicable disease.
* Multi-agency response to an infectious disease health threat.
* Notification by an LPH agency/CHB for the need for regional coordination of coalition members.
* Response to a more routine public health event (e.g., a small outbreak) that will benefit from the use of ICS to organize the response and provide an opportunity to exercise implementation of ICS.

When the RHPC or a local health authority identifies that the infectious disease outbreak meets the triggers identified above and additional resources may be needed, this annex will be activated at the discretion of the RHPC or their designee. Regional or local partners, a local Emergency Manager, LPH, or a representative of another health or medical organization may request activation. Coalition staff should consider the likelihood that state resources will be employed, the need or potential need for specialized technical assistance, and the status or activation forecast of the State EOC when determining whether or when to activate the HMAC and the plan.

HMAC activation is likely, and activation protocol may be initiated.

RHPC will coordinate with HMAC representatives to relay responsibilities, provide collected background data from assessments, and aid with priority tasks. The RHPC may encourage healthcare facilities to activate their facility pandemic plan and assist with the reporting and monitoring of reportable illnesses.

Activation of the HMAC and implementation of the Infectious Disease Surge Plan will be coordinated with both state and local partners. Members should consider that infectious disease events might create unforeseen recovery challenges for both state and local agencies, some of which may not be clearly recognized during the response. As a minimum, consideration should be given to:

* Disease and illness forecasts or verifiable trends
* Expected timing of and challenges associated with deactivation or demobilization of state-owned or controlled resources or teams; and
* Possible recovery needs that may require facilitation, coordination or technical assistance that was provided by the coalition during the response phase.

See [B.2.2 Role of the Coalition in Events](#_Role_of_the) for further information regarding HMAC activation during a response.

The Coalition uses a four-level system to describe different levels of emergency response activation. This system will be used in an infectious disease emergency. The table below depicts the activation and readiness levels as they apply in an infectious disease emergency.

Table . Infectious Disease Activation and Readiness Levels

| **Level** | **Definition** | **Description/Activities** |
| --- | --- | --- |
| IV | ***Routine Operations****:* No confirmed human cases having infectious disease potential identified in Minnesota | ***Infectious diseases or pandemic events pose a minimal immediate risk to the region.***   * The region continues to conduct normal business and monitor threats. * LPH Departments track infectious diseases and influenza-like illnesses that are present among those seeking treatment. * This is the default level of readiness and activation for the coalition with an emphasis on prevention and preparedness activities. * The RHPC will monitor the situation and communicate with MDH to ensure integration with the state Infectious Disease CONOPS. * The RHPC will coordinate with other state and regional entities, local jurisdictions, and private sector/not-for-profit partners to identify resources, undocumented capabilities, and previously unrecognized limitations. |
| III | ***Enhanced Operations****:* Sporadic confirmed, isolated, travel-related human cases of infectious disease or suspected infectious disease detected in Minnesota | **Infectious diseases or pandemic events pose an *increased* risk to the region.**   * Conducting coordination meetings or conference calls with local partners. Increased health monitoring and education activities. * RHPC will review their assigned responsibilities and tasks in this annex and communicate with state, regional, and local partners as necessary. |
| II | ***Increased Readiness Operations****:* Single confirmed, non-travel related human case of infectious disease or suspected infectious disease detected in Minnesota | **Infectious diseases or pandemic events pose a *significant* risk to the region. The coalition partners have most, if not all, of the resources required to immediately respond to the event, although increased coordination among regional partners and outside agencies may occur. Local operations and activities may be impacted or canceled due to absenteeism or to prevent the spread of disease.**   * Implementation of social distancing guidelines and modification of operations that may include shift work or teleworking. * RHPC will begin identifying initial priority tasks. During a period of Increased Readiness, the RHPC may designate a frequency for such assessment. |
| I | ***Escalated Operations****:* Multiple confirmed non-travel-related human cases of infectious disease or suspected infectious disease within a defined geographic area in Minnesota  **Emergency Response Operations***:* Multiple confirmed non-travel-related human cases of infectious disease or suspected infectious disease detected in Minnesota: | **Infectious diseases or pandemic events pose a *major* risk to the region. The coalition partners may not have all of the resources required to respond to the event, and significant coordination among coalition partners and outside agencies is required. Local operations will be impacted or canceled due to absenteeism or to prevent the spread of disease.**   * Cancellation of face-to-face meetings and other activities. * Distribution of PPE from the coalition cache or other acquired sources. * RHPC will begin preparing to activate the HMAC. * RHPC will continue to assess priority tasks (those that may be already underway or will be within the first operational period of the HMAC) and will begin to assess any unique and immediate regional issues (such as many public gatherings, temporary unavailability of substantial resources, etc.) that may impact the completion of priority tasks. * RHPC will establish and maintain contact with key partners and resources and may provide liaisons or SMEs to support regional efforts. |

##### Operational Mission Areas

###### Surveillance

Given an infectious disease incident, epidemiologists will conduct investigations on cases and identify contacts. Multiple disease surveillance systems will be used to detect potential cases, and specialized epidemiological studies may be initiated to increase understanding. Persons with a certain travel history, exposures, and/or symptoms may need to be monitored. Risk, impact, and needs assessments also may be conducted. Depending on the incident, various pharmaceutical or non-pharmaceutical disease control interventions may be recommended—including mass vaccinations, isolation, quarantine, social distancing, or vector control operations.

Surveillance of communicable diseases is completed at the local level with the assistance of the Minnesota Electronic Disease Surveillance System (MEDSS). MEDSS enables LPH, hospitals, laboratories, and Infelicitous Disease Epidemiology Prevention and Control (IDEPC) to collaborate electronically as they perform disease reporting and surveillance activities across the state. MEDSS is widely used by hospitals, laboratories, and public health agencies statewide. In special circumstances of a widespread issue, assistance with contact tracing may be made available from the Minnesota Department of Public Health.

###### Safety and Infectious Control and Prevention

See [B.13.7 Infection Control Plan](#_Infection_Control_Plan).

The Coalition has supported long term care facilities that needed assistance with Respiratory Protection Plan development and implementation. The coalition has trained facility staff to conduct fit testing utilizing the Qualitative fit testing kits. Facilities were provided fit testing kits, respiratory plan templates, and forms. The coalition will continue to provide guidance and, as funding allows, may be able to distribute additional fit testing kits. Facilities are required to obtain their own PPE and maintain the kits for facility use as necessary. In addition to fit testing kit distribution, the coalition has provided SNFs with one Powered Air Purifying Respirator (PAPR). These facilities are required to maintain the PAPR in working order. A small cache of PAPRs will be maintained by the coalition for additional needs.

The coalition provides the opportunity for healthcare and EMS to receive annual first receiver training.

###### Non-Pharmaceutical Interventions

Non-pharmaceutical interventions (NPIs) will be the principal means of disease control until adequate supplies of vaccines and/or antiviral medications are available. NPIs are extremely important for infection control and are known to decrease the transmission of communicable diseases. The NPIs recommended for all community members when dealing with a pandemic or disease outbreak include:

* Staying home when sick
* Covering coughs and sneezes
* Frequent and appropriate hand washing
* Routine cleaning of frequently touched surfaces

A Governor’s Proclamation may create limitations for mass gatherings or closures.

The coalition shares guidance developed by the CDC and MDH on an ongoing basis throughout the outbreak. These may include PPE actions, isolation and quarantine directions, and visitor restrictions.

See the [Infectious Disease Surge Resources and References](#_Infectious_Disease_Surge) for CDC NPI links.

During the COVID-19 pandemic, the Society of Critical Care Medicine (SCCM) recommended the utilization of a tiered staffing model for hospitals to expand the existing capacity of patient care areas, specifically ICUs. The strategy utilizes lessons learned in EM responses and fire safety about the span of control. Tiered staffing allows one experienced critical care physician to supervise four ICU teams.

Diagram

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Figure . Tiered Staffing Strategy for Pandemic

###### Support Services

Support services may include any healthcare or non-healthcare staff or material resources required to support the care of infectious disease patients. This may include dialysis providers, blood banks/blood product providers, laboratory services, infection prevention/control, waste and material management, food and dietary services, and environmental services. Support service providers will work with local healthcare to prepare and respond by assisting healthcare organizations in the care of infectious disease patients. All healthcare partners are strongly encouraged to make arrangements with their suppliers and support services in advance of an emergency.

Laboratory

The Minnesota Infectious Disease Laboratory is Minnesota’s environmental and public health laboratory, serving all 87 counties by testing and tracking infectious diseases and illnesses. Clinical laboratories serving Minnesota are required by state statute to submit specific microbial isolates, allowing MDH laboratory to provide surveillance, reference, and diagnostic testing services that are generally not otherwise available in the state. In addition, the Infectious Disease Laboratory is prepared to respond to emergencies and outbreaks that threaten the public's health. Not all patients and diseases qualify to be tested at the Minnesota Infectious Disease Laboratory.

Testing may also be completed at the hospital laboratories and reference laboratories.

LPH may also support testing efforts within the counties. MDH can provide testing teams for regions; however, the support received may be limited. Healthcare facilities, including hospitals and clinics, will be expected to provide testing support to fill in the gaps when able.

See the [Infectious Disease Surge Resources and References](#_Infectious_Disease_Surge) for the appropriate MDH links.

Waste Management and Decontamination

Healthcare organizations will work through their normal vendors and channels to ensure all waste produced in the screening and care of infectious disease patients will be handled and disposed of appropriately.

See [B.8.11 Handling of Solid Waste Contaminated with Infectious Waste](#_Handling_of_Solid_1).

Table . Infectious Disease Categories and Associated Waste Management Requirements and Risks

| **Infectious Disease Category** | **Pathogen** | **Requires Category A Waste Management?** | **Generalized Lab Risk from Raw Specimen?** | **Transmission Risk to Frontline HC Workers** | **Need for a robust institutional response?** |
| --- | --- | --- | --- | --- | --- |
| Category 1 | Ebola, Marburg, Lassa, Crimean-Congo, Smallpox  Note: low prevalence only – if high prevalence then these  pathogens might be Category 2 | Yes | Yes | Yes | Yes |
| Category 2 | MERS-CoV, SARS-CoV, Avian Influenza, Measles | No | Yes | Yes | Yes |
| Category 3 | Pneumonic Plague, Cutaneous Anthrax, Antibiotic Resistant  Infections | No | No | Yes | Yes |
| Category 4 | Botulism, Tularemia, Glanders, Melioidosis | No | No | No | Yes |

Adapted from, Tosh Pritish, MD (Mayo Clinic). A Preparedness/Response Model & Computer Simulation Modeling for High Consequence Infectious Disease. National Healthcare Coalition Preparedness Conference. December 2016.

###### Patient Care and Management

See [B.5 Regional Patient Tracking Plan](#_Regional_Patient_Tracking).

The coalition will work with the Coalition Medical advisor to share information about clinical and operational protocols based upon guidance from the World Health Organization (WHO) and the CDC. The coalition will also work closely with MDH and will share any guidance provided by the Infectious Disease Epidemiology, Prevention and Control (IDEPC) division.

To ensure awareness of infectious disease outbreaks globally the coalition will provide an annual epidemiology update by inviting the Regional Epidemiologist to present to the group.

The coalition will maintain an up-to-date Annex 1 WC Regional Healthcare Assets and Essential Services. This tool identifies the resources and specialties available within the region.

See [Infectious Disease Surge Resources and References](#_Infectious_Disease_Surge) to links for the tools.

During a response to an infectious disease event, hospitals will need to take measures to ensure that their facility does not become a spreader of disease. Hospitals may choose to limit visitors within the hospital. Some possible restrictions include:

* Visitations with patients are limited to one support person.
* Patients on end-of-life support are limited to two support persons.
* Visitors are to be age 16 or older.
* Visitors are to be free of any signs of illness and/or exposure to infectious diseases.
* Adhere to strict physical distancing guidelines and hygiene protocols.
* Visitors may need to wear PPE.
* Stay in their respective patient’s room, as appropriate, unless using the laboratory or utilizing food services.
* Closure of common areas (e.g., waiting rooms, cafeteria)

###### Medical Countermeasures

During the COVID-19 response, the coalition developed a hub and spoke plan for the redistribution of vaccines between hospitals, clinics, LPH, and pharmacies. This annex can be adapted for use in other responses requiring redistribution of products/resources. The coalition also partnered with local EM to assist in the redistribution of PPE and other supporting resources.

Public Health has the primary responsibility in Point of Dispensing (POD) and MCM planning. These agencies may act independently or in conjunction with each other, intra-jurisdictional service area counties, and inter-service area wide counties situation dependent. Within these counties, primary and secondary receiving/distribution sites are pre-designated. The coalition will support as needed and requested.

One of the regional hospitals maintains the CHEMPACK for the region. The coalition works with MDH and the facility to ensure that the CHEMPACK and its’ contents are maintained per the federal guidelines.

See the [Infectious Disease Surge Resources and References](#_Infectious_Disease_Surge) for links to more information about the CHEMPACK and MCM.

###### Community-Based Testing

Community-based testing relies on a partnership between LPH and healthcare. During times where there is a patient surge and hospitals are unable to provide routine testing, the reliance will be on public health to support the needs of the community. Healthcare facilities may need to limit or reduce elective services to ensure the capacity to maintain community testing.

Lessons learned during the COVID-19 response showed the WC region that we need to be creative when looking for community-based testing options. The State of MN typically did not have the resources to assist beyond the large metropolitan borders. As assets became available, limited testing support was created in Moorhead, MN. Targeting the larger communities (Moorhead) and communities with larger educational institutions, such as the University of Minnesota in Morris, MN, as sites for larger community-based testing sites will provide more output.

Recognizing that there may be a need to support facilities in obtaining specimens for COVID-19 testing, the HCC, along with its partner agencies, LPH, and regional EMS, have developed a plan to assist in this response.

**Goal:**

Through collaboration, the goal of this annex is to support facilities by providing tools and resources to ensure that specimens can be obtained for testing in a timely manner.

**Roles:**

Facility Response:

* Obtain specimen collection kits and ensure that all residents and staff are tested according to the State of Minnesota guidelines.
* If the facility is unable to collect the specimens, they are to reach out to their system and vendors for support.
* Contract with lab services.
* Contract with healthcare agencies.

Local Response:

* Assess the availability of LPH to assist with testing at the facility level.
* Consider activation of MN Responds.
* Assess the availability of local EM to assist with testing at the facility level.
* Assess the availability of local first responders to assist with testing at the facility level.

Regional Coalition Response: (If local response is not available)

* Utilize the regional MOU to reach out to hospitals within the region to request staffing support for specimen collection.
* Create a team of individuals from surrounding counties that could assist in the process including reaching out to neighboring LPH and local first responders for assistance.
* Reach out to neighboring HCC leadership to assist in filling any regional gaps.
* Provide just-in-time training to all personnel to ensure they understand their roles, thereby maximizing the efficiency of operations and reducing workplace safety risks. It is essential that workers receive training in the donning, doffing, usage, and disposal of the PPE they will wear prior to participating in operations.
* It is essential that individuals collecting the specimens be trained in the technique to ensure that the correct collection technique is utilized. Provide just-in-time training to all personnel to ensure they have the tools and techniques to provide the service.
* NETEC training video for COVID-19 testing: <https://www.youtube.com/watch?v=osl9W-O0O5g>

Compensation:

The requesting facility/entity will be required to reimburse any agency that provides on-site specimen collection support. The sending facility/agency will invoice the requesting facility and reimbursement is requested within 30 days of receipt of the invoice.

###### Patient Transport

Most EMS have the capability of handling Category B and C infectious disease patients, and the situation should be handled on a case-by-case basis.

Sick individuals may self-present to a medical facility or require transportation. Should a patient present at a hospital with an infectious disease, the patient may need to be transported to a designated assessment hospital and possibly a specialized treatment facility (such as an approved Ebola Treatment Facility in the case of Ebola virus disease). Surge strategies may need to be implemented if the number or complexity of patients is great. If an individual is determined to be a case, contaminated material may need to be removed from locations visited by the person, and further environmental decontamination may be required. Pets/service animals also may need to be cared for and monitored for symptoms.

The State of Minnesota identified seven EMS services for Category A infectious diseases.

See the [Infectious Disease Surge Resources and References](#_Infectious_Disease_Surge) for the State of Minnesota Concept of Operations: Ebola Virus Disease Chapter of the Healthcare Surge Annex.

###### Mass Fatality

Counties should follow their local guidelines with coalition support.

See [B.12 Mass Fatality and Family Reunification Center Planning](#_Mass_Fatality_and).

##### Special Considerations

###### Behavioral Health

During an infectious disease outbreak, a range of mental health and chemical abuse (behavioral health) and stress management problems may surface. Social isolation, infection control measures, and mandated activities increase the feeling of loss of control. The healthcare response during an infectious disease outbreak can include working long hours, dealing with issues that are beyond their normal day-to-day practice, and suffering from isolation from support networks. During the COVID-19 response, it was recognized that there was a need to develop tools and resources to support the healthcare worker. The WellnessMN.org website was created to ensure that healthcare and responders to COVID-19 had access to these tools. All employers, all leaders, and all staff are encouraged to access this information.

The State of MN developed a Regional Behavioral Health Coordinator position during the COVID-19 response. Regional Behavioral Health Coordinators are disaster behavioral health SMEs who engage in outreach and educational activities within each of the public health regions across the state to facilitate the resiliency and recovery of survivors and responders from disasters, terrorism, and public health emergencies.

Behavioral health services are limited during the best of times. Access to inpatient behavioral health beds is difficult. Lake Region Health has 17 inpatient behavioral beds, and these beds are always at 90% occupancy. Hospitals are often forced to board behavioral health patients waiting for in-patient services.

There are two 16-bed inpatient Community Behavioral Health Hospitals in the WC region. One in Fergus Falls and the other in Alexandria. Access to these facilities is through referral by social services.

###### At-Risk Populations During Infectious Disease Emergencies

See the [Infectious Disease Surge Resources and References](#_Infectious_Disease_Surge) and [A.3.3 Health Equity and Access and Functional Needs](#_Health_Equity_and) for more AFN resources.

###### Situational Awareness

EEI is any critical information required by coalition members to ensure that they are able to respond to any event. This allows members to make informed decisions. The EEI is specific to a particular event or thing. The EEI is written out in advance of an event so that when the event occurs, this information is obtained.

To ensure situational readiness during a response to infectious disease – the following EEI, in addition to the EEI listed in [B.3.2 Essential Elements of Information](#_Essential_Elements_of), should be considered for healthcare organizations and response partners:

* Epidemiological, surveillance, or lab data (e.g., test results, case counts, deaths)
* POD/mass vaccination sites data (e.g., throughput, open/set-up status, etc.)
* AFN sheltering status

###### Communications

Communications during an infectious disease emergency will correspond with the [B.3 Communications](#_Demobilization_(Response_2.3.1.6)).

During an infectious disease incident, the Coalition supports MDH efforts to disseminate public health, disease prevention, and behavioral health information to the partners. Data may be requested from local healthcare to support initiatives and response needs by the State. The State of Minnesota may utilize the MNTrac platform or REDCap surveys to obtain information for healthcare. It is essential that healthcare members respond appropriately to these data requests. The coalition will support the state by providing guidance on reporting the data as requested.

###### Jurisdictional-Specific Considerations

The WC region follows the I-94 corridor and borders with North Dakota. Moorhead, MN, is a micropolitan community located in Clay County. This community is unique as they do not have a hospital within their boundaries. The closest hospital is across the border in Fargo, North Dakota. This requires close communications between the region, Clay County PH, and our healthcare partners and public health in North Dakota. Moorhead has a large population of homelessness that will have a direct impact on an infectious disease response. Oftentimes, the city of Moorhead has had to fend for itself, and during an infectious disease outbreak, they need the support of not just their own county but of the region as a whole. Cross-border collaboration is essential.

###### Training and Exercises

Exercise templates and training tools can be found at: <https://www.health.state.mn.us/diseases/hcid/>

Several infectious disease trainings can be found at:

* [TRAIN Learning Network](https://www.train.org/)
* [Centers for Disease Control and Prevention](https://www.cdc.gov/)
* [National Emerging Special Pathogens Training and Education Center](https://www.netec.org/)
* [World Health Organization](https://www.who.int/)

###### Deactivation and Recovery

As in any response, demobilization and recovery planning should begin immediately. When an infectious disease outbreak is involved, the process may be long-term and will require accurate record-keeping. As the local healthcare facilities, LPH, and local EM monitor the coordination and the response, they will determine when the response concludes. Consideration will need to include regional and state decision-making processes as well.

#### Infectious Disease Surge Resources and References

ASPR Tracie

* [AFN](https://asprtracie.hhs.gov/technical-resources/62/access-and-functional-needs)

CDC:

* [Nonpharmaceutical interventions:](https://www.cdc.gov/nonpharmaceutical-interventions/index.html)

MDH

* [All-Hazards Response and Recovery Plan STATE OF MINNESOTA CONCEPT OF OPERATIONS: EBOLA VIRUS DISEASE CHAPTER OF THE HEALTH CARE SURGE ANNEX](https://www.health.state.mn.us/communities/ep/plans/allhazardsebola.pdf)
* [MDH Lab](https://www.health.state.mn.us/about/org/phl/topics/index.html)
* [Crisis Standards of Care Plan](https://www.health.state.mn.us/communities/ep/surge/crisis/index.html#scarce)
* [High Consequence Infectious Disease Ambulance Transport](https://www.health.state.mn.us/communities/ep/surge/infectious/transportems.pdf)
* [Patient Care Strategies for Scarce Resource Situations](https://www.health.state.mn.us/communities/ep/surge/crisis/standards.pdf)
* [SNS Chempack Project](https://www.health.state.mn.us/communities/ep/mcm/chempack.html)
* [MCM](https://www.health.state.mn.us/communities/ep/mcm/index.html)
* [Regional Behavioral Health](https://www.health.state.mn.us/communities/ep/behavioral/rbhc.html)

National Institute of Allergy and Infectious Diseases:

* [NIAID Emerging Infectious Diseases/ Pathogens | NIH: National Institute of Allergy and Infectious Diseases](https://www.niaid.nih.gov/research/emerging-infectious-diseases-pathogens#:~:text=Category%20A%20pathogens%20are%20those%20organisms%2Fbiological%20agents%20that,have%20the%20potential%20for%20major%20public%20health%20impact)

SCCM:

* [United States Resource Availability for COVID-19](https://www.sccm.org/sccm/media/PDFs/PastPresidents/United-States-Resource-Availability-for-COVID-19.pdf)

National Emerging Special Pathogens Training and Education Center

* [PPE (COVID-19) Use and Conservation](https://repository.netecweb.org/exhibits/show/ppecons)

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<https://www.who.int/emergencies/diseases/en/>

## 

### Handling of Solid Waste Contaminated with a Category A Infectious Waste

#### Purpose & Scope

The purpose of this section is to define the role of the Coalition and the RHPC regarding hazardous waste management. The WCMHPC and the RHPC will provide education, reference materials, and share information with the hospitals and other healthcare providers within the coalition.

This document serves as a reference for handling Category ‘A’ infectious substances safely in both the hospital setting as well as for EMS. Hospitals and EMS are required to have a waste management plan that addresses the handling of highly infectious substances. It is the expectation that the hospitals and the EMS agencies share their waste management plans with each other.

The WCMHPC does not have a stockpile of materials used in waste management. Hospitals, EMS, and other healthcare providers are required to maintain their own supply.

EMS agencies within the WC region have a varying degree of supplies available to them. Many of the agencies are volunteer services, and due to limited funds, they do not have PPE training and supplies adequate to respond to a patient with a known highly infectious disease. As a result of these limitations, the WC region will require the use of outside agencies to transport such a patient. The two “Ebola Ready” services that would respond within the region are Sanford EMS from North Dakota and Mayo EMS/CentraCare EMS from St. Cloud. Each of these services is expected to have its own protocol for handling Category A waste.

See [B.13.7 Infection Control Plan](#_Infection_Control_Plan).

#### What Constitutes Category ‘A’ Agents

The CDC defines Category ‘A’ agents as high-priority organisms that may pose a risk to national security because they can be easily transmitted from person to person, have the potential to result in high mortality rates and public health impact, and can cause public/social panic and/or disruption. Category ‘A’ agents include:

* Anthrax (Bacillus anthracis)
* Botulism (Clostridium botulinum toxin)
* Plague (Yersinia pestis)
* Smallpox (variola major)
* Tularemia (Francisella tularensis)
* Viral hemorrhagic fevers (filoviruses [e.g., Ebola, Manburg] and arenaviruses [e.g., Lassa, Machupo])  
  <https://www.cdc.gov/phpr/publications/2008/appendix6.pdf>

#### Healthcare Facility Guidance

Category A infectious waste products contain highly infectious agents contained within blood or bodily fluids (urine, saliva, sweat, feces, vomit, breast milk, and semen) from an infected person. Contact via direct contact (through broken skin or mucous membranes such as eyes, nose, or mouth) with another person can spread the infection to others.

Objects such as needles, syringes, PPE, or textiles that have been exposed to the highly infectious agent may transmit the disease to another person. Therefore, proper disinfection and waste disposal practices are vital when healthcare workers are caring for a patient with a suspected or confirmed highly infectious disease.

NOTE: Handling suspected or confirmed highly infectious disease-associated waste should be done with strict guidelines for handling, transport, and disposal. However, if a treated patient is no longer considered a highly infectious disease risk patient, then any waste generated for the remainder of the patient's care should be treated as regulated medical waste as set forth by the healthcare facility’s guidelines for waste disposal.

##### Isolation and Management of Highly Infectious Disease-Contaminated Solid Medical Waste

Medical waste contaminated with highly infectious disease contaminants and any waste co-mingled with highly infectious disease-contaminated waste must be kept isolated from and disposed of separately from other regulated medical waste.

* Waste generated during the treatment of a suspected or confirmed highly infectious disease patient should be collected in the patient's room or designated area and identified as highly infectious disease waste.
* All contaminated waste should be disposed of in a leak-proof bag that is initially placed in a rigid container to provide support and decrease contamination to the exterior of the waste bag.
* This bag should be considered full when the waste receptacle has reached 75% capacity. • Prior to closure, treat the bagged waste with a non-aerosol liquid solution of U.S. EPA-registered hospital disinfectant with a label claim for a non-enveloped virus (e.g., norovirus, rotavirus, adenovirus, poliovirus) that is recommended by the CDC for use as a disinfectant for the highly infectious disease virus. Use a small amount sufficient to coat the surface of the materials contained within the bag without creating free liquids in the bottom. Do not attempt to stir or mix the contents.
* Tie off the top of the bag with a knot or equally effective means such as heat sealing, tape, or adhesive to ensure any liquid cannot leak from the packaging.
* Disinfect the exterior of the bag using bleach wipes or other non-aerosol liquid solution of U.S. EPA-registered hospital disinfectant with a label claim for a non-enveloped virus (e.g., norovirus, rotavirus, adenovirus, poliovirus) that is recommended by the CDC for use as a disinfectant for the Highly infectious disease virus.
* Place this bag in secondary packaging and tie off the top of the bag with a knot or equally effective means such as heat sealing, tape, or adhesive to ensure any liquid cannot leak from the packaging.
* Disinfect the exterior of the secondary packaging using bleach wipes or other non-aerosol liquid solution U.S. EPA-registered hospital disinfectant with a label claim for a non-enveloped virus (e.g., norovirus, rotavirus, adenovirus, poliovirus) that is recommended by the CDC for use as a disinfectant for the Highly infectious disease virus.

##### Onsite Treatment of Highly Infectious Disease-Contamination Solid Medical Waste

Waste generated during the care of a suspected or confirmed highly infectious disease patient can be treated onsite through inactivation or incineration.

Onsite inactivation:

* Highly infectious disease-associated waste may be inactivated using appropriate autoclaves.

Onsite incineration:

* Highly infectious disease-associated waste may be inactivated using appropriate incineration.

Link to CDC guidance on disinfection and sterilization in healthcare facilities: <https://www.cdc.gov/infectioncontrol/guidelines/disinfection/index.html>

Highly infectious disease-associated waste that has been appropriately incinerated, autoclaved, or otherwise inactivated is no longer infectious, does not pose a health risk, and is not considered to be regulated medical waste or a hazardous material under Federal law. Products of incineration of highly infectious disease-associated waste can be transported and disposed of in accordance with state/local regulations and standard protocols for hospital waste disposal.

##### Offsite Transport of Highly Infectious Disease-Contaminated Solid Medical Waste

Highly infectious disease is regulated as a Category A infectious substance and is considered a hazardous material under the U.S. Department of Transportation's (DOT) Hazardous Materials Regulation (HMR; 49 C.F.R. Parts 171-180). Therefore, certain disposal protocols set forth by this regulation must be met prior to transporting highly infectious disease-associated waste to an offsite that has not been inactivated onsite.

Prior to transport offsite, a Category A infectious substance must be tripled packed in a primary watertight receptacle, a watertight secondary packaging, and a rigid outer packaging.

***Individual plastic film packaging***

* Must weigh no more than 10kg (22lbs) when full
* Must be 175 liters (46 gallons) or smaller
* Must be marked and certified by its manufacturer as having an impact resistance of 165 grams and a tearing resistance of 480 grams in both parallel and perpendicular planes with respect to the length of the bag when tested in accordance with ASTM D 1709 and ASTM D 1922
* Must be compatible with the non-aerosol liquid solution EPA-registered hospital disinfectant with a label claim for a non-enveloped virus (e.g., norovirus, rotavirus, adenovirus, poliovirus) that is recommended by the CDC for use as a disinfectant for the Highly infectious disease virus.

***Rigid outer packaging***

* Must be either a United Nations (UN) Standard or DOT-approved non-bulk packaging − Drums made of plastic or triple wall corrugated fiberboard (authorized under approval) − Boxes made of plastic or triple wall fiberboard.
* Must be certified and tested to the PG II Level for medium danger
* Must have a minimum of a 6-millimeter polyethylene plastic liner if the outer packaging is fiberboard
* Must be marked and labeled in accordance with U.S. DOT HMR.

After the outer packaging has been closed as specified by the manufacturer of the packaging, disinfect the exterior surface of the outer packaging with a non-aerosol liquid solution EPA-registered hospital disinfectant with a label claim for a non-enveloped virus (e.g., norovirus, rotavirus, adenovirus, poliovirus) that is recommended by the CDC for use as a disinfectant for the Highly infectious disease virus.

NOTE: It is important that healthcare facilities coordinate with their current waste management vendor to discuss their protocol for disposal of waste contaminated with infectious viral hemorrhagic fever. Be sure to include questions such as:

* Whether the vendor has an arrangement with a waste disposal or processing facility that holds the required permits to receive waste contaminated with a highly infectious disease or other infectious viral hemorrhagic fever
  + Waste disposal and processing facilities must have the state's approval to receive and treat highly infectious disease-associated waste.
* Whether the vendor can properly package a U.S. DOT regulated Category A infectious substance according to Hazardous Waste Regulations for transportation offsite
* Whether the vendor knows the proper protocol for requesting the Special Permit from U.S. DOT if they may need to transport a Category A infectious substance from the healthcare facility

IMPORTANT: There are four requirements to be approved for the Special Permit as regulated by the U.S. DOT:

* Waste must be triple-packaged as instructed in the previous section
* Transport containers must be labeled as UN number 2814 infectious substances affecting humans
* Transport must have a security plan and en-route security detail
* Facilities must develop an emergency response plan in the event of a spill or other emergency

U.S. DOT has confirmed that they will not issue the Special Permit in advance. This permit can only be issued once the regulated medical waste is suspected or confirmed to be a Category A infectious substance.

##### Recommendations for Liquid Waste Disposal

Wastewater treatment facilities are appropriately able to administer sewage handling processes that are designed to inactivate infectious agents. However, certain disinfection measures should be taken in the case of human exposure prior to delivery to the wastewater treatment facility.

* Any liquid generated by the patient or during treatment (i.e., blood transfusion, dialysis, used saline, irrigation procedures) should be delivered to a sanitary sewage receptacle and treated with 1 cup of bleach for 5-10 minutes prior to flushing.

CAUTION: EPA warns that this method may expose an individual without respiratory protection to chlorine gas. Please make sure to isolate the sanitary sewer with standing bleach to prevent exposure to any generated chlorine gas during this disinfection process. Additional care is needed when adding any liquid treatment to sewage to ensure no splashing occurs.

* While CDC guidelines state that liquid waste infected with highly infectious disease viruses can be flushed without disinfection treatment, disinfection measures are a precautionary measure against splashes, spills, or service required by public works staff, as well as for local wastewater operators.

NOTE: Please be sure to contact your local wastewater treatment facility to notify them in advance of the intent to bleach incoming sanitary sewage infected with highly infectious disease viruses.

##### Additional Waste Management Information

For additional information, refer to the following links:

* [CDC Guideline for Disinfection and Sterilization in Healthcare Facilities](https://www.cdc.gov/infection-control/hcp/disinfection-and-sterilization/index.html)
* [U.S. DOT Pipeline and Hazardous Materials Safety Administration Transporting Infectious Substances](https://www.phmsa.dot.gov/transporting-infectious-substances/transporting-infectious-substances-safely)
* [CDC Interim Guidance for Environmental Infection Control in Hospitals for Highly Infectious Disease Virus](https://www.cdc.gov/viral-hemorrhagic-fevers/hcp/infection-control/environmental-infection-control-hospitals.html)

#### EMS Agency Guidance

##### Patient Assessment

This assessment should take place before the transport of the patient. To minimize potential exposure, only one EMS should approach the patient and perform the initial screening from at least 3 feet away. If this initial assessment provides the EMS provider with suspicions that the patient could have an infectious disease, such as a highly infectious disease, then PPE should be put on before coming into close contact with the patient.

##### Protection of EMS Personnel

Protection begins during handling, treatment, transport, or disposal of suspected or known Category A contaminated waste. This begins before the waste is generated, and the best first strategy for protecting EMS personnel is to control the hazard at its source by minimizing the amount of waste generated and ensuring that plans are in place to deal with waste before further generating it. Implement protective measures once the waste is generated under OSHA standards for bloodborne pathogens by using PPE and respiratory protection (i.e., respirators). (emailed document; OSHA Bloodborne Pathogens Standard. 29 CFR § 1910.1030 (2012), OSHA, U.S. Department of Labor.)

Throughout the entire waste handling process, EMS personnel should:

* Limit the number of personnel that handle the waste.
* When changing or removing gloves, hands should be washed with soap and water for at least 20 seconds; use alcohol-based scrubs if soap and water are not available.
* Clothing must be changed as soon as it becomes soiled.
* Do not touch the face or other exposed parts of the body before washing properly.
* Discard soiled clothing and PPE with other contaminated waste in a biohazard bag.
* Wear washable footwear or disposable booties.
* If blood, bodily fluids, secretions, or excretions from a patient under investigation (PUI) come in direct contact with the EMS provider’s unprotected skin or mucous membranes, then the EMS provider should immediately stop working and wash the affected skin.

If the patient is not showing obvious signs of bleeding, vomiting, or diarrhea and there is no concern for this, EMS personnel should follow the [PPE guidance for clinically stable PUIs](https://www.cdc.gov/viral-hemorrhagic-fevers/hcp/guidance/ppe-clinically-stable-puis.html).

* PPE should be put on before entering the scene and continue to be worn until providers are no longer in contact with the patient.
* Limit the use of needles and other sharps and handle them with extreme care. Dispose of sharps in puncture-proof, sealed containers specific to the care of the patient, in accordance with OSHA’s bloodborne pathogens standard.
* If the patient is vomiting, give them a large red biohazard bag.
* Wrap the patient in an impermeable sheet to reduce contamination of other surfaces if the patient has profuse diarrhea.

##### After Transport Clean-Up

The following are general guidelines per CDC regulations for cleaning or maintaining EMS transport vehicles and equipment after transporting a PUI:

* EMS providers should wear PPE if performing cleaning and disinfection where body fluids are present (vomit, diarrhea, sweat, urine, or blood). If no body fluids are present, then minimal PPE can be worn:
  + Face shield with surgical face mask
  + Impermeable gown
  + Two pairs of gloves
* Patient-care surfaces (including stretchers, railings, door handles, medical equipment control panels, and adjacent flooring, walls, and work surfaces) should be cleaned and disinfected thoroughly.
* Contaminated reusable patient care equipment (i.e., blood pressure cuff) should be placed in a biohazard bag and labeled for cleaning and disinfection or disposal according to agency policies and manufacturer’s instructions by trained personnel wearing correct PPE.

##### Disposal of Waste

Treatment, storage, and disposal of hazardous waste is regulated under the Resource Conservation and Recovery Act (RCRA) and Minnesota Hazardous Waste Rules.

See the [Key Contacts](#_Key_Contacts) section for contact information for Minnesota Hazardous Waste offices.

#### Waste Management Resources and References

* [Minnesota Pollution Control Agency](https://www.pca.state.mn.us/business-with-us/hazardous-waste-reporting-and-licensing)
* CDC
  + [Procedures for Safe Handling and Management of Ebola-Associated Waste](https://stacks.cdc.gov/pdfjs/web/viewer.html?file=https://stacks.cdc.gov/view/cdc/54052/cdc_54052_DS1.pdf)
  + [Guidance on PPE To Be Used By Healthcare Workers during Management of Patients with Confirmed Ebola or Persons under Investigation (PUIs) for Ebola who are Clinically Unstable or Have Bleeding, Vomiting, or Diarrhea in U.S. Hospitals, Including Procedures for Donning and Doffing PPE](https://www.cdc.gov/ebola/php/healthcare-facilities/interim-guidance-for-preparing-frontline-healthcare-facilities-for-patients-under-investigation.html)
  + [Interim Guidance for EMS Systems and 9-1-1 Public Safety Answering Points (PSAPs) for Management of Patients Under Investigation (PUIs) for Ebola Virus Disease (EVD) in the United States](https://www.cdc.gov/viral-hemorrhagic-fevers/hcp/emergency-guidance/ems-911.html)
* Interagency Board
  + [Recommendations on Selection and Use of PPE for First Responders against Ebola Exposure Hazards](https://www.keanfiresafety.com/wp-content/uploads/2014/10/IAB-Ebola-PPE-Recommendations_10-24-14.pdf)

### Radiation Emergency Surge Annex

#### Introduction

According to the WHO, radiation emergencies are non-routine situations or events that require prompt action to mitigate a radio-nuclear hazard or its adverse consequences for human life, health, property, or the environment.

Nuclear emergencies involve the release of energy resulting from a nuclear chain reaction or the decay of the products of a chain reaction (e.g., nuclear power plant accidents such as the Chernobyl and Fukushima accidents). Radiological emergencies are situations involving radiation exposure from a radioactive source. When referring to an emergency, regardless of its type, the “radiation emergency” term is often used.

Radiation emergencies may result from the misuse of radioactive sources during industrial, medical, or research applications, accidental exposure to uncontrolled (abandoned, lost, or stolen) radiation sources, and accidents during the transport of radioactive materials. They also can be combined with conventional emergencies (a fire or a release of chemical substances), natural disasters, military conflicts, or malicious acts involving radiation sources.

##### Purpose

The WCMHPC Radiation Emergency Surge Annex provides guidance to support a coordinated healthcare response to a radiation emergency in which the number and severity of exposed or possibly exposed patients challenge the capability of HCC member facilities. The annex outlines suggestions for planning for, managing, and caring for patients during a radiological emergency.

There have been no large-scale radiological emergencies in the United States; however, planning and preparing to respond is imperative to a successful response if an event occurs.

The likelihood of a radiological event to occur in the WC region is minimal; however, if an event were to occur anywhere in the United States – patients may be diverted to the Metro region, which may impact the WC region by requiring the WC region to surge up. At a minimum the WC region should consider activation of their facility-based surge plans.

The purpose of the plan is to:

* Identify the local and regional risks such as power plant, industrial/research, radiological dispersal device (RDD), and nuclear detonation.
* Discuss the roles and responsibilities of healthcare, public health, local response agencies, EM, community, non-governmental, and local, state, federal, and tribal partners in a radiological response in the region.
* Identify the decision-making structure to be used to determine HCC response actions and priorities and identify the indicators/triggers and processes for alerting/notifying appropriate members of a radiation emergency.
* Identify processes to consider for patient placement, transfer protocols, and care.
* Identify the coalitions’ role and procedures for sharing and/or prioritizing scarce resources, as well as how those activities will relate to cross-regional and statewide efforts. The plan will also identify some specific radiological resources that can support the response efforts.
* Identify the coalition's process for communications and coordination amongst membership and partners. To include initial coordination and information gathering to determine the impact and needs
* Describe healthcare planning and response needs to include triage/screening and the alignment of the coalition's regional plan with LPH and EM plans.
* Discuss potential treatment options.
* Discuss training opportunities available
* Identify detection and dosimetry equipment options for EMS/hospitals
* Briefly identify/summarize decontamination protocols.
* Provide a list of SMEs to be utilized when necessary, including the Radiation Injury Treatment Network (RITN) (see [Radiation Resources](#_References))

This annex will NOT:

* Replace local-level/facility plans
* Provide specific patient care treatment guidance

The annex will serve as a guide toward response.

##### Scope

The annex is part of the regional response plan.

##### Overview of HCC and Situation

The HCC has indicated via their HVA that a radiological incident is low. A plan that identifies the response to a radiological event is, however, necessary regardless of the type of event that occurs (i.e., act of terrorism or nuclear melt-release).

The State of Minnesota is responsible for licensing, rulemaking, inspection, and enforcement activities for:

* radioactive materials produced because of processes related to the production or utilization of special nuclear material
* uranium and thorium source materials
* special nuclear material in quantities not sufficient to form a critical mass

Most of these licenses are for medical and industrial uses of radioactive material.

MDH maintains an environmental monitoring program for radioactivity around the state’s two nuclear power generating plants, which are in Monticello and Prairie Island.

The Nuclear Regulatory Commission (NRC) retained jurisdiction over several activities identified in 10 CFR Part 150, including regulation of commercial nuclear power plants and federal agencies using certain nuclear material in the state. In addition, the NRC retained authority for the review, evaluation, and approval of sealed sources and devices containing certain nuclear materials manufactured in Minnesota and distributed throughout the country.

The closest nuclear-generating plant to the WC region is in the Central region. The Monticello Nuclear Generating Plant is a nuclear power plant in Monticello, Minnesota, which is in Wright County and is approximately 95 miles south east of the border of the eastern edge of the WC region. The plant is a single nuclear reactor, which is a boiling water reactor. It is owned by Excel Energy and operated by Northern States Power. The facility is currently licensed until September 2030.

According to the United States NRC, there are two emergency planning zones around nuclear power plants:

* Plume exposure pathway zone with a radius of 10 miles (16 km), concerned primarily with exposure to, and inhalation of, airborne radioactive contamination.
* Ingestion pathway zone of about 50 miles (80 km), concerned primarily with ingestion of food and liquid contaminated by radioactivity.

The WC region is outside of the emergency planning zone outside of the Monticello nuclear power plant. However, if there is an event at the plant, the regional healthcare facilities may be impacted by accepting patients who normally go to sites that are within the zones.

##### Planning Assumptions

Planning assumptions for this annex include:

* Radiation incidents may be accidental (e.g., industrial or transportation accidents) or intentional
* Incidents may require prolonged response and extensive resource management challenges
* Substantial differences in response protocols and priorities exist between power plant / industrial, terrorist (e.g., RDD/dirty bomb), and nuclear bomb detonation.
* The plan should emphasize the scenario(s) most relevant to the community
* The coalition annex does not replace the need for protocols at each hospital and EMS agency
* Different agencies may have authority over the management of power plant, transportation, and terrorist incidents, including the authority to implement shelter-in-place and evacuation orders
* The roles and responsibilities of agencies and organizations will change depending on the severity and scale of the incident and the respective level of activation by impacted jurisdictions and should be outlined before an incident
* Federal, state, and local emergency resources will all be needed during a large-scale event
* Staff at coalition facilities may be impacted by exposure, fear of exposure, or family obligations (e.g., child/family care if schools are closed or acute care facilities are affected).
* Fear from the incident will cause a worried well surge in emergency departments and pharmacies
* Consider how a limited understanding of radiation and nuclear contamination will contribute to public anxiety and require multi-modal solutions.
* Public safety (e.g., police, fire, EMS) and other first responder personnel are considered a high-risk population: the implementation of protocols for monitoring control zones and effective contamination control measures will be essential for workforce protection.
* Federal resources (e.g., ambulance contracts, National Disaster Medical System [NDMS] teams) cannot be relied upon to mobilize and deploy for the first 72 hours
* Management of contaminated waste from decontamination should be managed in consultation with SMEs, EPA, and local water authorities.

As members of the coalition, healthcare providers should understand that:

* Hospitals and healthcare systems should have their own plans for a radiation emergency
* Rural areas may be severely impacted by citizens fleeing an affected area and seeking care
* Implementation of surge protocols specific to a radiation emergency will occur quickly, and facility staff must be prepared to activate and operationalize appropriate procedures immediately.
* Initial trauma care should precede radiation injury management
* Radiation contamination assessments will require rapid protocol and education implementation
* Staff will need to evaluate real versus suspected exposure, internal versus external contamination, and assess overall exposure levels for at-risk patients based on serial blood testing
* Specialized expertise (such as clinical advisors) will be needed to manage the complexities of a major radiological incident (e.g., dose estimation, exposure type, treatment plans, site evaluations, decontamination protocol)
* Contaminated injury care and decontamination may require rapid expert consultation
* Community screening sites will be required to assess low-risk patients
* Depending on the scale of the radiological event, it may be necessary to establish ACSs, especially for radiological exposure requiring higher levels of care
* Emergency departments, outpatient care centers, and ACSs must be prepared to rapidly screen large groups of potentially exposed people and triage and transport them as needed
* Allocation of limited/scarce resources and their distribution should be based on agreed-upon prioritization systems/methods
* Large-scale radiological incidents may require the recruitment of volunteers (e.g., Medical Reserve Corp), retirees, and trainees to support and relieve screeners and healthcare workers
* Some healthcare facilities may require large-scale fatality management support
* Community-based interventions will require significant public health efforts if an evacuation or shelter-in-place order is necessary.
* CI will be impacted (e.g., food distribution, isolation assistance, surveillance activities)
* Health concerns, prolonged response requirements, difficult work environments, and stress may
* present behavioral health challenges among staff of coalition members and the public

#### Concept of Operations

##### Activation

This annex may be activated during any radiological emergency that requires coordination between healthcare organizations and coalition partners when the existing resources and plans are limited or inhibit the ability to adequately respond to the event.

* Potential triggers to activate the Radiation Emergency Surge Annex include:
* Regional coordination to monitor or coordinate patient movement etc.
* Multiple counties were affected by the event, requiring a coordinated response
* Regional coordination is required for risk communication, public information, and/or media response.
* Public health response to a community impacted by a radiological incident
* Multi-agency response to radiation health threat
* Notification by an LPH agency/CHB for the need for regional coordination of coalition members

When the RHPC or a local health authority identifies that an event meets the triggers identified above and additional resources may be needed, this annex will be activated at the discretion of the RHPC or their designee. Regional or local partners, a local emergency manager, LPH, or a representative of another health or medical organization may request activation. Coalition staff should consider the likelihood that state and/or federal resources will be employed, the need or potential need for specialized technical assistance, and the status or activation forecast of the state EOC when determining whether or when to activate the HMAC system and the plan.

HMAC activation is likely, and activation protocol may be initiated.

Activation of the HMAC and implementation of the annex will be coordinated with all partners. Members should consider that radiation events might create unforeseen recovery challenges for both state and local agencies, some of which may not be clearly recognized during the response. As a minimum, consideration should be given to:

* Activation of federal assets and following the lead of the federal agencies with the understanding that the federal agencies may not be available for up to 72 hours after the incident or requests have been made
* Expected timing of and challenges associated with deactivation or demobilization of state-owned or controlled resources or teams; and
* Possible recovery needs that may require facilitation, coordination or technical assistance that was provided by the coalition during the response phase.

See [B.2.2 Role of the Coalition in Events](#_Role_of_the) for further information regarding HMAC activation during a response.

The Coalition will use the seven-level International Nuclear and Radiological Event Scale (INES) as a basis for response activation. According to the United States NRC, the scale can be applied to any event associated with nuclear facilities, transport, storage, and use of radioactive material and radiation sources. The use of INES serves to promote a common understanding of the significance of reported events among governments, the nuclear community, the media, and the public.

Activation of the coalition Radiation Emergency Surge Annex can be determined by the level identified in the INES; however, it is understood that even an incident at level 2 may exceed the available resources and may require activation. As with all coalition responses – activation of the coalition HMAC is based upon the needs of the coalition members and its partners and will be event-driven.

Chart

Description automatically generated

* The INES consists of a 7-level event classification system.
* Events of greater safety significance (Levels 4-7) are termed "accidents" and events of lesser safety significance (Levels 1-3) are termed "incidents."
* Events without safety significance are termed "deviations" and are classified below Level 0.
* A description of INES, including an explanation of the various levels and a copy of the IAEA INES User's Manual (2008 edition) can be found at NRC's [INES web page](https://www.nrc.gov/about-nrc.html)

Figure . International Nuclear and Radiological Event Scale

##### Activation and Notification Flow

See [B.2.3 Response Operations](#_Response_Operations) for an in-depth description of the coalition activation and notification process.

See [B.3 Communications](#_Demobilization_(Response_2.3.1.6)), which specifically discusses the mechanisms in place to notify/communicate with coalition members and partners.

Upon notification to the above-listed partners – additional notifications can be made by the local and state partners to:

* [Radiation Control](https://www.nrc.gov/about-nrc/emerg-preparedness/emerg-classification/ines.pdf)
* Homeland Security and EM
* MN DOT
* [MN Radiation Emergency Volunteers (MREV)](https://www.health.state.mn.us/communities/environment/radiation/radioactive/mrev.html)
* US Department of Energy
* US Environmental Protection Agency (EPA)
* [Federal Radiological Monitoring and Assessment Center (FRMAC)](https://nnss.gov/mission/federal-radiological-monitoring-and-assessment-center-frmac/)
* [NRC](https://www.cambridge.org/core/journals/disaster-medicine-and-public-health-preparedness/article/radiation-injury-after-a-nuclear-detonation-medical-consequences-and-the-need-for-scarce-resources-allocation/9B21C41217C4AED5C0A683C493543B0E)
* Federal Emergency Management Agency (FEMA)
* [Nuclear Emergency Support Team](https://www.cambridge.org/core/journals/disaster-medicine-and-public-health-preparedness/article/triage-and-treatment-tools-for-use-in-a-scarce-resourcescrisis-standards-of-care-setting-after-a-nuclear-detonation/C1D02459F496FE30E9D1CF6F9901605F)
* Federal Drug Agency (FDA)
* [RITN](https://www.mayoclinic.org/diseases-conditions/radiation-sickness/symptoms-causes/syc-20377058)
* CDC/ASPR

MDH maintains a [Nuclear and Radiation Emergencies website](https://www.health.state.mn.us/communities/ep/surge/nuclear/index.html) with multiple planning, education, and response resources for HCCs, healthcare facilities, and EMS.

If the incident is catastrophic and the affected HCC forecasts state resources will be depleted and/or surge capacity is exceeded, a request can be made to MDH-EPR to escalate the plan beyond state borders to inter-state partners through the Great Lakes Healthcare Partnership (GLHP) existing plans and procedures. The GLHP is the HHS Region V coalition.

In response to a national disaster, HHS-ASPR will lead the medical portion of the federal response and activate the NDMS. NDMS will distribute patients for definitive medical care across the United States to NDMS-participating hospitals.

##### Roles and Responsibilities

The roles and responsibilities of the Coalition and its members/partners during a radiation incident align with those outlined in the [Response Plan](#_Role_of_the).

##### Logistics

###### Space

Responding to a radiation incident requires adequate space to operationalize decontamination protocols. This includes:

* EOC
* Security zone
* Decontamination area (may be multiple locations i.e., scene, hospital)
* Triage/treatment zone
* Patient reunification center
* Decontamination waste cleanup area
* Media room

Healthcare facilities should plan accordingly to address these factors

Local healthcare providers are encouraged to work with their LPH and local EM to identify appropriate locations for support facilities.

The HCC will support local efforts by activation of the HMAC, either virtually or in person, and will also support the local EOC.

###### Staff

Responding to a radiation incident may require specialized staffing resources. The [Minnesota Radiation Emergency Volunteers (MREV)](https://www.health.state.mn.us/communities/environment/radiation/radioactive/mrev.html) may be activated by submitting a request to a local emergency manager.

Healthcare facilities are encouraged to develop a Hospital Emergency Response Team (HERT) who are trained in decontamination – including setting up a decontamination zone at the facility and having the appropriate PPE available for staff. This team should be trained and exercised annually. The HCC offers annual HERT training for its membership.

Healthcare facilities are encouraged to develop arrangements with subject-matter experts, such as radiologists and radiation oncologists.

The MDH Nuclear and Radiation Emergencies website contains multiple resources for planning, education and just-in-time training tools online at: [Nuclear and Radiation Emergencies - Minnesota Dept. of Health (state.mn.us)](https://www.health.state.mn.us/communities/ep/surge/nuclear/index.html), including direct links to REMM and RITN materials.

Additionally, the MDH Burn Surge website contains just-in-time training resources online: [Minnesota Burn Surge - Minnesota Dept. of Health (state.mn.us)](https://www.health.state.mn.us/communities/ep/surge/burn/index.html). These include videos, quick references to determine burn depth and surface area, order sets, and Resource and Triage Cards in the [Patient Care Strategies for Scarce Resource Situations](https://www.health.state.mn.us/communities/ep/surge/crisis/standards.pdf).

See [Radiation Resources](#_References)

###### Supplies

Response to a radiological event can severely impact the resources available. These resources include but are not limited to:

* Staff
* PPE
* Treatment/countermeasures
* Bed availability

The Coalition maintains a small cache of items that may be available for redistribution during times of scarcity. This includes PAPRs, decontamination suits/supplies, and decontamination tents. Facilities can contact the coalition and request assistance from the coalition or other facilities.

See [B.4 Resource Request Plan](#_Resource_Request_Plan).

Access to treatments and countermeasures may also be limited. Treatment considerations may need to be based on availability. Healthcare facilities are encouraged to develop plans to address scarcity.

[MDH Crisis Standards of Care - Strategies for Scarce Resource Situations](https://www.health.state.mn.us/communities/ep/surge/crisis/standards.pdf)

[Radiation Injury After a Nuclear Detonation: Medical Consequences and the Need for Scarce Resources Allocation](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3643117/)

[Triage and Treatment Tools for Use in Scarce Resources - Crisis Standards of Care Setting After a Nuclear Detonation](https://pubmed.ncbi.nlm.nih.gov/21402803/)

##### Operational Medical Care

The HCC encourages its partners to have well-thought-out plans obtained from reputable medical experts. The HCC is not made up of expert medical personnel for radiological events and has no relationships with such entities. The annex, however, has been reviewed by the clinical advisor.

As such, the steps below are a high-level overview and are not to be considered medical protocol:

1. All patients should be medically stabilized from their traumatic injuries before radiation injuries are considered. Patients are then evaluated for either external radiation exposure or radioactive contamination.
2. An external radiation source with enough intensity and energy can cause tissue damage (e.g., skin burns or marrow depression). This exposure from a source outside the person does not make the person radioactive. Even lethally exposed patients are no hazard to medical staff.
3. Nausea, vomiting, diarrhea, and skin erythema within four hours may indicate very high (but treatable) external radiation exposures. Such patients will show obvious lymphopenia within 8-24 hours. Evaluate with serial CBCs. The primary systems involved will be the skin, intestinal tract, and bone marrow. Treatment is supportive with fluids, antibiotics, and transfusions stimulating factors. If there are early CNS findings of unexplained hypotension, survival is unlikely.
4. Radioactive material may have been deposited on or in the person (contamination). More than 90% of surface radioactive contamination is removed by removal of the clothing. Most remaining contamination will be on exposed skin and is effectively removed with soap, warm water, and a washcloth. Do not damage the skin by scrubbing.
5. Protect yourself from radioactive contamination by observing standard precautions, including protective clothing, gloves, and a mask.
6. Radioactive contamination in wounds or burns should be handled as if it were simple dirt. If an unknown metallic object is encountered, it should only be handled with instruments such as forceps and should be placed in a protected or shielded area.
   1. Dry, solid waste can be stored in metal or plastic containers provided they have an inner plastic bag that has a securely fitting cover and are clearly labeled with a sign saying, “caution radioactive material” or “caution radioactive waste - do not empty.”
7. In a terrorist incident, there may be continuing exposure of the public that is essential to evaluate. Initially suggest sheltering and a change of clothing or showering. Evacuation may be necessary. Administration of potassium iodide (KI) is only indicated when there has been a release of radioiodine.
8. When there is any type of radiation incident, many people will want to know whether they have been exposed or are contaminated. Provisions need to be made to potentially deal with thousands of such people.
9. Radiation doses to people are expressed in gray (Gy) or sieverts (Sv). The older units for these are rad and rem. 1 gray = 100 rad and 1 Sv = 100 rem.

An approximation of the relative hazard is given:

Table . Radiation Doses and Relative Hazard

| **Dose** | **Relative Hazard** |
| --- | --- |
| About 10 milligray or 10 millisievert [1 rad or rem] or less | No acute effects and only a very small chance of subsequent cancer |
| About 0.1 gray or 0.1 sievert [10 rad or rem] | No acute effects, subsequent additional risk of cancer about 0.5% |
| About 1 gray or 1 sievert [100 rad or rem] | Nausea, vomiting possible, mild bone marrow depression, subsequent risk of cancer 5% |
| Greater than 2 gray or sievert [200 rad or rem] | Definite nausea, vomiting, medical evaluation, and treatment required. |

* Contamination: The amount of radioactivity (contamination) is measured in units of becquerels (Bq) (1disintegration per second). Sometimes, it is expressed in counts per minute.
* Decontamination: Decontamination is usually stopped if the item is reduced to two times the background count rate or if repeated decontamination efforts are ineffective.

1. The principle of time/distance/shielding is key. Even in the treatment of Chernobyl workers, doses to the medical staff were about 10 milligray or 10 millisievert.
   1. Doses to first responders at the scene, however, can be much higher, and appropriate dose rate meters must be available for evaluation.
   2. Radiation dose is reduced by reducing time spent in the radiation area (moderately effective), increasing distance from a radiation source (very effective), or using metal or concrete shielding (less practical).
   3. [Disaster Prep\_Final.qxd](https://aapm.org/pubs/reports/DisasterPreparednessV3.pdf) (aapm.org)

###### Triage and Screening

In rural areas, resources for radiological emergencies are limited. The majority of responding EMS agencies are volunteer and staffed with EMTs or First Responders and carry no medications used for radiological events.

The below triage steps are for reference only – facilities are encouraged to create their own facility-level plans. Facility-based plans should be robust enough to respond to a radiological event. The information provided by the coalition is meant to support the local response planning efforts but does not supersede any local plans.

In case of a radiological emergency resulting in mass casualties:

1. Establish the triage/first aid area outside the inner cordoned area and within the outer cordoned area.
2. Consider using a flashing blue light to draw people towards the triage/first aid area.
3. Categorize people: (you can utilize your existing facility-level triage categorizing system, i.e., SMART)
   1. Priority 1: Need immediate treatment
   2. Priority 2: Need early treatment
   3. Priority 3: Can wait for treatment
   4. No actions: No need for treatment
4. Consider utilizing the Exposure and Symptom Triage (EAST) Tool to Assess Radiation Exposure After a Nuclear Detonation tool. This can be used by both EMS and LPH on scene or at the community reception center.
   1. The following video explains the tool in detail: [EAST Tool for Medical Triage after a Nuclear Detonation - YouTube](https://www.youtube.com/watch?v=wN7Kt7aVDEs).
5. Tag victims with their medical conditions and category, per protocol.
   1. NOTE: Serious medical problems always have priority over radiological concerns. Those who can respond to a voice announcement to come to the gathering point most probably can wait for medical attention. Keep families together.
6. Provide first aid as required.
7. Obtain an estimate on the number of victims the transport unit and hospital can handle.
8. Take actions to limit the spread of contamination if there is an indication that people could be contaminated:
   1. People with life-threatening injuries should be wrapped in blankets or sheets and transported to the hospital immediately.
   2. People with non-life-threatening injuries and those without injury should undergo field decontamination/full decontamination, as appropriate.
9. Inform the transport unit and the receiving medical facilities on the nature of the event, number of injured people, nature of injuries, and cases of suspected or confirmed contamination or radiation exposure.
10. Arrange for transportation of injured depending on their injuries:
    1. Life-threatening injuries should be transferred to the nearest hospital.
    2. Non-life-threatening injuries should be transferred to the secondary hospital or designated hospital (for radiation-induced injuries).
11. Coordinate activities with law enforcement/security team when possible and if required.
12. Have the PIO make a public announcement to reduce the number of worried-well (self-presenters) going to the local hospital unless they are injured. Indicate the place where they can go for monitoring and reassurance.

###### Patient Care/Management

Hospitals/clinics/EMs are encouraged to develop their own radiological response plan with input from their medical providers. These plans should contain surge activity, prioritization for treatment, decontamination measures, patient movement/tracking, contamination, palliative care, and how to move from conventional to contingency to crisis care and back, as the situation requires. Resources should be readily available for just-in-time training for healthcare providers.

The coalition [patient tracking plan](#_Regional_Patient_Tracking) may be activated.

[REMM (Radiation Emergency Medical Management) (hhs.gov)](https://remm.hhs.gov)

###### Treatment

Healthcare providers should consider the specific circumstances of each patient encountered during an emergency and use their clinical judgment in providing care.

There are several resources available that discuss available treatment options. Healthcare providers are encouraged to explore these sites prior to an event and establish baseline protocols that can be enacted if/when an event occurs.

In a radiological event, the HCC can work with other HCCs to procure medications, equipment, transport, and hospital beds. The HCC will work with its partners to disseminate information, share resources, and liaison between the membership, local, State, and Federal partners. LPH is responsible for open and closed points of dispensing for communities.

The HHS REMM program website maintains up-to-date treatment protocols and information for healthcare providers. Healthcare providers should be familiar with the information on this website in the event of a nuclear or radiological incident.

Additional treatment order sets and protocols can be found on RITN’s website. All these materials are linked on the MDH Nuclear and Radiation Emergencies website as well. These resources can be found in the [Radiation Resources.](#_References)

Table . Recommended PPE for First Responders in a Radiation Emergency

| **First Responder: Recommended PPE and practices in a radiation emergency** | |
| --- | --- |
| **Emergency Type** | **Recommended PPE** |
| Radiation plus chemical and/or biological hazard: "combined hazard" event | * **Before** combined hazard(s) are well-characterized: first responders should be instructed to wear PPE ensembles that protect against **anticipated** (potentially multiple) hazards * **After** combined hazards are confirmed: first responders should be instructed to wear PPE ensembles that protect against **identified** hazards |
| Radiation-only event with high risk of contamination (and non-radiation hazards have been excluded): e.g., RDD | [Level C PPE](https://file.lacounty.gov/SDSInter/dhs/216885_AmbulanceGuidelinesforResponsetoRadiationEventsRev7-20131030.pdf#levelC) usually provides sufficient respiratory and dermal protection |
| Radiation-only event with high risk of exposure (and non-radiation hazards have been excluded): e.g., Radiological Exposure Device (RED) | * **PPE confers no protection** against high energy, highly penetrating forms of ionizing radiation * Factors that help decrease radiation dose from exposure   + Minimizing time spent near a radiation source   + Maximizing distance from a radiation source   + Increasing the physical shielding between a person and a radiation source |

In all cases where radiation is suspected, first responders should also wear personal radiation dosimeters that enable them to read dose rate and/or accumulated dose in real time.

First Receivers

The first receiver is the hospital healthcare worker and are not at the site of the hazardous release. Since victims may arrive for treatment contaminated with hazardous materials, first receivers need to protect themselves against secondary contamination by putting on appropriate PPE before delivering medical care.

Table . Recommended PPE for First Receivers in a Radiation Emergency

| **First Receiver: Recommended PPE and practices in a radiation emergency** | | | |
| --- | --- | --- | --- |
| **Emergency Type** | **Response Role** | **Recommended PPE\*** | **Notes, Caveats, & Concerns** |
| Radiation plus chemical and/or biological hazard: "combined hazard" event | First receivers delivering care to contaminated victims | * Before incident hazard(s) are well characterized: first receivers should be instructed to wear PPE ensembles that protect against anticipated hazards * First receivers may need to wear a higher level of PPE than they are accustomed to wearing until hazard characterization is complete * After combined hazards are confirmed: first receivers should be instructed to wear PPE ensembles that protect against identified hazards | * Higher level PPE ensembles are generally not available in most hospitals |
| Radiation only event with high risk of contamination (and non-radiation hazards have been excluded): e.g., RDD | First receivers delivering care to victims more likely to be externally contaminated: i.e., healthcare providers working in pre-decontamination (triage) and decontamination areas | * [Level C PPE](https://cdp.dhs.gov/training/course/PER-324#levelC) usually provides sufficient level of respiratory and skin protection * Level C PPE should be worn until risk characterization determines that [Level D PPE](https://www.osha.gov/emergency-preparedness/radiation#levelD) provides sufficient protection | * Recommended respiratory PPE includes a full-face piece air purifying respirator with a P-100 or High Efficiency Particulate Air (HEPA) filter. * Other respiratory protective equipment (e.g., a simple surgical facemask, N-95 respirators), non-fit tested respirators, or ad hoc respiratory protection do not deliver appropriate or sufficient respiratory protection; environmental testing and hazard assessment by a safety professional can help identify hazards and risk levels and direct choices of permissible PPE. * Lead aprons are cumbersome and do not protect against exposure from high-energy, highly penetrating ionizing radiation. |
| First receivers delivering care to victims less likely to be externally contaminated: i.e., healthcare providers working in post-decontamination areas of the hospital | * Level D PPE provides sufficient respiratory and skin protection for first receivers working in post-decontamination areas of the hospital; this includes those delivering care to persons who may not yet be decontaminated (e.g., patients who self-refer or who arrive by transport with life- and limb-threatening injuries) * Level D PPE also protects skin and personal clothing against possible splashes of contaminated blood and body fluids (urine, feces, wound drainage, etc.) * Level D PPE is equivalent to Standard Precautions PPE worn in medical facilities as protection against transmission of biohazards from patients to providers | * Do not delay stabilization of any patient to first perform decontamination * Perform life- and limb-saving tasks before managing radiation problems |
| First receivers delivering care to victims with suspected or confirmed internal contamination i.e., healthcare providers working in post-decontamination areas of the hospital | * Level D PPE also protects skin and personal clothing against possible contamination from blood and body fluids (urine, feces, wound drainage, etc.) * Level D PPE is equivalent to Standard Precautions PPE worn in medical facilities as protection against transmission of biohazards from patients to providers | * Hospital radiation safety officer or health physicist will routinely monitor work areas and patient blood and body fluids for radioactive contamination or elevated radiation levels |
| Radiation only event with high risk of exposure (and non-radiation hazards have been excluded): e.g., RED | First receivers delivering care to victims in all areas of the hospital | * Level D (Standard Precautions) PPE should be used by healthcare workers when caring for victims of radiation exposure | * Patients exposed to radiation but not contaminated with radioactive material pose no threat of exposure to healthcare providers |

In all cases where radiation is suspected, first receivers should also wear a personal radiation dosimeter to monitor their radiation absorbed dose.

Dose Monitoring

Responders must be monitored for exposure to radiation. Priority should be given to those responding to the scene and those conducting decontamination efforts. Detecting a radiation dose rate (radiation dose received over some amount of time) of 10 milliroentgens (mR) per hour (mR/h, or approximately 0.0001 Gy/h) may help employers and workers identify the boundaries of areas with radiation levels of concern.

In areas where there is radiation (i.e., above background), response workers should be equipped with appropriate radiation monitoring equipment. If possible, use equipment that provides unambiguous alarms based on predefined levels (i.e., turn-back doses set by an Incident Commander, ideally well below OSHA dose limits and that indicate when workers should leave an area where they are exposed to certain levels of radiation). Workers should be trained on the specific actions to take during an instrument alarm.

Although there are several types of dosimeters, only alarming electronic dosimeters meet the above criteria.

The WCMHPC does not have dosimeters for HCC members. Members are responsible for obtaining and maintaining the appropriate dosimeters to appropriately respond to a radiological event.

Since it is assumed that there is no radiation dose threshold below which there is no associated risk from radiation, responders who are reasonably expected to receive more than 25 percent of the occupational dose limit should be appropriately trained and monitored. See paragraph (d) of the Ionizing Radiation standard for general industry [(29 CFR 1910.1096](https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.1096)).

The coalition provides the opportunity for healthcare and EMS to receive annual first receiver training.

Decontamination

Decontamination involves not only the victims but those that are responding to and taking care of patients from the event.

Decontamination activities will occur at the scene by EMS and fire agencies and will also occur at the receiving healthcare facilities. Healthcare facilities should have decontamination plans to address how to do mass decontamination and triage of individuals exposed to radioactive materials.

Decontamination of individuals exposed, patients, and emergency response workers, their clothing, and any equipment, including PPE, is essential to limit radiation dose and prevent the spread of radioactive contamination outside of the response area.

Employers whose workers may be contaminated should establish procedures for radiological monitoring or surveying workers to identify which, if any, are contaminated and, if possible, to what extent.

On-scene decontamination facilities should be established that could:

* Provide an area to remove contaminated clothing
* Provide showers to shampoo hair, wash skin, and put on clean clothes
* Store contaminated waste (including clothing and equipment) at a safe distance from people and animals

Employers should refer to interagency resources that provide guidance on decontamination procedures, including:

[US EPA Protective Action Guides (PAGs)](https://www.epa.gov/radiation/protective-action-guides-pags)

[OSHA Radiation Emergency Preparedness and Response](https://www.osha.gov/emergency-preparedness/radiation)

Waste Management

Healthcare organizations will work through their normal vendors and channels to ensure all waste produced in the decontamination process and the care of radiologically exposed or suspected patients will be handled and disposed of appropriately.

* In small radiation events, the collection and containment of contaminated effluent water in appropriate containers may be feasible. This includes large barrels and plastic bags.
* Sampling and suitable disposal of contaminated water may be performed later.
* In large events, collection of waste water may not be feasible.
* Clothing/personal items must be placed in plastic bags and sealed

###### Fatality Management

Exposure to radioactive materials can cause injury and death. It is important for medical certifiers such as medical examiners and coroners to understand the health effects of radiation so that they can accurately determine the illnesses or injuries that caused the death.

Deaths from radiation exposure may be initial or delayed. Initial deaths are related to the actual event and can include blast injuries and thermal injuries. Delayed deaths can include Acute Radiation Syndrome (ARS) or a combination of injuries and ARS. Handling decedents that have been exposed to radiation requires appropriate safety measures for staff.

Counties should follow their local guidelines with coalition support.

See [B.12 Mass Fatality and Family Reunification Center Planning](#_Mass_Fatality_and).

The following two documents provide valuable information regarding handling decedents with exposure to radioactive materials.

[Guidelines for Handling Decedents Contaminated with Radioactive Materials (cdc.gov)](https://www.cdc.gov/nchs/data/nvss/vsrg/vsrg01.pdf)

[Reference Guide for Certification of Deaths - Radiological disaster](https://www.cdc.gov/nchs/data/nvss/vsrg/vsrg01.pdf)

The coalition will support the information and resource sharing necessary in a radiological response.

###### Transport

Treatment of a patient with severe medical conditions must be considered prior to decontamination as the delay of treatment will directly impact the success of recovery. This requires first responder units to have the necessary PPE to protect themselves so that they can provide the necessary care.

* Transporting a radiological patient who has not been decontaminated:
* Increases the risk to the EMS crew
* Takes the rig out of service until it can be decontaminated
* Requires notification to the receiving facility so that appropriate measures can be taken to protect receiving staff

Transportation considerations include keeping already-contaminated rigs in use to transport additional contaminated patients from a scene to the hospital – ideally in a mass casualty situation.

Consideration should be made to ensure that there are enough non-contaminated vehicles available to transport the decontaminated patients either related to the incident or not related to the incident.

Exposed individuals may self-present to a medical facility or require transportation. Should an exposed patient present at a hospital, the patient may need to be transported to a different hospital; one designated to receive the patients from the event. If somebody is determined to be a case, contaminated material may need to be removed from locations visited by the person, and further environmental decontamination may be required. Pets/service animals also may need to be cared for and monitored for symptoms.

[Ambulance Guidelines for Response to Radiation Events](https://www.cdc.gov/nceh/radiation/emergencies/pdf/radiation-decedent-guidelines.pdf#:~:text=The%20Los%20Angeles%20County%20Emergency%20Medical%20Services%20%28EMS%29,a%20radiological%20dispersal%20device%20%28RDD%20or%20%E2%80%9Cdirty%20bomb%E2%80%9D%29.)

###### Rehabilitation, Outpatient Follow-Up Services

People exposed to radiation require outpatient follow-up and possible continued care. Healthcare facilities are encouraged to include plans on how to track patients and ensure that they are receiving the appropriate after care.

The coalition [patient tracking plan](#_Regional_Patient_Tracking) can be used to track the patients and record where patients were transferred.

###### Deactivation and Recovery

As in any response, demobilization and recovery planning should begin immediately. When a radiological event occurs the recovery phase can extend beyond 30 days.

Diagram

Description automatically generated

Figure . Radiation Emergency Incident Response Timeline

Patients with exposure may require treatment and monitoring for years. The behavioral health response may also be extended as these situations are outside of normal day-to-day threats.

As local healthcare facilities, LPH, and local EM monitor the coordination and response, they will determine when the response concludes. Consideration will need to include regional, state, and federal decision-making processes as well.

##### Special Considerations

###### Behavioral Health

During a radiological event, a range of mental health, chemical abuse (behavioral health), and stress management problems may surface. The healthcare response can include working long hours, dealing with issues that are beyond their normal day-to-day practice, and suffer from isolation from support networks.

The State of MN developed a Regional Behavioral Health Coordinator position during the COVID-10 response. Regional Behavioral Health Coordinators are disaster behavioral health subject-matter experts who engage in outreach and educational activities within each of the public health regions across the state to facilitate the resiliency and recovery of survivors and responders from disasters, terrorism, and public health emergencies.

Behavioral health services are limited during the best of times. Access to inpatient behavioral health beds is difficult. Hospitals are often forced to board behavioral health patients waiting for inpatient services.

###### Pediatric and At-Risk Populations

Pediatric patients may have a higher level of external and internal radiation exposure levels due to shorter and smaller body structure and organs. Facilities’ radiation emergency plans should address the specific needs of this population.

[Pediatric Considerations Before, During, and After Radiological or Nuclear Emergencies | Pediatrics | American Academy of Pediatrics (aap.org)](https://www.cdc.gov/nceh/radiation/emergencies/countermeasures.htm)

###### Communications

Communications during a radiation incident will align with processes identified in the [B.3 Communications](#_Demobilization_(Response_2.3.1.6)) of the WCMHPC Response Plan.

To ensure situational readiness during a response to a radiological event – the following EEI, in addition to the EEI listed in [B.3.2 Essential Elements of Information](#_Essential_Elements_of) the following should be considered for healthcare organizations and response partners:

* Decontamination process/needs/resources
* Reunification center status

The following link provides a more in-depth look at EEI’s related to a radiological event – of note – there is a large amount of behavioral health needs/information:

<https://www.phe.gov/Preparedness/planning/playbooks/rdd/Pages/essentialelements.aspx>

###### Jurisdictional – Specific Considerations

The WC region follows the I-94 corridor (East/West) and borders with North and South Dakota. Moorhead, Minnesota borders with Fargo, North Dakota, and relies on Fargo for its medical care. The largest healthcare facilities in the WC region are along I-94 and are level 3 trauma centers. One facility, Lake Region does have a Cancer radiological treatment center.

###### Training and Exercises

The coalition also provides four Hospital Emergency Response Trainings for first receivers/decontamination yearly and can customize trainings for facilities on request. Healthcare facilities are encouraged to participate in the trainings offered by the Center for Domestic Preparedness – Anniston, Alabama, to ensure staff/decon teams are prepared during a radiological event.

##### Radiation Resources

* American Academy of Pediatrics
  + [Pediatric Considerations Before, During, and After Radiological or Nuclear Emergencies | Pediatrics | American Academy of Pediatrics (aap.org)](https://publications.aap.org/pediatrics/article/142/6/e20183000/37501/Pediatric-Considerations-Before-During-and-After)
* ASPR TRACIE:
  + [AFN | ASPR TRACIE (hhs.gov)](https://asprtracie.hhs.gov/technical-resources/resource/7333/hhs-aspr-access-and-functional-needs)
  + [Ambulance Guidelines for Response to Radiation Events](https://asprtracie.hhs.gov/technical-resources/resource/1491/ambulance-guidelines-for-response-to-radiation-events)
* CDC
  + [CDC - MCM for Radiation Exposure and Contamination](https://www.cdc.gov/radiation-emergencies/hcp/training/countermeasures-training.html)
  + [Reference Guide for Certification of Deaths - Radiological disaster](https://stacks.cdc.gov/view/cdc/49294)
  + [Guidelines for Handling Decedents Contaminated with Radioactive Materials](https://www.cdc.gov/radiation-emergencies/media/pdfs/2024/04/radiation-decedent-guidelines.pdf?CDC_AAref_Val=https://www.cdc.gov/nceh/radiation/emergencies/pdf/radiation-decedent-guidelines.pdf)
* American College of Radiology
  + [Disaster Preparedness for Radiology Professionals](https://aapm.org/pubs/reports/DisasterPreparednessV3.pdf)
* [NRC](https://www.nrc.gov/)
  + [INES](https://www.nrc.gov/about-nrc/emerg-preparedness/about-emerg-preparedness/emerg-classification/event-scale.html)
* Mayo Clinic
  + [Radiation Sickness](https://www.mayoclinic.org/diseases-conditions/radiation-sickness/symptoms-causes/syc-20377058)
  + [Nevada National Security Site](https://nnss.gov/)
* National Nuclear Security Administration
  + [Nuclear Emergency Support Team](https://www.energy.gov/nnsa/nuclear-emergency-support-team-nest)
* MDH
  + [Radiological Emergencies](https://www.health.state.mn.us/communities/environment/emergency/radiological.html)
  + [MREV](https://www.health.state.mn.us/communities/environment/radiation/radioactive/mrev.html)
  + [Crisis Standards of Care Plan](https://www.health.state.mn.us/communities/ep/surge/crisis/index.html)
  + [Patient Care Strategies for Scarce Resource Situations](https://www.health.state.mn.us/communities/ep/surge/crisis/standards.pdf)
  + [Regional Behavioral Health](https://www.health.state.mn.us/communities/ep/behavioral/rbhc.html)
* [RITN](https://ritn.net/)
* National Institutes of Health
  + DiCarlo A L et al. (2013)
    1. [Radiation Injury After a Nuclear Detonation: Medical Consequences and the Need for Scarce Resources Allocation](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3643117/)
  + Coleman C N et al. (2011)
    1. [Triage and Treatment Tools for Use in a Scarce Resources – Crisis Standards of Care Setting After a Nuclear Detonation](https://pubmed.ncbi.nlm.nih.gov/21402803/)
* [REMM](https://remm.hhs.gov/)
  + [Exposure and Symptom Triage (EAST) Tool to Assess Radiation Exposure After a Nuclear Detonation](https://remm.hhs.gov/EAST-tool-notes.htm)
* FEMA – Center for Domestic Preparedness
  + [Healthcare Emergency Response Operations for CBRNE Incidents](https://cdp.dhs.gov/training/course/PER-324)

### Medical Surge Training and Exercise

The Coalition completes a training and exercise workshop annually outlining the goals for the next three years. These will include a regional communications exercise twice per year, first receiver training, and a coalition surge exercise annually. Facilities should regularly test their plans and procedures to ensure staff know what to do during a real-world incident.

### Resources for Medical Surge

#### SHCC Critical Care Coordination Center (C4)

As a result of COVID-19, the SHCC developed the C4. This was funded and operated during the COVID-19 response. This resource may not be available outside of the COVID-19 operational period; however, it may be able to be reactivated for future longer-term events.

##### Functions of C4:

* Monitor ICU bed availability and acuity.
* Facilitate medical ICU transfer placement.
* Provide support for level-loading of multiple critical care patients.
* Provide critical care advice/support when awaiting required resources.
* Handoff to EMSRB on-call for assistance with transportation if usual resources are exhausted.

##### Functions C4 does *not* manage (contact RHPC):

* Specialty transfers (trauma, pediatric, burn, etc.)
* Non-emergent transfers of patients
* Hospital to long-term care transfers
* Level-loading of medical/surgical patients
* Regional coordination of healthcare resources (ventilators, staff, other resources)

#### Mobile Medical Team (MN-MMT)

The MN-MMT is a group of volunteer medical and support professionals who have received training and practice in providing acute medical care in a mobile field environment. When a community experiences a tornado, flood, or other incident that temporarily overwhelms its ability to provide healthcare services, the MMT can deploy either with the equipment needed to establish a range of clinical services (Type I) or without equipment to support staffing needs in existing care facilities (Type II). There are currently two MMTs organized under one model that could respond to incidents in Minnesota.

If a WCMHPC member wants to request the MN-MMT, they should call their local EM. Local EM will refer that request to the Minnesota Department of Homeland Security and Emergency Management (HSEM) or State Duty Officer, who will pass the request to the MDH. MDH will pass the request to the MN-MMT Leadership to finalize the request and plan for activation.

#### Regional Caches and Supplies

The Region does have a cache of supplies and equipment that coalition members can request. See [B.4 Resource Request Plan](#_Resource_Request_Plan) for details.

## Crisis Standards of Care

Certain situations, such as medical surges, cause shortages of supplies at the local level as well as regional and state levels. This shortage may even extend nationally/globally. MDH has created the Crisis Standards of Care plan that addresses how major shortages would be handled. WCMHPC members should plan for limited resources and implement Crisis Standards of Care.

### Allocation of resources along the care capacity continuum

As incident demand/resource imbalances increase the risk of morbidity/mortality to patient increases.

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Conventional** | **Contingency** | **Crisis** |
| **Space** | Usual patient care space fully utilized | Patient care areas re-purposed example: post anesthesia monitored units used for ICU care | Facility damaged/unsafe or non-patient care areas (classrooms etc.) used for patient care |
| **Staff** | Usual staff called in and utilized | Staff extension (brief deferrals on non-emergent service, supervision of broader groups of patients, change in responsibilities, documentation, etc.) | Trained staff unavailable or unable to adequately care for volume of patients even with extension techniques |
| **Supplies** | Cached and usual supplies used | Conservation, adaptation, and substitution of supplies with occasional re-use of select supplies | Critical supplies lacking, possible reallocation of life-sustaining resources |
| **Standards of care** | Usual care | Functionally equivalent care | Crisis standards of care |
| **Normal Operating Conditions** |  |  | **Extreme operating conditions** |

### RHPC Role

As dictated by the event or as requested by the WCMHPC member, the RHPC can be contacted to assist. Depending upon the situation, the RHPC may activate the HMAC in support of Coalition members.

See [B.13.6 HMAC Job Aids and Position Descriptions](#_HMAC_Job_Aids) for further detail the RHPC’s role.

Regional resources will be made available to its membership. See [B.4 Resource Request Plan](#_Resource_Request_Plan).

The HCC offers training opportunities for its membership about resource allocation and the request process through the coalition.

The RHPC will also share information received from the State of Minnesota, Federal Government, and other resources/subject matter experts about options available to healthcare providers when there is a scarce resource situation. WCMPHC Communications plan will be used to manage resource request regionally. The MNHCC CONOPS provides resources for inter-coalition and statewide communications and collaboration amongst responding coalition partner agencies. The coalition will include partner agencies in planning for indicators, triggers, and response strategies during crisis conditions via representatives on advisory committee.

### Planning Resources

MDH has developed strategies for events that overwhelm the healthcare system. Clinical guidelines to ethically care for patients when a healthcare facility is overwhelmed are available for all regions and facilities to use. During a disaster, healthcare facilities need to uphold certain standards of care.

* [Patient Care Strategies for Scarce Resource Situations](https://www.health.state.mn.us/communities/ep/surge/crisis/standards.pdf)
  + A standardized framework to assist Minnesota hospitals, clinics, or primary care settings in determining the best use of specialized equipment and supplies during a public health emergency.
* [Pharmaceutical Shortages for MN Hospitals](https://www.health.state.mn.us/communities/ep/surge/crisis/pharmfaq.pdf)
  + Frequently Asked Questions
* [Pandemic Incident Command Considerations for Health Care Facilities](https://www.health.state.mn.us/communities/ep/surge/crisis/panstages.html)
  + Part of the state of Minnesota’s efforts to plan for the possibility of an influenza pandemic.
* [Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response](https://www.health.state.mn.us/communities/ep/surge/crisis/framework.pdf)
  + National guidance in establishing and implementing standards of care that should apply in disaster situations, both naturally occurring and man-made, under conditions of scarce resources

## Evacuation and Shelter-in-Place Planning

Evacuation of a healthcare facility should be the last option to minimize the disruption to patients/patients, staff, and visitors. All healthcare facilities should have plans for evacuation as well as plans for shelter-in-place. 7

### Purpose

This section supports [B.5 Regional Patient Tracking plan](#_Regional_Patient_Tracking). The resources contained within this section are designed to provide resources for healthcare facilities in their evacuation and shelter-in-place planning efforts.

### Scope

This section is divided into three sections.

1. **Decision making** – will provide a decision-making tree to assist facilities in determining whether to evacuate or to shelter-in-place.
2. **Evacuation** – will provide recommendations to support the facility-level evacuation process and identify the coalition's role in such a process. This section will also highlight the importance of working with local partners.
3. **Shelter-in-Place** – will provide recommendations to support the facility-level shelter-in-place planning process. It will discuss how the coalition will support a shelter-in-place response as well as highlight the importance of working with local partners.

### Planning Assumptions

* Utilization of the Hospital Incident Command System (HICS) and the Nursing Home Incident Command System (NHICS) forms and processes will ensure that the facility has the necessary documentation to support the response – including patient tracking.
* Planning considerations are provided to assist healthcare facilities in developing their plans and procedures to ensure that patients/patients, visitors, and personnel are safely sheltered in place or evacuated to safety. This guidance is not intended to provide all the details or resources necessary for facilities to develop their plans, nor is it necessary to address every item that is identified.
* Each facility should assess and address the considerations that are essential for a successful evacuation or shelter-in-place response and incorporate these into their plans, such as:
  + Working with local EM, law enforcement, fire, and EMS
  + Including MOUs with appropriate transportation partners
* If several facilities within the region needed to be evacuated, the HMAC would assist in the coordination of the incident as requested.
* The hospitals are equipped with Med Sleds to assist in the evacuation of non-ambulatory patients.
* Individual hospitals can activate their mutual aid agreements with other hospitals in the region for personnel, supplies, and resources as needed.

### Decision Making

**Shelter-In-Place** assures the maximal safety of individuals in their present location when the dangers of movement exceed the relative risk from the threat or movement cannot be safely completed in a reasonable timeframe.

**Evacuation** - movement of patients out of the affected facility when the facility cannot maintain a safe environment of care. Evacuations may be emergent (fire or other immediate life safety threat) or non-emergent (delayed life-safety threat or anticipated evacuation)

The decision-making process can be stressful for staff – having a well-defined process – including triggers, will assist in decreasing the impact on the facility and eliminate any additional. The following is an algorithm designed to assist in the decision-making process regarding evacuation or shelter-in-place:

A picture containing text, screenshot, font, parallel

Description automatically generated

Figure . Evacuation/Shelter-in-Place Decision Tree

#### Resources for Decision-Making Regarding Evacuation or Shelter-in-Place

[MDH – Should I Stay or Should I Go? (PowerPoint Presentation)](https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.health.state.mn.us%2Fcommunities%2Fep%2Fsurge%2Fsheltering%2Fhcshelterevac.pptx&wdOrigin=BROWSELINKhttps://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.health.state.mn.us%2Fcommunities%2Fep%2Fsurge%2Fsheltering%2Fhcshelterevac.pptx&wdOrigin=BROWSELINK)

### Facility Evacuation Planning

In evacuation planning, facilities need to ensure that they have an adequate plan in place prior to an event.

There are two types of evacuation:

1. **Complete evacuation** – the complete evacuation of a facility due to an unsafe environment of care – usually will involve facility shutdown actions.
2. **Partial evacuation** – Evacuation of a subset of facility patients – this may involve patients requiring specialized care that can no longer be safely delivered at the affected facility (intensive care, dialysis).

While evacuation is typically not preferred, there may be times when this option is safest for the patients and staff. Due to the varied abilities of patients, evacuation can be a daunting task without appropriate consideration and planning. To maximize the safety of patients, staff, visitors, and volunteers – plans need to be put into place, exercised, and appropriate memorandums of understanding created prior to the event.

Prior planning should consider:

* How patients will be transported
* Who will provide the transportation
* What specialty types of vehicles will be needed, and where they will come from
* What supplies, food, water, medications, and other physical items will be needed to maintain safety
* Identify pre-determined locations for immediate evacuation. These locations should meet the needs of the evacuees.
* Facilities should have more than one location identified – with at least one of the locations being some distance away so it is less likely to be affected by the incident.

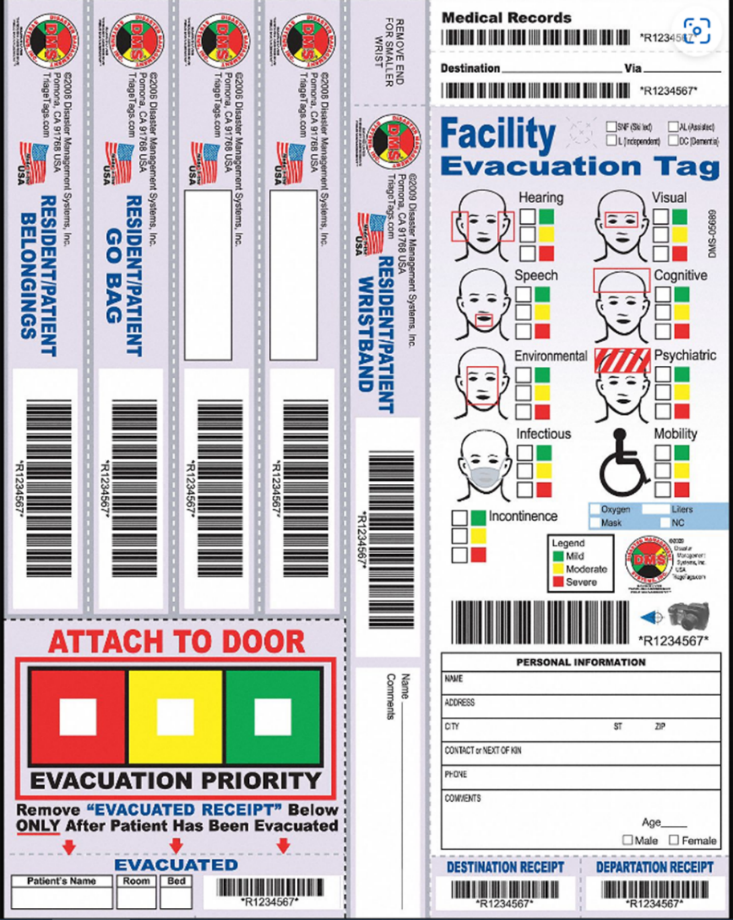
Once the decision is made to evacuate a facility, it is essential that the facility reach out to their local EM as well as the coalition to support the evacuation efforts. The primary support agencies should be local first. Notifying the coalition about the evacuation early in the process will also ensure quicker support activities, including activation of the HMAC.

The following is a graphic representation of ‘reverse triage’ for movement out of the facility, then ‘usual triage’ once in staging. Note green patients may be moved by bus or other asset and not an ambulance. This system is designed to ensure that there is no delay in evacuations by evacuating patients that require more resources and staff before evacuating those that require minimal assistance

Table . Reverse Triage Levels

| **Triage Level** | **Priority for Evacuation Off Nursing Unit**  **(REVERSED START PRIORITY)** | ***Priority for Transfer to Another Healthcare Facility***  ***(TRADITION START PRIORITY)*** |
| --- | --- | --- |
| **RED – STOP** | These patients require maximum assistance to move. In an evacuation, these patients move LAST from the inpatient unit. These patients may require 2-3 staff members to transport. | These patients require maximum support to sustain life in an evacuation. These patients move first as transfers from your facility to another healthcare facility. |
| **YELLOW – CAUTION** | These patients require some assistance and should be moved SECOND in priority from the inpatient unit. Patients may require wheelchairs or stretchers and 1-2 staff members to transport. | These patients will be moved SECOND in priority as transfers from your facility to another facility. |
| **GREEN – GO** | These patients require minimal assistance and can be moved FIRST from the unit. Patients are ambulatory and 1 staff member can safely lead several patients who fall into this category into the staging areas. | These patients will be moved LAST as transfers from your facility to another healthcare facility. |

It is recommended that facilities utilize an Evacuation tag system to ensure appropriate tracking. One such tag is created by Disaster Management System, Inc. and can be used for both hospitals and long-term care:



If a facility is planning on using this type of tag – it is recommended that the facility ensure that they maintain enough tags to evacuate their entire facility with full occupancy as well as have extra tags on hand for any walking wounded, etc.

During an evacuation of a healthcare facility, it is the responsibility of the facility to know where their patients are located. During an evacuation, facilities are required to be accountable for all staff, volunteers, and visitors. The evacuation patient tracking forms can be used to track locations of staff, volunteers, and visitors or the facility can utilize their own formats for tracking staff and visitors. It is recommended that the forms indicate that the individual listed is a staff person, volunteer, or visitor.

#### Evacuation Patient Tracking Process

1. An incident occurs, and a decision has been made to evacuate.
2. The facility notifies local EM and local support services.
3. The evacuating facility should prepare patients for evacuation and complete the Patient/Resident Evacuation Form (see [B.13.4 HICS 260 Patient Evacuation Tracking Form](#_HICS_260_Patient)) or EMTALA form if time allows. This form provides more patient-specific detail. The evacuating facility will assign a unique identifier (via a wristband or tags above if available) to the patient prior to transport (can utilize the facility's patient Medical Record Number). A copy of the patient’s medical record should also be printed and sent with the evacuating patient if available.
4. The evacuating facility should notify the coalition staff for HMAC Activation.
5. When a patient is received by a transporting unit (EMS or other unit), personnel will document the unique identifier that is attached to the patient (via wristband/tags if available. Unique identifiers should remain on/with the patient the entire time they are active in the incident.
6. If a manual patient tracking process is being used, the facility will notate where the patient is being transferred to and how they are being transferred.
7. If the facility wants the evacuation to be tracked via the MNTrac database – the tracking process should include the use of Master Patient tracking form. (See [B.5 Regional Patient Tracking Plan](#_Regional_Patient_Tracking))
8. The patient will be transferred to a receiving facility. This may occur via EMS, private vehicle, private ambulance, or other vehicles as necessary.
9. Upon receipt of the patient, the patient-receiving facility intake staff will ensure they have the minimum data elements outlined in [B.5 Regional Patient Tracking Plan](#_Regional_Patient_Tracking).
10. The receiving facility will be asked to complete the bottom section of the EMTALA form or Resident transfer form (which verifies that the patient has been received and that the receiving facility is considered the primary care provider at that time). The receiving facility will then fax back a copy of the Resident transfer form or EMTALA form to provide proof of arrival and care status.
11. If a patient is being transferred out to another facility, ensure the patient maintains their unique identifier and records in their file and profile on the patient tracking database when and where they are being sent. Ensure the patients’ receiving facility is provided with the appropriate information and unique identifier.
12. Upon receipt of a transferred patient, intake the patient as you would above. If a profile has already been created in the MNTrac patient tracking database, update that information with all relevant information. WCMHPC will follow up with patient-accepting facilities to make sure they are invited to and can participate in the patient tracking process on MNTrac.
13. If a patient is being discharged, ensure that their file and profile are updated appropriately.

#### Resources for Hospitals in Evacuation Planning and Response

* [California Hospital Evacuation Plan Checklist](https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.calhospitalprepare.org%2Fsites%2Fmain%2Ffiles%2Ffile-attachments%2Fhospitalevacuationplanchecklist102710.doc%3F1319663568&wdOrigin=BROWSELINK)
* [Hospital Evacuation Job Aid](https://www.health.state.mn.us/communities/ep/surge/sheltering/evachospjob.pdf)
* [Hospital Repopulation After Evacuation Guidelines and Checklist](https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.calhospitalprepare.org%2Fsites%2Fmain%2Ffiles%2Ffile-attachments%2Fcha_repopulation_checklist_10.23.2020.doc&wdOrigin=BROWSELINK)

#### Resources for Long-Term Care in Evacuation Planning and Response

* [NHICS Incident Response Guide for Evacuation](http://www.cahf.org/Portals/29/DisasterPreparedness/NHICS/EvacuationIRG_2017.pdf)
* MDH
  + [Appendix I Evacuation Checklists](https://www.health.state.mn.us/communities/ep/ltc/appendixi.pdf)
  + [Long-Term Care Toolkit – Appendix J: Evacuation Transportation](https://www.health.state.mn.us/communities/ep/ltc/appendixj.html)
  + [Long Term Care Preparedness Toolkit](https://www.health.state.mn.us/communities/ep/ltc/baseplan.pdf)

\*NOTE: The Coalition has a small cache of evacuation tags available upon request.

### Shelter-in-Place Planning

In certain situations, such as a tornado or chemical incident, your facility may be better off to stay and shelter in place. In an emergency, your facility may be without telephone or other communications, electric power, or water and sewer service for several days. The facility must be able to operate for at least 72 hours without outside assistance.

Your plan should include provisions for resident care (monitoring of medical conditions), facility safety and security, food, water, medications, contact with first responders (EM, fire, police, EMS, etc.), public health, transportation, staff, lighting, temperature control, waste disposal, and medical supplies.

The sheltering-in-place plan is not specific to the event requiring sheltering; instead, the plan should contain the following:

* Plan in place describing how three days of non-perishable meals are kept on hand for patients and staff. The Plan should include special dietary requirements.
* Plan in place describing how 72 hours of potable water is stored and available to patients and staff.
* Plan in place identifying 72 hours of necessary medications that are stored at the facility and how necessary temperature control and security requirements will be met.
* Plan in place to identify staff that will care for the patients during the event including any transportation needs that the staff might have and how the facility will meet those needs.
* Plan in place of an alternative power source, such as an on-site generator, and describe how 72 hours of fuel will be maintained and stored. An alternate power source plan provides for the necessary testing of the generator.
* Plan in place describing how the facility will dispose of or store waste and biological waste until normal waste removal is restored.
* Emergency Communications Plan in place, such as for cell phones, handheld radios, pagers, satellite phones, laptop computers for instant messaging, runners, etc.
* Planning considerations are given to the needs of patients, such as dialysis patients.
* Planning considerations are given to patients on oxygen.
* Planning considerations are given to patients using durable medical equipment such as masks, nasal cannulas, colostomy equipment, g-tube, etc.

#### Resources for Hospitals in Shelter-in-Place Planning and Response

* [California Hospital Association- Hospital Shelter-in-Place Planning](https://www.calhospitalprepare.org/sites/main/files/file-attachments/cha_shelterinplace_checklist_11.30.19.pdf)

#### Resources for Long Term Care in Shelter-in-Place Planning and Response

* [NHICS Incident Response Guide for Sheltering-in-Place](http://www.cahf.org/Portals/29/DisasterPreparedness/NHICS/ShelterInPlaceIRG_2017.pdf)

* [MDH – Appendix H: Facility Shelter-in-Place and Response Items](https://www.health.state.mn.us/communities/ep/ltc/appendixh.pdf)

Note – the coalition has a small cache of evacuation tags available upon request.

## MN Responds Volunteer Workforce Plan

### Program Overview

#### Mission

The WC Region MN Responds MRC is a partnership that integrates local, regional, and statewide volunteer programs to assist our public health and healthcare systems during a disaster. It is part of a national initiative to coordinate and mobilize health volunteers to respond to emergent incidents, ongoing public and community health events, and exercises.

The Unit will recruit, organize, train, deploy, and debrief these vetted volunteers. Volunteers may be of medical or non-medical backgrounds who agree to contribute their skills and expertise in response to emergent incidents and events. Local and regional administrators and coordinators will be able to assist in achieving a prepared volunteer base.

#### Goals and Objectives

The goals and objectives of the Unit are as follows:

* To foster a culture of acceptance and recognition of the value of volunteers.
* To train, exercise and evaluate a volunteer unit able to provide a coordinated public health response.
* To assist in strengthening the public health infrastructure.
* To provide volunteers with a wide base of skills and experiences.
* To provide opportunities to assist with non-emergency public health or community initiatives.

#### Roles and Responsibilities

The WC MN Responds MRC Unit (herein referred to as Unit) is facilitated as joint unit directors by each of the 3 Community Health Boards (CHBs) within the region: Clay–Wilkin, Horizon (Douglas, Pope, Stevens Traverse Grant), and Otter Tail. The fiscal host for the Unit is CentraCare, based in St. Cloud, with monies divided between the CHBs with the understanding that utilization is done collaboratively.

* Each county entity will maintain a local administrator/coordinator to facilitate the county’s MN Responds unit.
* Each CHB will have a designee to the regional work group and request input from all county programs within the CHB.
* Specific roles and responsibilities for each level are listed in the attachments.
* Contact information is listed in the attachments.

MN Responds is the statewide initiative to pre-register, credential, and train volunteers. MDH maintains the website [www.mnresponds.org](file:///C:\Users\Emily%20Peterson\All%20Clear%20Dropbox\_Projects\CentralAndWCHPC_MN\Plan%20Reorg%202024\3_AllHazardsPlan\West%20Central\Plan\www.mnresponds.org). It provides support, guidance, and training for county and regional program administrators. It provides the credential check for medically licensed volunteers.

The Unit is registered with both MDH and the United States Office of the Surgeon General as the WC MN Responds MRC.

#### Legal Authority

Attachments address some of the legal protection issues in more detail.

* Each county accepts responsibility for the volunteers deployed within their county.
* The state assumes responsibility for those requested on the state’s behalf.

#### Activation Authority

Volunteer notification and activation will occur when the county identifies the need for volunteers to respond. This will occur by:

* Following NIMS and Incident Command Structure (ICS).
* Being consistent with the county’s public health and emergency plans.
* Deployment is to be done by the local administrator/coordinator or designee.
* Following deployment procedures.
* Healthcare entities accessing volunteers must coordinate through appropriate ICS.

Volunteers may also be requested by other counties within the Unit. These would be requested through the Multi-Agency Coordination Center. WC coordinators do have access to each other’s county units to serve as redundant coordinators. Requests for volunteers at the state level may come through either the MACC or directly to the local county to request interested volunteers.

### Volunteer Relations

#### Guiding Principles

The WC Region MN Responds/MRC follows these guiding principles in regard to volunteers:

* We treat all people, volunteers, clients, and co-workers with respect and dignity in all situations.
* We honor the commitment of our volunteers who contribute their time and skills to the MR while staying prepared through ongoing trainings.
* We will communicate clearly and consistently with MRC volunteers.
* We value and encourage input from volunteers.
* No volunteer will be asked to perform beyond the scope of his or her licensure, credentials, training, or comfort level.
* We work to ensure that no member will knowingly be placed at risk during training or deployment.
* We provide volunteers with the option of refusing an assignment for any reason.
* We believe that a response to disasters outside of their community and region is voluntary.
* We ask that no member will self-deploy. The Unit Coordinator will activate its volunteers.
* We consistently seek inclusion of residents across all demographics in order to ensure a balanced representation of all the citizens in the county.
* Roles and responsibilities depend on the member’s physical ability, interest, training, and expertise. All service is voluntary.

#### Recruitment

The Unit strives to recruit individuals who have a vested interest in assisting with emergencies. Volunteers are not limited to those with healthcare backgrounds. Some ideas may be as follows:

* Placing materials in healthcare facilities.
* Educational sessions.
* Recruitment during training and exercises.
* Media relations: papers, radio, social networking, web-based information.
* Displays at health fairs, community events, etc.

#### Orientation

* Accepted volunteers will receive either a letter or email acknowledging acceptance. A sample letter is found in the attachments.
* Online orientation will be encouraged. If unable to access by volunteer, the county will make arrangements for orientation to be viewed at the county setting.
* Orientation materials will include online training suggestions, personal preparedness materials, MRC Core Competency materials, and others.
* New volunteers will be encouraged to make themselves and family ready for deployment by making personal emergency plans, go kits, and gather more information.
* Materials are also found in the attachments.

#### Training and Exercising

* The unit volunteer training plan is shared with all volunteers.
* Volunteers are encouraged to track trainings within the MN Responds system as well as MN Train.
* Classroom trainings will occur at a minimum of twice a year. They may include topics other than a basic orientation.
* Volunteers will be notified of local Psychological First Aid trainings.
* Volunteers will be encouraged to keep CPR/First Aid certification up to date.
* Volunteer will be notified when there is a role to participate in exercises.
* Attachments identify materials supporting training.

#### Newsletters

* Quarterly newsletters will be sent to volunteers.

#### Profiles and Credentialing

* Volunteers will be encouraged to update their profiles routinely.
* Badging procedures will follow the MDH guidelines.
* Photo badging of volunteers will take place by the local county. Attached is a draft photo consent.

### Utilization of Volunteers

The WC MN Responds/MRC volunteers are to be used predominately to deepen the infrastructure of LPH health activities. These may or may not be of an emergent nature.

Non-emergent activation may include:

* Vaccination clinics
* Public Health promotions and education events
* Health screenings
* Exercises

#### Deployment

* Deployment requests will be recorded in detail on the Volunteer Mission Request Form.
* Activation authority will be followed.
* Just-in-time training will be clarified.
* Communications with volunteers will be clear, concise, accurate and contain contact information.
* Demobilization will be addressed shortly after activation.
* Debriefing and follow up resources or referrals will be offered for volunteers.

Scheduling, tracking and other administrative tools are located in the attachment sections.

### Administrative Duties

Counties involved will maintain accountability for the local and regional WC MN Responds/MRC program. These duties include the roles and responsibilities outlined in the attachments.

## Mass Fatality and Family Reunification Center Planning

### Purpose

The purpose of this document is to outline the role of the WCMHPC in response to a mass fatality incident (MFI) as well as to discuss the FRC. This chapter also provides guidance to the WCMHPC members and partners for their planning purposes.

A key point in this section is the need to collaborate with local partners. EM has plans in place to support these instances. Healthcare needs to work with their local Emergency Manager to ensure that facility plans align with local/county plans.

### Fatality Management Operations

* Local EM is responsible for Fatality Management Operations.
* Fatality Management Operations will occur in accordance with local EOPs and contracts with the local Medical Examiners and/or Coroners. Refer to local EOPs for details.
* The Coroner or Medical Examiner must be notified of any death where the cause of death is other than natural (i.e., accident, homicide, and suicide). Minnesota state statutes list additional circumstances when the county coroner or medical examiner must be notified (Refer to [Minnesota Statutes Section 390.11, Subdivision 1](https://www.revisor.mn.gov/statutes/cite/390.11#:~:text=Subdivision%201.&text=The%20coroner%20or%20medical%20examiner%20shall%20determine%20the%20extent%20of,performed%2C%20subject%20to%20subdivision%202b.). Reports of death. “All sudden or unexpected deaths and all deaths that may be due entirely or in part to any factor other than natural disease processes must be promptly reported to the coroner or medical examiner for evaluation. Sufficient information must be provided to the coroner or medical examiner.”)
* MFI is an EM term used to identify an incident involving more dead bodies and/or body parts that can be located, identified, and processed for final disposition by available response resources.
* At any time, the counties can request assistance from The Minnesota Office of the State Medical Examiner.
* The State Funeral Directors Association may also provide needed supplies, equipment, vehicles, and personnel. If called upon, the State Funeral Directors Association staff are there to assist the Medical Examiner only; they do not work under any local response agency.
* The WC Region may be activated to assist with the response (see [B.13.6 HMAC Job Aids and Position Descriptions](#_HMAC_Job_Aids)).

### Roles of the RHPC in Fatality Management

* Assist WCMHPC members in Fatality Management Operations
  + Anticipate storage needs for a surge of human remains
  + Guide development of hospital mass fatality plans.
  + Components for information related to hospital-based fatality management operations.
  + Procure mortuary storage equipment
* Family Assistance Center (FAC)
  + An FAC may be setup to provide for the support of family members. Local EM are the lead agencies for a FAC, which may include working with other partners such as LPH and/or HHS.
  + The RHPC (or the WC HMAC) may assist with the FAC by providing situational awareness, communications, or other support.
* Mental and Behavioral Health Support
  + Mental Health and Behavioral Health are available to the WCMHPC members. The RHPC can assist with requesting these resources.
    - For resources – refer to [Mental Health and Well-being - MN Dept. of Health (state.mn.us)](https://www.health.state.mn.us/people/mentalhealth.html)

### WCMHPC Fatality Plan Components

* Process for Identification of Remains
  + To the extent possible, remains and associated personal effects should be identified.
  + When identification is not possible, a good augmentation plan ensures a unique designation is assigned to each body and/or body part. This system of designation should also be used for personal effects; effects and remains are given the same number only when it is certain the remains and effects are associated with each other.
  + When multiple remains are involved, articles of identification are not to be removed from the body until an alternative method (toe tag, etc.) has been attached to that body.
  + In some circumstances, the augmentation plan may need to provide a place for next of kin to identify the remains. This space should not have multiple bodies in it during the identification; it should provide privacy for family members to view the remains.
* Security
  + The remains and the personal effects must be kept secure while in the custody of the medical facility. Existing morgues may be adequate. If not, plans should reflect alternative locations and methods of providing security.
  + Plans must clearly spell out when and to whom remains and personal effects can be released. When the death is not a coroner’s case, it will probably be appropriate to release the personal property of the deceased to the next of kin. For coroner’s cases, all personal property must be given to the coroner/medical examiner, who will arrange for its return to appropriate members of the family.
  + Logs and other forms will be helpful in keeping track of which remains are in custody, where the remains are located, and when remains have been released to the custody of another.
* Coordination
* During an MFI, coordination could be required among several agencies, organizations, and individuals. Example include:
  + Office of the coroner/medical examiner.
  + Law enforcement agencies.
  + EMS.
  + Physicians who have cared for the deceased in the past.
  + Government representatives (city, county, state, federal).
  + Members of the family of the deceased.
  + Mortuaries.
  + Media Volunteer organizations.
* Storage
* Respect: Remains and personal effects must be kept in ways that provide security, dignity, and safety. Remains should be stored in ways that do not have an adverse effect on identification, post-mortem examination, or rituals and religious services for the deceased.
* Body bags or pouches: Vinyl or plastic pouches provide a barrier between the body and hospital / mortuary personnel and are recommended when the cause of death is an infectious disease. In traumatic or disfiguring deaths, pouches facilitate storage and transfer. When several bodies are present in one location, pouches offer a degree of privacy and a sense of dignity.
* Climate: Temperature controls are an important consideration when choosing a storage facility. Ideally, human remains should be stored between 38 and 42 degrees Fahrenheit. This slows changes to the body that affect the outcomes of medico-legal investigations, post-mortem examinations, and embalming/restoration (if this option is selected by family members).
* Freezing. Freezing distorts the physical appearance of the body, requires a thawing period before certain examinations and procedures can be completed, and causes inter-cellular damage and changes to tissue color. These may compromise subsequent exams, interpretations of injuries, and embalming/restorative efforts. In limited circumstances, freezing may be required to stop post-mortem changes and allow certain procedures to be performed (e.g., jaw bone removal to assist in identification). Freezing may be considered when bodies have been dead for a considerable time, and extensive decomposition (without mummification) has taken place, such as if a body has been submerged in water for several days.
* Stacking: Stacking of bodies must be avoided. Stacking shows a lack of respect for the people who have died; it can cause distortion of features (which makes identification and restoration more difficult), and it is harder to access and move bodies that have been stacked. Shelves or racks increase the number of bodies that can be stored per square foot of floor space in a temperature-controlled room or container.

### Special Considerations in Managing Fatalities

Religious and cultural practices that follow death should be considered when possible. Working with SMEs is very important. Some examples to consider:

* For practicing Muslims – burials must occur within 24 hours of death. When this is not possible due to the chaos of the situation, an increase in anxiety and stressors for the families is expected.
* Some cultures view cremation as taboo – there are some instances – for example, highly infectious diseases that require the bodies to be cremated. Working with religious leaders will help decrease the angst in the community.
* The practice of family members dying alone occurred during the COVID-19 response due to isolation and quarantine practices. To some, dying alone is considered a “bad” death.”

### Family Reunification Center

It is recommended that all hospitals have a plan in place to manage a surge of concerned family members, guardians, and friends that may present following a disaster, especially if large numbers of unaccompanied pediatric patients could be involved in the event. The number of family members presenting to the hospital can overwhelm hospital lobbies and other care areas and, as a result, adversely affect clinical operations.

FRCs provide a location for families and others to gather while awaiting news. Hospitals/healthcare should work with their local emergency managers to establish the Reunification Center. A Reunification Center may work in conjunction with the FAC. Family reunification efforts are coordinated at the local level via LPH and local EM.

The FRC is meant to:

* Provide a private and secure place for families to gather, receive, and provide information regarding children and other loved ones who may have been involved in the incident.
* Provide a secure area for these families away from the media and curiosity seekers.
* Facilitate efficient information sharing among hospitals and other response partners to support family reunification.
* Identify and support the psychosocial, spiritual, informational, medical, and logistical needs of family members to the best of the hospital’s ability.
* Coordinate death notifications when necessary.

Considerations in FRC locations:

* Locate the HFRC away from the hospital Emergency Department and media staging location.
* Ensure there is sufficient space to accommodate many individuals.
* Adequate space facilitates communication between designated hospital personnel and family members.
* Provide nearby access to smaller rooms that may be used for confidential discussions, notifications, and provision of other support.
* Distraught family members may need additional space; alcoves or additional rooms may help both psychologically and with security.
* Ensure the space has an area for food and beverage.
* Ensure restrooms are easily accessible.
* Ensure the space is accessible to patients and family members with considerations for AFN.
* Access to the FRC can be controlled, and security can be assured within the site.

Equipment, Supplies, and Resources for the FRC include:

* Multiple computers with Internet access. (Paper backups of digital forms should, of course, be available as well.) Templates should permit families to input as much detail as possible regarding their loved ones, including information that would be used for parent/child verification.\*
* A mechanism to upload photos of the loved ones to assist with the reunification process.\*
* Sign-in–sign-out sheets for those presenting at the HFRC, with name, contact number, and time of sign-in–sign-out for tracking purposes.
* Access to appropriate support assistance and resources (e.g., psychological or spiritual support).
* Phone chargers with multiple kinds of plugs.
* Posted contact information for any available community disaster resources and information.
* Toileting and sanitation, including diaper-changing area.
* The ability to acquire food and drink.
* Chairs and tables.
* Writing utensils/paper/clipboards.
* Language interpreters.

\*Privacy rules, including the HIPAA of 1996, apply to information collected; consult the hospital’s Privacy Office or legal counsel regarding the collection and storage of this information.

## 

## Response Appendices

### Assets and Essential Services



### Essential Elements of Information



### Essential Elements of Information Template



### HICS 260 Patient Evacuation Tracking Form

[HICS 260 Patient Evacuation Tracking Form](https://emsa.ca.gov/wp-content/uploads/sites/71/2022/05/HICS-260-Patient-Evac-Transfer-Tracking.pdf)

### HICS Forms



### HMAC Job Aids and Position Descriptions



### Infection Control Plan



### Master Patient Tracking Form



### MDH Inter-regional Communications



### MNHCC All-Hazards ConOps



### Organizational Level Continuity Planning Resources



### Patient Tracking Form



### Resident Transfer Form



### Resource Request, Receipt, and Promissory Agreement



# Section C: Recovery

## Demobilization

As the response comes to an end, the HMAC, in collaboration with supported organizations and MDH, if activated, will determine the need to demobilize the HMAC. Demobilization may occur in a tiered fashion as certain functions/organizations return to normal operations or all at once. Intentions to demobilize should be communicated to all applicable stakeholders. Notification of demobilization may occur via MNTrac or email.

The HMAC members, in collaboration with partners, should consider the following criteria when determining the need to demobilize the HMAC:

* Projected end of an outbreak.
* Ability to provide inpatient care without surge activities.
* Ability to provide emergency services without surge activities.
* Resumption of normal operations is imminent/completed.
* Ability to provide emergency services without mutual aid (EMS).

Planning for demobilization shall be considered throughout the HMAC activation period. If the HMAC is set up at a remote location, the demobilization process will include returning all supplies and equipment and returning the office space/location to pre-event status. All paperwork created in the response process will be collected, collated, and reviewed for inclusion in the AAR. Copies of paperwork that identify any expenses incurred, such as resource allocation, time sheets, and receipts, will be shared with the local emergency manager in the affected county (if the local EOC is activated).   
All paperwork collected will be scanned and saved in an electronic file labeled for the event.   
An after-action review will be conducted to identify what went well and opportunities for improvement. The HMAC staff will create a Survey Monkey survey to gather feedback from all participants and incorporate the data collected in the regional AAR. At the facility level, participants in the activity will complete an individual evaluation and submit the same to the facility emergency preparedness representative. The facilitator will compile the information obtained from the individual participants and submit a report via SurveyMonkey and be prepared to discuss the same during the face-to-face After-Action meeting. Facilities impacted are asked to create their own facility-based AAR and provide a copy to the region.

## Recovery/Return to Pre-Disaster State

Healthcare facilities and the coalition must work together to restore the regional healthcare delivery system quickly to meet the needs of the public. Individual healthcare facilities are required to have an emergency operation plan with an accompanying continuity of operations plan.

The role of the coalition in response depends on the size and scope of the disaster. The coalition may:

* Facilitate communication with regional and state partners.
* EMS assistance with transportation coordination
* Communicating diversion and capacity to EMS providers
* Share resources to aid in the recovery process
* Work with local EM officials, as necessary
* Aid in the regional patient tracking process
* Restore the regional cache as applicable to ensure its availability for future responses.

# Administrative Support

The WCMHPC Regional Staff are responsible for managing and maintaining the Organizational and Emergency Operations Plan, along with its associated appendices and annexes. These documents will be reviewed and updated, as needed, annually, or as needed related to lessons learned or updated guidance/principles. The review of the Response Plan, specifically, will be conducted during the first quarter of each grant period. Utilizing lessons learned in responses and training as well as adapting to ASPR grant guidelines, any changes to the plan will require the approval of the coalition advisory committee. All revisions and changes will be tracked utilizing the table at the beginning of this document. The plan will be distributed to all members as well as be posted on the coalition website.

# Key Contacts

## 24/7 Emergency Contact

The 24/7 Emergency contact phone is housed at Saint Cloud Hospital and is answered 24 hours a day.

The number is **(320) 654-2720.**

## Regional Contacts

|  |  |  |  |
| --- | --- | --- | --- |
| **HPP Leadership** | | | |
| **Name** | **Position** | **Email** | **Phone number** |
| Shawn Stoen | Program Manager | [Shawn.stoen@centracare.com](mailto:Shawn.stoen@centracare.com) | 320-760-3513  320-654-2720 (24/7 number) |
| Cheyenne Orcutt | Director of Emergency Preparedness | [orcuttc@centracare.com](mailto:orcuttc@centracare.com) | 320-251-2700  Ext. 70837 |
| Phil Luitjens | VP of Acute Care | [juitjensp@centracare.com](mailto:juitjensp@centracare.com) | 320-251-2700  Ext. 54248 |
| **HCC Staff** | | | |
| Michelle Reents | WC RHPC | michelle.reents@centracare.com | 320-424-0177 |
| David Miller | Exercise & Training Coord | [millerdave@centracare.com](mailto:millerdave@centracare.com) | 320-251-2700  Ext. 53045 |
| Katrina Hennen | Central RHPC | [hennenkat@centracare.com](mailto:hennenkat@centracare.com) | 320-292-6036 |
| Amy Card | Northwest RHPC | [amy.card@sanfordhealth.org](mailto:amy.card@sanfordhealth.org) | 218-333-5918 |
| **West Central EMS** | | | |
| Mark McCabe | Executive Director | [wcmnems@gctel.com](mailto:wcmnems@gctel.com) | 320-760-1596 |
| **West Central Public Health Preparedness Consultant** | | | |
| Michelle Moritz | PHPC | [Michelle.moritz@state.mn.us](mailto:Michelle.moritz@state.mn.us) |  |

## Hazardous Waste Contacts

* County Hazardous Waste Offices
  + **West Central Region:**
    - **Clay County:** 218-299-5077
    - **Douglas County:** 320-763-9340
    - **Grant County:** 218-685-8225
    - **Otter Tail County:** 218-998-8909
    - **Pope County:** 320-763-9340
    - **Stevens County:** 320-208-6558
    - **Traverse County:** 320-422-7726
    - **Wilkin County:** 218-643-5815
  + **Metro Region**
    - **Anoka County:** 763-422-7093
    - **Carver County:** 952-361-1800
    - **Dakota County:** 952-891-7557
    - **Hennepin County:** 612-348-3777
    - **Ramsey County:** 651-266-1199
    - **Scott County:** 952-496-8177
    - **Washington County:** 651-430-6655
* **Minnesota Pollution Control Agency**
  + **Toll-free:** 800-657-3864
  + **Brainerd:** 218-828-2492
  + **Detroit Lakes:** 218-847-1519
  + **Duluth:** 218-723-4660
  + **Mankato**: 507-389-5977
  + **Marshall:** 507-537-7146
  + **Rochester:** 507-285-7343
  + **St. Paul:** 651-296-6300
  + **Willmar:** 320-214-3786

# Acronyms and Abbreviations

|  |  |
| --- | --- |
| Acronym/Abbreviation | Definition |
| AAR | After-Action Report |
| ABLS | Advanced Burn Life Support |
| ACHC | Accreditation Commission for Health Care |
| ACS | Alternate Care Site |
| ADA | Americans with Disabilities Act |
| AFN | Access and Functional Needs |
| ALS | Advanced Life Support |
| ARMER | Allied Radio Matrix for Emergency Response |
| ARS | Acute Radiation Syndrome |
| ASPR | Administration for Strategic Preparedness and Response |
| BLS | Basic Life Support |
| C4 | Statewide Healthcare Coordination Center – Critical Care Coordination Center |
| CACS | Community-Based Alternate Care Sites |
| CBRNE | Chemical, Biological, Radiological, Nuclear, and high yield Explosives |
| CDC | Centers for Disease Control and Prevention |
| CHB | Community Health Board |
| CI | Critical infrastructure |
| CLIA | Clinical Laboratory Improvement Amendments |
| CMHPC | Central Minnesota Health Preparedness Coalition |
| CMS | Centers for Medicare and Medical Services |
| CRT | Coalition Response Team |
| DOC | Department Operations Center |
| DOT | Department of Transportation |
| EAST | Exposure and Symptom Triage |
| EEI | Essential elements of information |
| EM | Emergency management |
| EMS | Emergency medical services |
| EMSRB | Emergency Medical Service Regulatory Board |
| EMTALA | Emergency Medical Treatment and Labor Act |
| EOC | Emergency operations center |
| EOP | Emergency operations plan |
| EPA | Environmental Protection Agency |
| EPR | Emergency Preparedness and Response |
| FAC | Family Assistance Center |
| FDA | Federal Drug Administration |
| FEMA | Federal Emergency Management Agency |
| FRC | Family Reunification Center |
| FRMAC | Federal Radiological Monitoring and Assessment Center |
| GETS | Government Emergency Telecommunications Service |
| GLHP | Great Lakes Healthcare Partnership |
| HACS | Hospital-Based Alternate Care Sites |
| HAN | Health Alert Network |
| HCMC | Hennepin County Medical Center |
| HEPA | High Efficiency Particulate Air (Filter) |
| HERT | Hospital Emergency Response Team |
| HFAP | Healthcare Facilities Accreditation Program |
| HHS | Department of Health and Human Services |
| HICS | Hospital Incident Command System |
| HIPAA | Health Insurance Portability and Accountability Act |
| HMAC | Healthcare Multi-Agency Coordination |
| HMR | Hazardous Materials Regulation |
| HPP | Hospital Preparedness Program |
| HVA | Hazard Vulnerability Analysis |
| ICU | Intensive Care Unit |
| IDEPC | Infectious Disease, Epidemiology, Prevention, and Control Division |
| INES | International Nuclear and Radiological Event Scale |
| IP | Improvement Plan |
| IPP | Integrated Preparedness Plan |
| KR | Key Resources |
| LPH | Local public health |
| MAC | Multi-agency coordination center |
| MCM | Medical Countermeasures |
| MDH | Minnesota Department of Health |
| MEDSS | Minnesota Electronic Disease Surveillance System |
| MFI | Mass fatality incident |
| MNHCC | Minnesota Healthcare Coalition Collaborative |
| MN-MMT | Minnesota Mobile Medical Team |
| MNTrac | Minnesota System for Tracking Resources, Alerts, and Communication |
| MOA | Memorandum of Agreement |
| MOU | Memorandum of Understanding |
| MRC | Medical Reserve Corps |
| MREV | Minnesota Radiation Emergency Volunteers |
| NDMS | National Disaster Medical System |
| NHICS | Nursing Home Incident Command System |
| NIMS | National Incident Management System |
| NRC | Nuclear Regulatory Commission |
| OSHA | Occupational Safety and Health Administration |
| PAPR | Powered Air Purifying Respirator |
| PHI | Protected Health Information |
| PHPC | Public Health Preparedness Consultant |
| PHS | Public Health Service |
| PIO | Public Information Officer |
| POD | Point of Dispensing |
| POTS | Plain Old Telephone Service |
| PPE | Personal protective equipment |
| PSAP | Public Safety Answering Point |
| PUI | Patient Under Investigation |
| RCRA | Resource Conservation and Recovery Act |
| RDD | Radiological Dispersal Device |
| RED | Radiation Exposure Device |
| REMM | Radiation Emergency Medical Management |
| RHPC | Regional Health Care Preparedness Coordinator |
| RITN | Radiation Injury Treatment Network |
| RMOCC | Region Medical Operations Coordination Cell |
| SCCM | Society of Critical Care Medicine |
| SCH | St. Cloud Hospital |
| SCPC | State Coordinating Pediatric Trauma Center |
| SHCC | Statewide Healthcare Coordination Center |
| SME | Subject matter expert |
| SNF | Skilled nursing facility |
| TJC | The Joint Commission |
| UN | United Nations |
| VOAD | Volunteer Organization Active in Disasters |
| VPN | Virtual Private Network |
| WC | West Central |
| WCHMAC | West Central Health Multi-Agency Coordination Center |
| WCMHPC | West Central Minnesota Healthcare Preparedness Coalition |
| WHO | World Health Organization |
| WPS | Wireless Priority Service |

# Important Definitions

|  |  |
| --- | --- |
| **Term** | **Definition** |
| Access and Functional Needs | People with physical, developmental, or intellectual disabilities that may interfere with their ability to access or receive medical care before, during, or after a disaster or emergency. Irrespective of specific diagnosis, status, or label, the term “AFN” is a broad set of common, crosscutting, access, and function-based needs.  Access-based needs require ensuring that resources are accessible to all individuals, such as social services, accommodations, information, transportation, medications to maintain health, and so on.  Function-based needs refer to restrictions or limitations an individual may have that requires assistance before, during, and/or after a disaster or public health emergency.  Included in this group are people who are physically or mentally disabled (e.g. blind, deaf, hard of hearing, have learning disabilities, mental illness or mobility limitations), people with limited English language skills, geographically or culturally isolated people, homeless people, senior citizens, and children |
| After Action Report | A summary document of the strengths and opportunities for improvement of an exercise or significant incident delineating specific improvement actions and responsibilities. |
| After Action Review | A formal and documented debriefing of response actions that occurred during an emergency exercise or a significant incident. A facilitator in a sequential fashion to capture the strengths and areas for improvement from the involved departments/agencies/organizations coordinates the discussions. The comments from the review are incorporated into the AAR. |
| Clinical & Business Continuity | The ability of a healthcare organization to provide clinical services and support for its customers and to maintain its viability before, during, and after an incident. |
| “Closed” Status | “Closed” refers to hospitals that are unable to accept ambulance patients because patient care demands in the emergency department or in-house exceed available resources. In the case of trauma-receiving hospitals, closed status may also apply to the lack of available surgical resources for major trauma. |
| Communities Most Impacted by Disasters | Per the 2024 NOFO, ASPR defines “communities most impacted by disasters” as being inclusive of the following:   * At-Risk Individuals, including children, pregnant individuals, older adults, individuals with disabilities, or others who may have access and functional needs in the event of an emergency, such as those with chronic physical or behavioral health conditions or immunocompromised individuals. Individuals may also be at risk due to their geographic location and/or limited access to health care, such as those in rural, frontier, or otherwise isolated areas. * Individuals and groups who may be at risk due to the specific risk profile of a disaster or emergency. * Populations experiencing structural inequities, which include historically and currently marginalized communities. * Other populations disproportionately impacted by disasters in your jurisdiction, identified through data collection or assessments. |
| Continuity of Operations | Ensuring Primary Mission Critical Functions continue to be performed during an emergency or disaster incident. |
| Disaster | A type of incident that, due to its complexity, scope, or duration, threatens a Work Area or the organization’s capabilities and requires assistance beyond what is routinely and readily available to sustain patient care, safety, or security functions. A disaster requires activation of an organizational coordination center or community EOC to coordinate response or recovery activities. |
| Emergency | An unexpected or sudden incident that significantly disrupts a department/organization’s ability to perform its primary mission but is manageable with routinely and readily available resources. An emergency does not require activation of an organizational coordination center/operations center or community EOC to coordinate response and recovery activities. |
| Essential Supporting Activities (ESA) | Enablers/actions that make it possible for the healthcare sector to perform its essential services. ESA might be essential or deferrable. |
| Diversion | The re-direction of an ambulance from the intended receiving facility to an alternate receiving facility due to the critical condition of the patient, extreme environmental conditions, disaster, or due to a temporary lack of critical resources at the facility. |
| Foundational Dependencies | A system of critical non-medical elements that are considered essential infrastructure. |
| Health Equity | The CDC defines Health Equity as the state in which everyone has a fair and just opportunity to attain their highest level of health. Achieving this requires focused and ongoing societal efforts to address historical and contemporary injustices; overcome economic, social, and other obstacles to health and healthcare; and eliminate preventable health disparities |
| Hospital | All hospitals within the WC region including:   * Alomere Health * Glacial Ridge Health System * Lake Region Health * Perham Health * Prairie Ridge Health * St. Francis Health * Sanford Health – Wheaton * Stevens Community Medical Center |
| Hospital Resource Tracking System (MNTrac) | The internet-based hospital tracking system used in the region for entering and monitoring hospital open, divert, and closed status and for bed availability. |
| Mission Critical Function | Any process necessary for the department to achieve its primary purpose (e.g., registration, billing); Service Level (e.g., Department, Division); Defined through Business Impact Assessment (BIA) Note: A non-essential service will have mission critical functions. |
| Multi-Agency Coordination Center | In the event of an emergency the WCMHPC will activate the MACC to facilitate situational awareness, patient tracking, resource matching, communications, and coordination among regional healthcare providers and partner agencies. |
| “Open” Status | “Open" refers to hospitals that are able to accept all categories and types of patients brought by ambulance to their emergency department. |
| Patient | An individual who requires assessment and/or treatment because of their involvement in an incident as defined by local plans |
| Patient Tracking | The process for documenting and following information about a patient including the patient’s physical location and other limited information about the patient such as condition, disposition, and patient identifying information. |
| Special Medical Needs | A person with medical special needs includes someone who:   * would need assistance during evacuation and sheltering because of physical or mental disabilities * requires the level of care and resources beyond the basic first aid level of care that is available in the shelters for the general populations |
| Unusual Conditions | Heavy snow, ice storms, tornadoes, civil unrest, or other unusual conditions may prevent ambulance crews from transporting patients to their hospital of choice. The ambulance service supervisor will initially authorize ambulance crews to transport patients to the closest appropriate hospital or stand-alone ED. |