

Southeast Wyoming Healthcare Coalition Response Plan

Southeast Wyoming Healthcare Coalition

Serving the citizens of Albany, Goshen, Laramie and Platte Counties



WYOMING
HEALTHCARE
PREPAREDNESS

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Annexes

All Annexes are provided as separate documents due to their individual size

Burn Annex

Chemical Annex

Infectious Disease Annex

Pediatric Annex

Radiation Annex

Record of Changes and Distribution

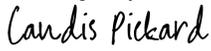
The following changes and revisions have been made to this plan since its creation and adoption in July of 2024.

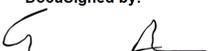
Revision/Modification	Revised by:	Revised date:	Notes:	Distributed to Coalition (Y/N)
	Jeanine West	7/15/2024	<ul style="list-style-type: none"> Update Signature Page Sent to all Board members and Clinical Advisor for review 	Y
3.5.1			Added type of agencies instead of names of individuals	Y

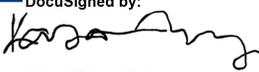
Signatures and Endorsements

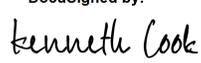
This Response Plan and it's Annexes will be reviewed annually during the **first fiscal quarter** and revised to reflect changes in regulatory/funding requirements, best practices and emerging needs, and improvements identified in exercises, real-life events, etc. By affixing the signatures indicated below, this plan, and it's Annexes, are hereby approved for implementation and intended to supersede all previous versions. This plan was established to promote a system to: save lives; protect the health and ensure the safety of our communities; alleviate damage and hardship; and reduce future vulnerability. Further, this document indicates a commitment to annual planning, training, and exercise activities to ensure the appropriate level of preparedness exists within our healthcare coalition to effectively respond to emergencies or incidents across our communities.

Date Last Reviewed: (July 2024)

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1. Introduction

1.1 Purpose of Plan

The purpose of this plan is to provide general guidance for preparation, response, and recovery to all hazards events that threaten the healthcare system and that result in illness or injury to the population within the coalition's boundaries and the healthcare system.

1.2 Scope

This plan applies to all member organizations when an event occurs that is beyond the individual healthcare organization's ability to manage the response and is limited to those compacts and other documents signed by coalition members. This plan enhances and does not supersede or conflict with applicable laws and statutes.

Contact information for coalition members is maintained by the coalition coordinator and can be made available if needed. It is not included in this Plan.

1.3 Situation and Assumptions

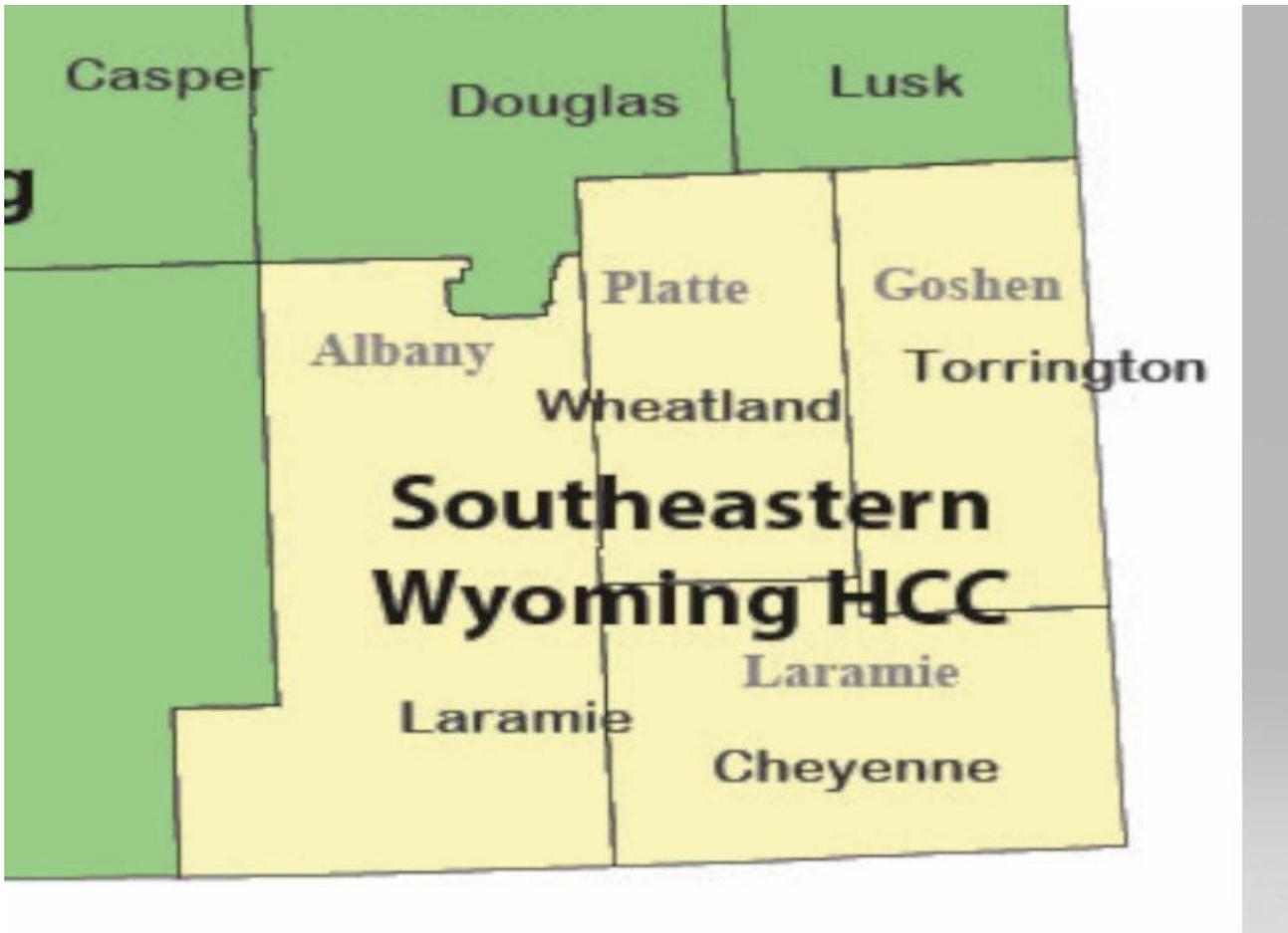
The following assumptions have been accepted by the coalition; many were noted in the preparedness plan and others were added when this response plan was created:

- Preparedness efforts are based on events that are most likely to occur and/or those that will be the most impactful to operations (from the annual hazard and vulnerability assessment). However, as it is impossible to determine exactly which emergency will occur, activities are based on an "all hazards" approach and a generalized response framework.
- Most emergencies will occur with little or no warning. Events can range from those that impact only a single healthcare organization, to those that disrupt healthcare services (and/or other activities) across the community, state, nation, and world.
- Basic services, including electrical, water, natural gas, heat, telecommunications, and information systems may be interrupted during these emergencies and may disrupt the coalition's (and other healthcare providers') ability to operate.
- Buildings and other structures may be damaged by natural disasters, man-made events, etc. and this may cause the immediate evacuation of a healthcare facility and result in a surge.
- Certain portions of the population are particularly at risk to communicable disease and/or other events due to health issues, limited access to healthcare, and other quality of life resources.
- In emergency response situations, we may have trouble communicating operational changes with coalition partners.
- Normal operating procedures, often conducted by and between healthcare entities without government involvement, may become overburdened to such an extent that external support is required.

- Normal suppliers may not be able to deliver goods, coalition partners may limit or cease operations, and external disruptions may impact coalition members' ability to operate.
- In most emergencies, coalition members will rely on the support of other member agencies such as police, fire, EMS, public health, and other healthcare entities, vendors, the community, etc. To successfully achieve this coordination, the coalition will focus on activities that grow relationships, mutually supportive response practices, etc. These relationships will be established through healthcare coalition activities (meetings, trainings, drills, exercises, and improvement initiatives) and member partnerships within their jurisdiction.
- In some situations, when significant disruptions occur to the healthcare system (surge events, loss of health facilities, etc.) members will be required to operate outside of their normally established corporate entities, operational models, etc.
- The coalition, its members, and other responding groups will comply with federal, state, local, and regulatory laws/requirements during all preparedness, response, and recovery efforts. This may include operating under crisis/altered standards of care as prescribed by emergency declarations and orders. These modified practices will be approved only by government and/or organizational leadership, and the healthcare coalition does not have the legal authority to approve these altered processes.
- Local resources will be used first, and then State resources, followed by a Federal request as needed, however State and Federal resources may not be available for 72-96 hours. Under some circumstances, State, and possibly Federal, resources may be staged closer to an impact area to avoid delays.
- The increased number of area residents and staff needing medical help may burden and/or overcome the health and medical infrastructure. This increase in demand may require a regionally coordinated response and/or subsequent city, county, state, and/or federal level of assistance.
- Facilities will communicate their medical needs to the ESF-8 coordinator.
- Healthcare organizations will take internal steps to increase patient capacity and implement surge plans before requesting outside assistance.
- Processes and procedures outlined in the response plan are designed to support and not supplant individual healthcare organization emergency response efforts.
- The use of National Incident Management System (NIMS) consistent processes and procedures by the Coalition will promote integration with public sector response efforts.
- Except in unusual circumstances, individual private healthcare organizations retain their respective decision-making sovereignty during emergencies.

In summary, as was noted in the National Standards for State, Local, Tribal, and Territorial Public Health report issued by the Centers for Disease Control and Prevention's Division of State and Local Readiness in October of 2018, **"During the initial response, (to an emergency) the people and communities that are impacted must rely on local community resources. As a result, all state, local, tribal, and territorial emergency response stakeholders must be prepared to coordinate, cooperate, and collaborate with cross-sector partners and organizations at all governmental levels when emergencies occur, regardless of the type, scale, or severity."**

The coalition's geographical and jurisdictional boundaries encompass four counties, Albany, Goshen, Laramie and Platte, comprising a vast area of Southeast Wyoming, covering 11,340 square miles with a population of 158,344 people which computes to a population density of 13.9 per square mile.



Within our healthcare coalition, routine healthcare is provided through the following format:

- Routine/day-to-day care is provided by physician practices, long term care facilities, home health entities, and other out-of-hospital providers in each of our 4 counties.
- Low acuity hospital patients (i.e. patients hospitalized for non-emergency needs, existing health conditions, post-operative care, etc.) are treated at critical access and other acute hospitals:
 - Cheyenne Regional Medical Center; Cheyenne, WY. Regional Trauma Center (reference ACS Level II/III) (verified ACS Level III)

- Ivinson Memorial Hospital; Laramie, WY. Community Trauma Hospital (reference ACS Level IV)
 - Platte County Memorial Hospital; Wheatland, WY. Trauma Receiving Facility
 - Community Hospital; Torrington, WY. Trauma Receiving Facility (Provisional)
-
- Medium acuity hospital patients are generally treated at the sites listed above or sent to Cheyenne Regional Medical Center; Cheyenne, WY or Ivinson Memorial Hospital; Laramie, WY
 - High acuity patients are generally treated at Cheyenne Regional Medical Center or sent to facilities in Fort Collins, CO; Casper, WY; Scotts Bluff, NE; Denver, CO; Greeley, CO.
 - Pediatric high acuity patients are sent to Denver, CO.
 - Burn patients are sent to the Northern Colorado Burn Center, Greeley, CO.
 - Several areas of the coalition operate volunteer EMS agencies with EMT-B/I service providers. Cheyenne, Laramie and Torrington are the primary cities that provide advanced life support (ALS) EMS services.

During response to an emergency, the hospitals that provide service to the region will rely on their individual emergency operations and response plans, copies of which have been provided to the Coalition and reviewed as part of the creation of this plan. As part of their trauma certifications those hospitals have mutual aid agreements to facilitate resource support and to assist with the acquisition and distribution of aid. The coalition, as a consultative entity, will mobilize any of its available resources to support the hospitals where possible. In the event of an emergency, either the ESF 8, or representatives of the affected hospital or the Coalition's coordinator will be asked to survey nearby facilities for space availability.

Tracking of hospital patients will be accomplished using the statewide online Hospital Available Beds for Emergencies and Disasters (HAVBED) system, which is designed for use by hospitals and EMS agencies to share information on hospital bed and ambulance availability. The HAVBED system is tested quarterly.

Strategies for initial patient distribution or redistribution among the hospitals across the region will be coordinated between the hospitals and EMS agencies. An insufficient number of ambulances exist

to respond to a mass evacuation requirement. Other means will need to be used to evacuate patients, such as school buses or vans.

Encompassed in these geographical, jurisdictional, and operational considerations are the following unique considerations, patient needs, etc. included in the scope of this preparedness plan and the activities of the coalition.

- The first is the relationship between our coalition and Warren Air Force Base. As our coalition offers the primary medical capacity in the area, and staff from Warren AFB travel throughout Wyoming servicing federal and DOD installations, we must include considerations for these potential patients in an emergency.
- Secondly, our coalition does operate one of two major acute healthcare treatment facilities in the state (Cheyenne Regional Medical Center). As such, our coalition frequently receives patients from rural areas in Wyoming for medium to higher acuity treatment needs.

There is seasonal influx of dormitory students at the University of Wyoming, Eastern Wyoming college and Laramie County community college.

The Southeast Wyoming Healthcare Coalition conducts an annual Hazard Vulnerability Assessment (HVA) and the findings of that assessment inform and guide the group's planning processes, including the details of this plan. The complete HVA may be found in Appendix 3.2.

The geographic area covered by the Coalition creates special challenges for patient transport. Individual facilities within the coalition will activate their response plans. Facilities are encouraged to develop mass evacuation planning in two parts; taking into consideration both normal seasonal conditions as well as serious threatening weather. For a mass evacuation during inclement weather, the affected emergency management agency may elect to contact the governor to seek National Guard support to evacuate patients by air.

1.4 Administrative Support

This plan is managed by the Southeast Wyoming Healthcare Coalition and has been reviewed and approved by the members of the coalition, which meets quarterly. The plan will be reviewed annually by vote of the full coalition. Should there be a need to update the plan more frequently, such update may be undertaken by the coalition's Steering Committee, which meets quarterly.

Concept of Operations

2.1 Introduction

The process outlined below describes the basic flow of a response to disaster and emergency situations with the steps and the activities that may need to be accomplished. Not all steps and activities will apply to all hazards.

2.2 Role of the Coalition in Regional Events

The overall role of the coalition in response to an emergency event or disaster includes, but is not limited to the following:

- Promoting common operating picture through shared information
- Assisting with resource management between partner entities, particularly within the healthcare sector for healthcare resources to support patient tracking
- Supporting evacuation activities
- Supporting Shelter-in-Place activities
- Collaboration with the local ESF-8 and serving as the intermediary for healthcare and information sharing

2.2.1 Member Roles and Responsibilities

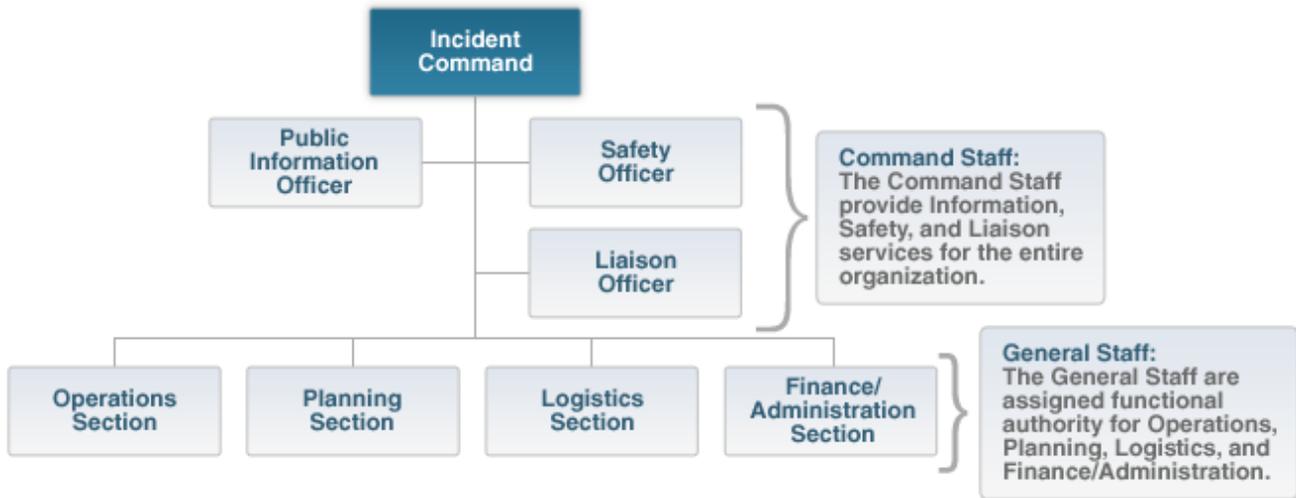
The following provides a general overview of the roles and responsibilities of the partner agencies and organizations during a response. More detailed roles and responsibilities are defined under the functional areas of the Plan.

- **Hospitals** – The region’s four hospitals will be responsible for providing primary medical care during and following an emergency. They will be expected to rely on existing mutual aid agreements to respond to patient surges and should use the statewide HAvBED system to update their situations and bed availabilities.
- **Emergency Medical Services (EMS)** – Emergency Medical Services play a wide variety of roles within the work of the healthcare coalition. During a mass casualty event it may serve as Incident Commander, Triage Team Leader Transportation Team Leader and Treatment Team Leader.
- **Emergency Management** – The region’s Emergency Management agencies will provide crucial support to response efforts by making available communications and consultative guidance.
- **Public Health** – Public health representatives from the four counties will serve as ESF-8 lead and will be responsible for guiding ESF-8 efforts.

- **Other member entities** – Other members of the coalition will support response efforts as possible.

2.2.2 Coalition Response Organizational Structure

In the event of an emergency, the coalition will rely on the organizational structure of the National Incident Management System (NIMS) as shown below:



The public health representative from the affected county will offer representation within the Incident Command structure as determined by the Incident Commander. Other members of the coalition or support agencies will consult with and cooperate initially on the county level and then on the coalition level to support operations, planning, logistics and finance/administration. While each of the general staff positions are important, there is no expectation that all or any will be filled full-time during a response, or that involvement will be limited to coalition members.

2.3 Response Operations

The coalition meets regularly and conducts periodic exercises to review and refine its preparedness and response planning. It is through these meetings and advanced planning that members assure proper response will be possible in the event of an emergency.

All emergencies begin locally, and while they may escalate quickly, it is most likely initial information will come from local law enforcement, fire or other first responder authorities, who will promptly notify the appropriate public health, ESF-8 and emergency management officials in their county. If appropriate, the ESF-8 may contact the coalition’s coordinator to assist as needed.

Using the NIMS organizational structure, the ESF-8 lead, working with county response partners, will begin the process of assessing the situation and determine what steps need to be taken. (Actions

could include widespread public notice, evacuation or shelter-in-place plans.) Management of the process will continue with expanded, static or diminished participation as appropriate.

2.3.1 Stages of Incident Response

The stages of incident response are:

- Incident Recognition
- Notification
- Mobilization
- Operations and Demobilization
- Recovery/Return to Pre-Disaster State

Maintenance of the response will continue throughout the time required until the incident commander and command staff determine entering demobilization and recovery phase.

2.3.1.1 Incident Recognition

There are multiple ways an incident may be identified and a request for coalition response issued. These include:

- A request to activate or monitor a situation made by a coalition member or partner, such as local emergency management, EMS, hospital, long term care or local public health agency
- Multi-jurisdictional incident or disease outbreak
- Awareness from traditional or social media or notification from local, state or federal entities
- Weather-related prognoses for blizzard, potential flooding or extremely low temperatures

2.3.1.2 Initial Notice

Initial notice of a potential emergency will likely be from local authorities. The coalition coordinator and other members of the coalition will undertake a series of telephone calls to assess the damage and potential effects of the event to plan for coordinate support of the response. The coordinator will be expected to communicate with state authorities. This role of role of upward communication may be made directly or as assigned by the coordinator to a member serving as liaison officer.

2.3.1.3 Activation

In case of an emergency, the coalition coordinator will be contacted by telephone and will reach out to the coalition's steering committee to schedule a conference call with members of the steering committee and other affected entities as appropriate. The results of that call will be a

decision whether activation is required, and if so, what level of activation is appropriate, and what additional steps are necessary. The Coalition's role is strictly consultative.

2.3.1.3 Notifications

The coalition coordinator or designee will consult with the local ESF-8 and if necessary, begin the process of notifying all coalition members using the WARN system, which is regularly tested.

The initial notice may be as brief as: ***"Hospital flooded in HS County, all coalition members please text to confirm availability for response situation. ESF-8 in your county will be notified of your availability. You will be contacted to coordinate response role."***

Notification of activation should include details of the event requiring activation, scope of the emergency, entities affected and agencies that are responding. If possible, follow up notifications should include the roles and responsibilities that are required to be filled and include a process for recipients to confirm their availability to provide support.

2.3.1.4 Mobilization

The Southeast Wyoming Healthcare Coalition will rely on the use of a virtual command center to maintain communications and provide coordination between the various members that comprise the coalition, including public health, emergency management, EMS and hospitals.

2.3.1.5 Incident Operations

In the event of an incident requiring response by the coalition, actions outlined in Section 2.2 above will be followed, including the reliance upon the NIMS structure described in Section 2.2.2. A virtual command center will be activated by the coalition members to ensure it is properly conducting incident action planning, resource coordination, information sharing and supporting real-time coalition-wide patient and / or bed tracking.

A regional situational awareness baseline document may be found at Annex 3.7 and may be used to query hospitals in the event of an emergency to determine their ability to deal with patient surge issues. The document's questions may be altered slightly for use with long-term care facilities for similar purposes. The survey of healthcare providers should be conducted periodically (every eight or 12 hours as appropriate) by the coalition coordinator or other assigned staffer, the results compiled and provided to the ESF-8 lead on a regular basis. Special attention shall be given to changes that significantly affect a provider's ability to serve its patients and those needing care.

2.3.1.5.1 Initial Healthcare Coalition Actions

Once activated, the coalition operating as a support team will work together virtually to gather information and distribute it to its members and other support agencies. The goal will be to assure timely and comprehensive information gathering, situational assessment to support development of initial incident action plans.

2.3.1.5.2 Ongoing Coalition Actions

Coalition members, led by the coordinator and members of the coalition's steering committee, will continue to support the response efforts of its members by maintaining and expanding its points of contact with local, regional, and state partners. It will also serve as a regular source of information on the response status and to support the incident command structure already in place.

2.3.1.5.3 Information Sharing

The Southeast Wyoming Healthcare Coalition will serve as a consultation agency within and among its members to support a JIC.

2.3.1.5.4 Resource Coordination

To coordinate the sharing and acquisition of resources during a response, the coalition will rely on its virtual command center to maintain regular contact with its members and potential providers of needed equipment and services. The strategies for initial patient distribution (or redistribution) across the region, among local hospitals in the event a facility becomes overwhelmed, will be hospital and EMS focused, with the coalition serving as a consultative coordinator, but not a manager of the response.

Inventory management will not be the responsibility of the coalition; instead those efforts will be undertaken by the individual members.

2.3.1.5.5 Patient Tracking

Patient tracking of transfers both inside and outside the coalition's borders is an important function. During the response to a disaster it will be important for hospitals to maintain a regular reporting protocol.

2.3.1.6 Demobilization

During an event, the leadership of the coalition, including the coordinator, the steering committee and other affected members, will be expected to regularly monitor the status of the response and determine if and when efforts should be de-escalated from fully-activated to limited activation, to monitoring and eventually to complete stand-down. Those decisions will be made jointly

with ESF-8 leadership from the affected community, appropriate hospital officials and state and federal agencies involved in the response.

If the coalition has participated in the creation of temporary facilities it will be required to assure proper deactivation and the return to normal state for those facilities.

An After-Action Review-Improvement Plan should be started soon after the completion of the demobilization and should honestly cover all actions taken by the members of the coalition.

Feedback for the AAR-IP will be gathered from leadership and the demobilization staff and integrated into a comprehensive post-event evaluation process. A formal AAR-IP should be anticipated and begun before it is requested.

2.3.1.7 Recovery/ Return to Pre-Disaster State

The healthcare coalition will maintain its role as a consultative coordinator, and not as the agency tasked with recovery / return.

2.4 Continuity of Operations

The coalition's role as a consultative entity relies on its ability to provide support for backup communication and coordination. Its limited staffing means sharing and delegation of responsibilities during an event are essential. If the coordinator is not available leadership of the coalition will fall to members of the steering committee, presuming they are available to assume the role. (Steering committee members are all professionals in their agencies and may be required to focus on their primary responsibilities and therefore unable to provide the leadership required for the coalition. In that case, members of the coalition who are able to support its response may be thrust into leadership roles.)

3 Appendices/Annexes

3.1 Contact Information

Contact information for coalition members is maintained by the coalition coordinator and may be accessed if needed by contacting the coordinator.

3.2 HVA

A copy of the most recent HVA may be found *****

3.3 Coalition Coordination Job/Aids/Position Descriptions

The coalition has no full-time staff members, and in the event of an emergency the part-time coordinator will work to mobilize coalition members and resources as appropriate. Therefore, no job aids or position descriptions currently exist.

3.4 Medical Surge Coordination

(Note: The following guidelines are based on *2017-2022 Health Care Preparedness and Response Capabilities*, which was produced by the Assistant Secretary for Preparedness and Response.)

Health care providers -- including hospitals, EMS, and out of-hospital providers – are expected to deliver timely and efficient care to their patients even when the demand for health care services exceeds available supply. The coalition, in collaboration with the ESF-8 lead agency, will support information sharing and allocation of available resources for its members to maintain surge response. (From *2017-2022 Health Care Preparedness and Response Capabilities*.) When an emergency overwhelms its collective resources, the coalition will support the healthcare delivery systems' transition to contingency and crisis surge response and promote a timely return to conventional standards of care as soon as possible.

A key element of medical surge coordination is the development of information collection and sharing procedures, and Individual coalition members should be able to easily access and collect timely, relevant, and actionable information about their own organizations and share it with the coalition. In the event of an emergency that requires mobilization/activation of the response plan, the coalition coordinator or a designee will be tasked with contacting the six hospitals in the region and recording a capacity baseline, using the Regional Situational Awareness Baseline Questions found in Annex 3.7. Communication will likely be accomplished by telephone or electronic conference applications, such as Video Conferencing.

FEMA considers important and standard information items needed to make timely and informed decisions “Essential Elements of Information (EEIs)” and for the purposes of this plan, the following information is considered part of the EEI, which provide context and contribute to analysis. EEIs are also included in situation reports. The collection and analysis of EEIs provides what is called a “Common Operating Picture.”

For the purposes of this plan, the following will be considered EEIs, to be collected and maintained by the Incident Command Team, with input from the coalition, specifically dealing with healthcare resources:

- Physical Boundaries of Emergency
- Status of Community Infrastructure (Road closures, power outages etc.)

- Status of Response Infrastructure (Police, fire, EMTs)
- Weather and Environmental Concerns (Flooding, blizzard, fire)
- Healthcare Resources (Including Immediate Bed Availability, available land and air ambulances, number of patients being treated as a result of the emergency, severity and types of illnesses or injuries, operating status, resource needs and requests, etc.)

The results of that survey will be assembled by the command staff and provided to the Incident Commander. The frequency of updates will be jointly determined by the IC and staff, generally every eight or 12 hours, to coincide with the IC’s schedule of command meetings. Based on that schedule, those collecting the information should plan to begin the process at least one hour before the information is needed by the commander, in order to allow for enough time to collect and assemble the information. (The coalition coordinator may determine that regular communication with healthcare providers will not be required, unless significant changes are experienced, in which case those changes should be reported immediately.)

All communications are expected to be conducted by telephone, unless alternate methods, such as email, are deemed preferable. This means primary, secondary and tertiary contact information for each healthcare provider should be maintained by the coalition.

Patient tracking shall not be the responsibility of the coalition, but rather falls to the hospitals involved in transfers. (The coalition will not require access to Electronic Health Records, so it will not need to create contingency plans to operate without that access.)

The Southeast Wyoming Healthcare Coalition is a consultative organization. It is not responsible for overseeing or coordinating evacuation of healthcare facilities and tracking of patients. Its members and their organizations will be supportive to the extent they are able. The coalition may rely on its members to provide information regarding patient space availability and transportation capabilities, but it’s modest staffing does not allow it to take a lead role in any of those aspects of an evacuation.

3.5 Coalition Membership List

3.5.1 Member Types

The following list representatives/agencies are the agencies or organizations identified as member types within the HPP Performance Measures Implementation Guidance:

- Acute Care Hospitals
- EMS (including inter-facility and other non-EMS patient transport systems)
- Emergency management organizations
- Public health agencies

- Hospitals and behavioral health services and organizations
- Community Emergency Response Team³⁴ and Medical Reserve Corps³⁵
- Dialysis centers and regional Centers for Medicare & Medicaid Services (CMS)-funded end-stage renal disease networks³⁶
- Federal facilities (e.g., U.S. Department of Veterans Affairs Medical Centers, Indian Health Service facilities, military treatment facilities)
- Home health agencies (including home and community-based services)
- Infrastructure companies (e.g., utility and communication companies)
- Jurisdictional partners, including cities, counties, and tribes
- Local chapters of health care professional organizations (e.g., medical society, professional society, hospital association)
- Local public safety agencies (e.g., law enforcement and fire services)
- Medical and device manufacturers and distributors
- Non-governmental organizations (e.g., American Red Cross, voluntary organizations active in disaster, amateur radio operators, etc.)
- Outpatient health care delivery (e.g., ambulatory care, clinics, community and tribal health centers, Federally Qualified Health Centers³⁷, urgent care centers, free standing emergency rooms, stand-alone surgery centers)
- Primary care providers, including pediatric and women's health care providers
- Public or private payers (e.g., Medicare and insurance companies)
- Schools and universities, including academic medical centers
- Skilled nursing, nursing, and long-term care facilities
- Support service providers (e.g., clinical laboratories, pharmacies, radiology, blood banks, poison control centers)
- Other (e.g., child care services, dental clinics, social work services, faith-based organizations)

3.7 Regional Situational Awareness Baseline Questions

Regional Situational Awareness Baseline Questions

CORE QUESTIONS

1. What is your facility status?
 - a. Fully functional
 - b. Partially functional
 - c. Non-functional
 - d. Unknown

2. Is your facility able to provide adequate and safe care to all patients? (Yes/No)

3. Do current patient care needs exceed your organization's normal capabilities?
 - a. No
 - b. 100-125% of normal
 - c. 125-150% of normal
 - d. >150% of normal

4. Are you experiencing staffing shortages of?
 - a. Physicians
 - b. Physician Assistants/Nurse Practitioners
 - c. Specialty Care Nurses (ICU, Critical Care, OR, ER etc.)
 - d. General Nurses (med surge, etc.)
 - e. Certified Nursing Assistants
 - f. Techs
 - g. Support Services (lab, radiology, etc.)
 - h. Non-medical staff
 - i. No shortages
 - j. Other (please describe)

5. Have you exhausted your internal surge capabilities for your organization? (Yes/No/NA)
If yes, please describe _____

6. What is your current bed availability? ***[If HAvBED is available use that to complete this information]***

Hospital Beds

Adult detox _____

Neg pressure ISO _____

- Adult ICU _____
- Adult med/surg _____
- Adult psych _____
- Burn _____
- Critical care unit _____
- Emergency department _____
- Geriatric psych _____
- Inpatient dialysis _____
- Labor & delivery _____
- NICU _____
- OR _____
- Outpatient surgery _____
- Pediatric ICU _____
- Pediatric Med/surg _____
- Pediatric Psych _____
- Psych _____
- Telemetry _____

LTC Beds

- Assisted Living _____
- Nursing Home _____
- Senior Independent Living _____

7. Do you have any current needs at this time? (Yes/No)

If Yes, please describe: _____

Infrastructure Related Incident Questions

1. Based on the current assessment, are any of the following infrastructure categories limited, damaged, or impacted in anyway? Additionally, are any of these categories limiting the ability to provide essential patient care services? (Check all that Apply)
 - a. Building/roads _
 - b. Communications/IT _
 - c. Security _
 - d. Staffing _
 - e. Supplies _
 - f. Power _
 - g. Water _
 - h. Other _
 - i. None of the above

If limiting essential patient care services, please describe the issue(s) and its impact(s):

2. How long can your facility continue to provide essential patient services in its current condition?
 - a. <24 hrs.
 - b. 24-48 hrs.
 - c. 48-72 hrs.
 - d. >72 hrs.
3. In what time frame does your facility anticipate requiring outside assistance in order to provide essential patient services?

- a. <24 hrs.
- b. 24-48 hrs.
- c. 48-72 hrs.
- d. >72 hrs.

- 4. Is your facility evacuating or considering evacuation in the next 24hr? (Yes/No)
- 5. What are your estimated number of injured and deceased individuals at your facility?
 - a. # Injured_
 - b. # Deceased_
- 6. Are you experiencing members of the public using your facility for emergency shelter?
If yes, please explain _____

Disease/Surge Related Incident Questions

- 1. Is your facility currently operating to your full licensure capacity (Yes/No/NA)
- 2. Has the percent of patient seeking care increased above normal in the last 48 hrs.?
 - a. No
 - b. 100 – 125% of normal
 - c. 125 – 150% of normal
 - d. >150% or normal
 - e. NA
- 3. Is your organization using any of the following methods to manage surge? (check all that apply)
 - a. Postponing/Cancelling/Rescheduling elective/outpatient surgeries
 - b. Augmenting your nurse triage lines to support additional respiratory illness capacity
 - c. Stretching staff responsibilities
 - d. Adjusting staff hours
 - e. Expanding clinic hours *due to respiratory surge
 - f. Increasing influenza public messaging regarding when to seek medical care
 - g. Expanding to use beds in alternate areas staying within licensed bed numbers
 - h. Other, please describe _____
- 4. Has your organization experienced any of the following: (Yes/No)
 - a. Boarding in your clinic, urgent care, emergency department, or floors?
 - b. Difficulty discharging your patients out of your facility?
 - c. Difficulty with case management placement?If yes to any of the above, please describe _____
- 5. Has the wait time for receiving patient care/diagnostic tests increased at your organization? (Yes/No/NA)

If yes, how long have you been experiencing this increased wait time? _____

6. Is your facility directing incoming patients to other facilities for care? (Yes/No)

If Yes, please describe _____

3.8 Master Patient Tracking Tool

Master-Patient-Trac
king.xlsx