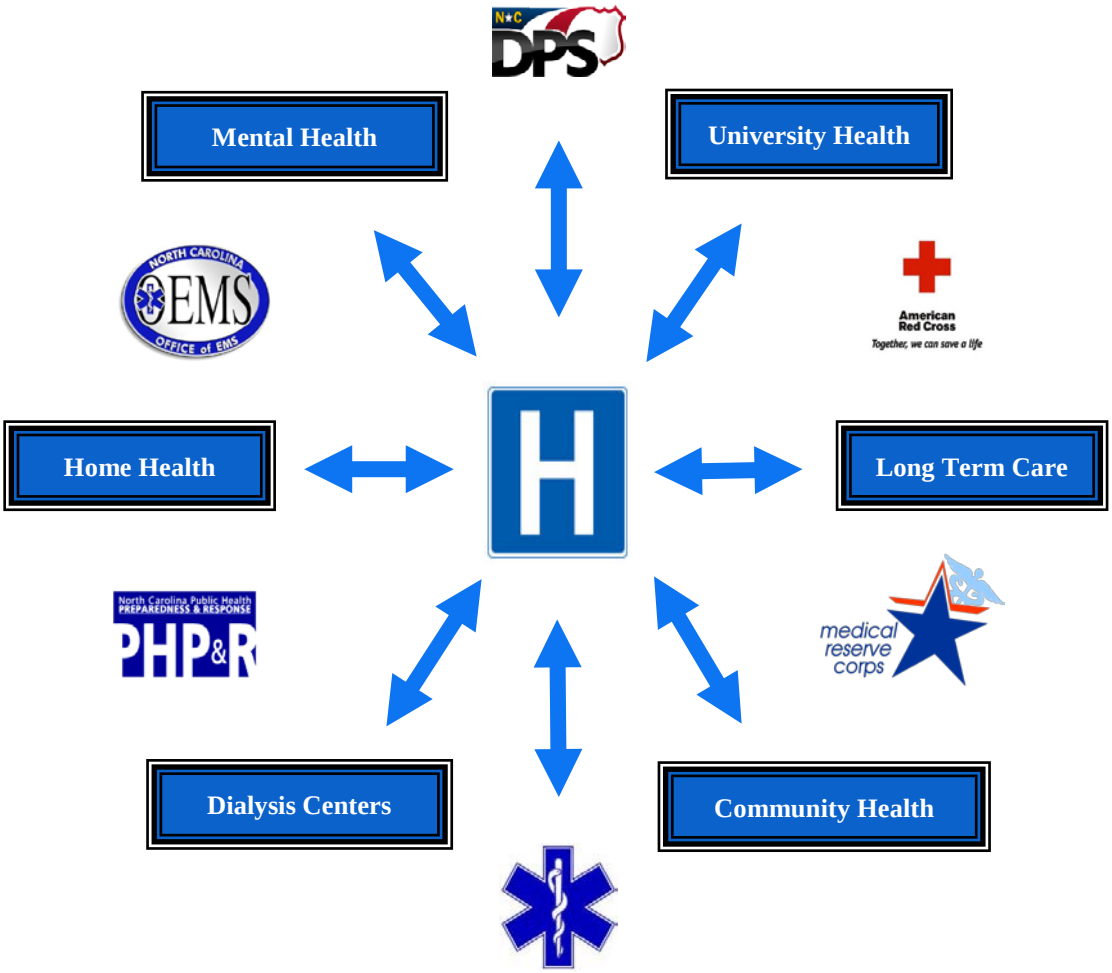


Healthcare Coalition Support Plan
NC Triangle Coalition
December 2015

Record of Evaluation and/or Revision

Date	Description	Made by
7/1/16	Updated Coalition Partner contact list	Hoffman
10/26/16	• Revision of Section IV, B • Revision of Section VII to separate demobilization from recovery and add AAR and IP to Incident Closeout.	NCTC Staff

CONTENTS

I. Introduction

A. Purpose

To provide a basic organizational structure with operational guidelines for the provision of ESF #8 support across the Healthcare Coalition. It is built upon a scalable, flexible, and adaptable coordinating structure to align key roles and responsibilities of the partners within the Healthcare Coalitions in North Carolina.

This plan is not intended to supersede any municipal, county or state emergency operation plans.

B. Approval Authority

This plan has been approved by the governing bodies of the NC Triangle Coalition, in accordance with their respective bylaws and guidelines.

II. Objective and Goals

To provide a reliable framework for healthcare partners, coalitions, and the SMRS to prepare for, respond to, and recover from, a disaster or major event. Response goals of the NC Triangle Coalition are to:

- facilitate information sharing among healthcare organizations and jurisdictional authorities to promote common situational awareness.
- facilitate resource support by expediting the mutual aid process or other resource sharing arrangements among Coalition members, and supporting the request and receipt of assistance from local, State, and Federal authorities.
- facilitate the coordination of incident response actions for the participating healthcare organizations so incident objectives, strategy, and tactics are consistent for the healthcare response.
- facilitate the interface between the Healthcare Coalition and relevant jurisdictional authorities to establish effective support for healthcare system resiliency and medical surge.

III. Concept of Operations

A. Organization

The NC Triangle Coalition is a collaborative effort among health care and emergency response agencies in the twenty-one counties in central North Carolina from the Capital, Duke and Mid Carolina regions.

B. Purpose

The purpose of the NC Triangle Coalition is to maximize the medical capacity and capabilities of the Healthcare Coalition through the support and coordination of response and recovery assets, resources, and activities.

C. Activation

Activation of this plan should be made to the local Emergency Management agency and the NC Triangle Coalition whenever a member organization anticipates or is experiencing an emergency or other event that is beyond the organization's capability/capacity to mitigate. Examples include:

- Potential or currently occurring infrastructure issue impacting the facility/agency (Examples: fire, power failure, chiller failure, phone/radio failure, etc.)
- Potential or currently occurring clinical issues that might require outside assistance (Examples: MCI/Surge, ED Closure, equipment shortages)
- Expected or unexpected opening of the organization's EOC or Command Center
- A significant event is planned which could require action on the part of the Coalition and/or its partners.
- Any issue where assistance may be needed in communicating an organization's situation to the Region/State (Examples: Situation reporting)

D. Activation Process

☐ Contact your respective local (county) Emergency Management staff (see Attachment 1D)

☐ Contact your respective Healthcare Preparedness Coalition staff (see Attachment 1C)

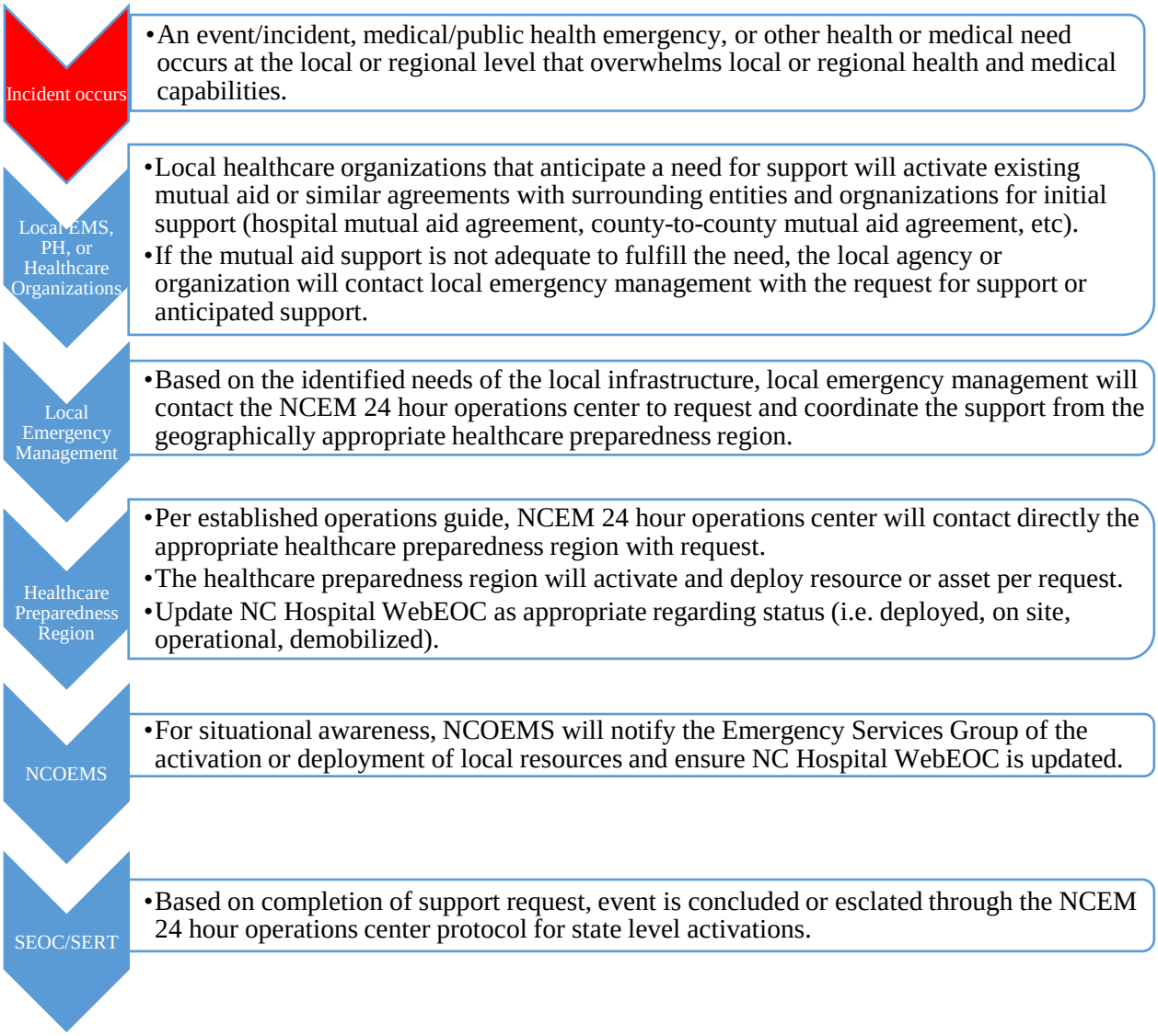
☐ Provide the following information: your name, location or facility name, contact information and overview of the situation (see Essential Elements of Information for examples of helpful situational information)

IV. Assets and Resource Requests

When an emergency or other event occurs that triggers the activation of this plan, affected Coalition member organizations may request assets and resources necessary to maintain their health and medical capacity and capability. Coalition members should use the algorithm below to request resources.

A. Resource Request Process:

Health and Medical Resource Request Algorithm*



*For planned events that may tax local healthcare resources, contact the Coalition.

B. Documentation and Other Associated Requirements

Assets and resources may be provided with requirements such as documentation of use, maintenance, or ongoing operational expenses to be met by the requester. For more information, refer to Attachment 3: Requesting NC SMRS Assets During an Emergency or consult Coalition staff.

V. Information Collection & Sharing

A. Overview

The ability to effectively support and sustain healthcare operations during an emergency or in preparation for other significant events is dependent on the establishment of a timely and accurate common operating picture through situation reporting.

The NC Triangle Coalition members are expected to share information through situation reporting whenever an emergency or other event triggers the activation of this plan (refer to Activation). The Healthcare Preparedness Coordinator (HPC) or their designee will initiate situation reporting at the Coalition level.

B. Process (Information Validation)

- ☐ Identify and gather essential elements of information relative to the event
- ☐ Verify information to the extent possible
- ☐ Transmit or otherwise deliver the information to the HPC or their designee utilizing available systems (VIPER, NCWebEOC, SMARTT, Email, phone, etc.).
- ☐ Confirm successful delivery of information

C. Essential Elements of Information

Elements of information to be provided in situation reports may include but are not limited to:

- ☐ Agency or jurisdiction Emergency Operations Center activation
- ☐ Health and safety concerns
- ☐ Facility or agency operating status
- ☐ Points of contact and operational communications system(s)
- ☐ Facility structural integrity
- ☐ Status of evacuations/shelter in-place operations
- ☐ Critical medical services status (e.g., trauma, critical care)
- ☐ Critical service status (e.g., electric, water, sanitation, heating, ventilation, and air conditioning)
- ☐ Critical healthcare delivery status (e.g., surge status, bed status, deaths, medical and pharmaceutical supplies, and medical equipment)
- ☐ Staffing status

☐ Emergency Medical Services (EMS) status involving patient transport, tracking, and availability

D. Dissemination of Information

1. Organizations

To further ensure a common operating picture, including the de-confliction of resource requests, information provided via situation reporting may be shared with organizations such as:

- Local and State Emergency Management
- Healthcare Organizations (e.g., hospitals, clinics, large corporate medical provider organizations and urgent care centers)
- Local and State Emergency Medical Services
- Local and State Public Health
- Local and State Law Enforcement
- Fusion Centers
- Tribal Organizations
- Organizations managing functionally or medically frail populations
- Fire Services
- Federal Agencies

2. Contacts

The Attachments to this Plan (listed below) should be utilized to assist with the information sharing process:

Attachment 1A: North Carolina Healthcare Preparedness Coalition Map

Attachment 1B: NC Triangle Coalition Map

Attachment 1C: NC Triangle Coalition Staff Contacts

Attachment 2A: North Carolina Division of Emergency Management Map

Attachment 2B: State OEMS and Emergency Management Contacts

Attachment 1D: NC Triangle Coalition Partner Contacts

Attachment 5: Public Health Preparedness Contacts

3. Information Handling – Operational

The Coalition staff shall be responsible for final validation of information and completion of the Sitrep, establishing the distribution list and distribution of document(s), and maintaining documents for record.

Healthcare partner representatives to the Coalition shall be responsible for the dissemination of information to relevant personnel, agencies, and organizations, in accordance with other applicable sections of this Plan.

4. Information Handling – Public

The dissemination of information to the public through press release or other media shall be at the discretion of each agency or jurisdiction. Coalition partners are urged to establish and maintain policies, procedures, and qualified personnel to provide information to the public.

While the Healthcare Coalitions possess no authority to restrict the release of information to the public by an agency or organization, it is the intent of the Triangle Healthcare Coalition to promote and support the sharing of accurate, relevant, and timely essential elements of information resulting from a unified coalition perspective.

VI. Communications and Information Systems

A. General

The NC Triangle Coalition maintains a wide range of communication and information system resources for use by staff and coalition member organizations to ensure that a common operating picture can be maintained within the coalition at all times. These resources provide redundant and interoperable system for voice communication, document/data transmission, and event/incident management purposes including situational awareness and reporting, messaging and mission coordination, mapping, and inventory/asset management. As a rule, information may be delivered using any appropriate mode available for use that can effectively transmit it.

VII. Demobilization and Recovery

A. Demobilization

Demobilization involves the cessation of field operations and the return of assets and resources to their home bases.

1. Assessment & Decision to Demobilize

   Assessments of the situation on site and decisions to demobilize will typically be made by the Incident Commander at the lowest jurisdictional level. If requested, the coalition staff and staff assigned to the SEOC ESF-8 Desk may also contribute to these decisions.

2. Incident Demobilization Planning and Implementation

   Planning for demobilization should begin once resources and assets are on site and operational. Implementation of a demobilization plan should begin with notification from the Incident Commander. The coalition staff should coordinate with the Incident Commander to provide any assistance with the execution of the demobilization plan, including any resource needs, and the time frame for demobilization.

B. Recovery

For the purposes of this Plan, Recovery includes the restoration of assets and resources to a ready state and the completion of mission-related tasks for reimbursement and operational review.

1. Operational Readiness
   a. The restoration of personnel, equipment, and supplies to a state of operational readiness is the responsibility of the Unit Leader and/or a designee of the HPC.
   b. The status of assets and resources should be updated in the SMRS dashboard of Healthcare WebEOC throughout the recovery process and designated as “available” at the earliest possible time.
2. Reimbursement and Replenishment of Supplies and Equipment
   a. This Plan is not intended to supersede or effect the processes contained in existing mutual aid agreements (MAA) to include the replenishment of supplies or the financial obligation(s) associated with fulfilling any such agreement.
   b. In accordance with Section IV of this Plan, reimbursement may be sought from the agencies, jurisdictions, or organizations which have fulfilled resource requests.
   c. Coalition staff will facilitate the reimbursement process resulting from the deployment of Healthcare Preparedness Coalition resources for local, regional, and state activations.

d. For local or regional deployments not assigned through the SEOC, the coalition will provide the required documentation (unit logs, accounting worksheets, etc.) to facilitate reimbursement or the replenishment of supplies.

e. For all SEOC-assigned deployments, the Coalition staff will complete or assist in the completion of a **Mission Reimbursement Workbook** which will be submitted to NCOEMS no later than 30 days following demobilization.

f. Any dispute regarding reimbursement between a requesting member jurisdiction and a responding member jurisdiction should be resolved by, and to the mutual satisfaction of those parties involved. If the parties are unable to resolve the dispute, the member jurisdiction asserting the dispute shall provide written notice to the other identifying the reimbursement issues in dispute. NCOEMS and NCEM shall serve as arbitrators and final authority in the dispute resolution.

3. After Action Reporting and Improvement Planning

C. Behavioral and Mental Health Support

The coalition can facilitate requests for behavioral and mental health support, including psychological first aid and/or critical incident stress management.

D. Incident Closeout

Following Response and Recovery activities (including personnel debriefing, reimbursement filings, WebEOC event termination, etc.), After Action Reports (AAR) and Improvement Plans (IP) may be developed. While this is not a requirement of Plan activation, the following steps may be used as a guideline for post-response and recovery review:

1. One or more hot wash sessions should be conducted with responders and participants following demobilization in order to capture the observations, opinions, and potential areas for improvement.
2. An AAR should be developed to identify the effectiveness of response and recovery as it relates to meeting the objectives of the mission assignment. A generally accepted method of identifying areas that were unsuccessful, accomplished with some difficulty, accomplished successfully, or best practice, should be included with each objective.
3. An Improvement Plan should be developed based on the AAR which includes the responsible parties, times to milestones or completion, budgets and financials if applicable, and other relevant information for each objective.

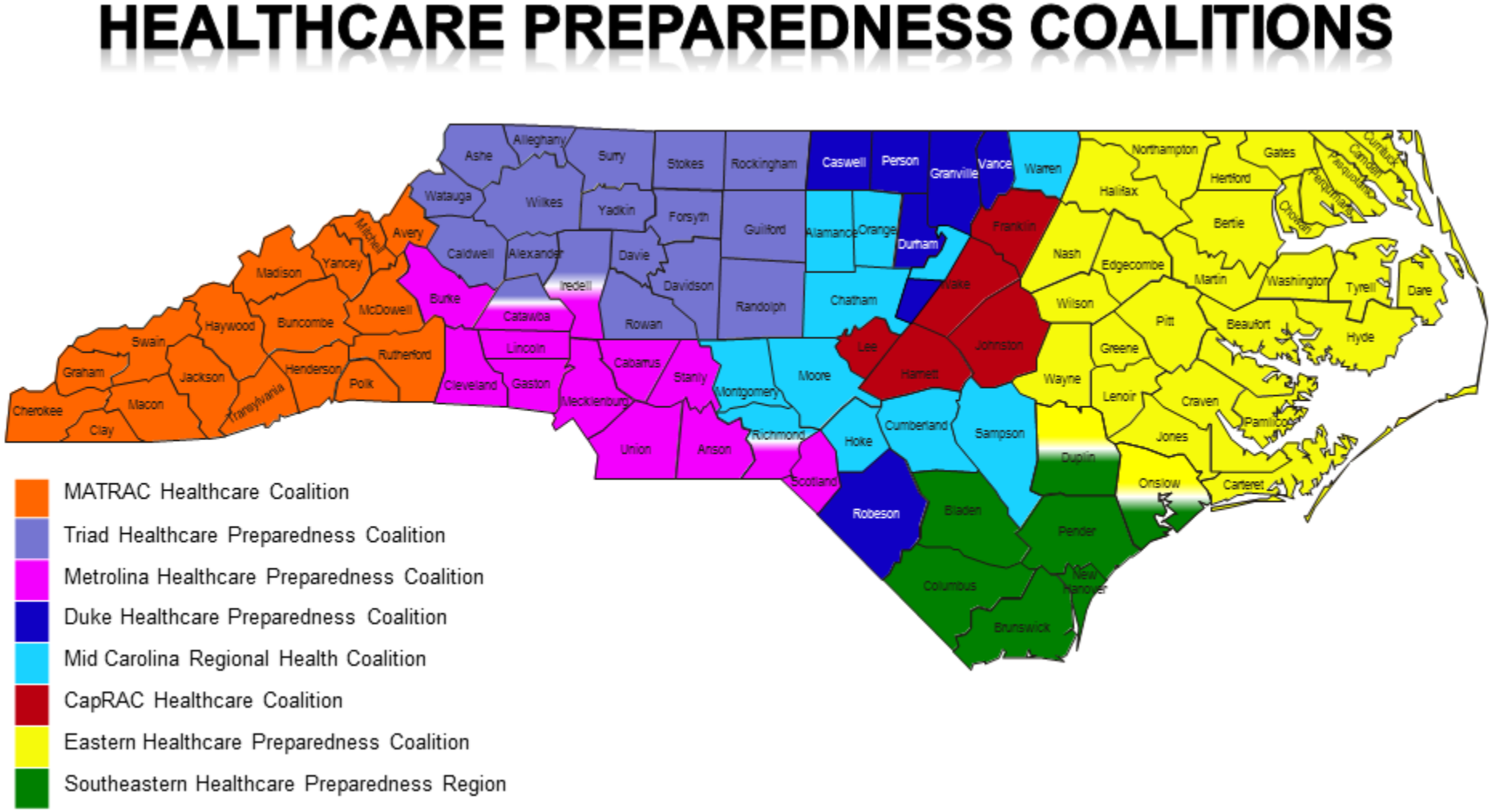
AAR and IP activities should be conducted under the direction of the HPC or his or her designee.

VIII. Plan Development and Maintenance

This plan will be reviewed at least annually to ensure that it meets the intended scope, purpose and goals of the Coalition. This plan is a "living document" and will be updated as needed after each evaluation. Exclusive of attachments and appendices, revisions are subject to the approval authority outlined in Section I. B. Approval Authority. Revised plans will be distributed electronically.

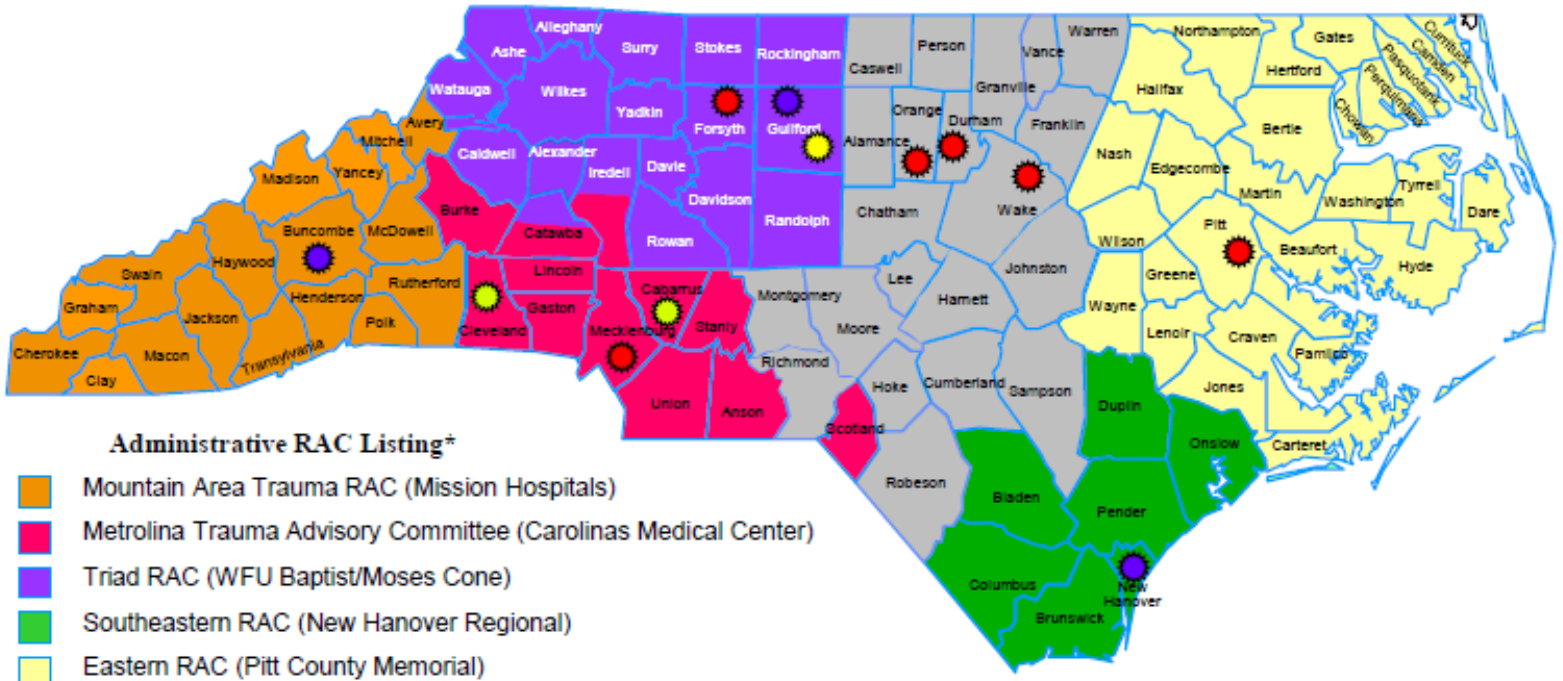
IX. Attachments

A. Attachment 1A: North Carolina Healthcare Preparedness Coalition Map



B. Attachment 1B: NC Triangle Coalition Map

North Carolina Regional Advisory Committee (RAC) Trauma Center Map With the Triangle Coalition - 2014



Administrative RAC Listing*

- Mountain Area Trauma RAC (Mission Hospitals)
- Metrolina Trauma Advisory Committee (Carolinas Medical Center)
- Triad RAC (WFU Baptist/Moses Cone)
- Southeastern RAC (New Hanover Regional)
- Eastern RAC (Pitt County Memorial)
- Duke RAC (Duke University Hospital)
- Mid Carolina Trauma RAC (UNC Health Care)
- Capital RAC (WakeMed)

- Indicates a Level I Trauma Center
- Indicates a Level II Trauma Center
- Indicates a Level III Trauma Center

Counties with different colors indicate two or more hospitals with different RAC affiliations as follows:

- **Catawba County:** Catawba Valley Medica Center – Metrolina; Frye Regional Medical Center – Triad
- **Iredell County:** Iredell Memorial Hospital – Triad; Davis Regional Medical Center – Triad; Lake Norman Regional Medical Center – Metrolina
- **Richmond County:** Sandhills Regional Medical Center – Metrolina; FirstHealth Richmond Memorial Hospital – MidCarolina
- **Wake County:** Duke Raleigh Hospital – Duke; Rex HealthCare – MidCarolina; WakeMed Hospital – CapRac

C. Attachment 1C: NC Triangle Coalition Staff Contacts

NC Triangle Coalition Staff Contacts			
Janis Brown, Healthcare Preparedness Grant Specialist, CapRAC	919.350.6265	janisbrown@wakemed.org	
Josh Fox, Assistant Healthcare Preparedness Coordinator, Mid Carolina Region	919.381.4412	Joshua.fox@unchealth.unc.edu	
Steve Harrison, Logistics & Training Specialist / SMAT Team Leader, CapRAC	919.350.2247	sharrison@wakemed.org	
Dale Hill, Manager / RAC Coordinator, CapRAC	919.350.7727	dahill@wakemed.org	
Randy Hoffman, Healthcare Preparedness Coordinator, Mid Carolina Region	919.381.5412	Randy.hoffman@unchealth.unc.edu	
Ken Shaw, Healthcare Preparedness Coordinator, Duke Region	919.613.8170	Kenneth.a.shaw@duke.edu	
Jim Starlin, Assistant Healthcare Preparedness Coordinator / SMAT Commander, Duke Region	919.613.7766	James.starlin@duke.edu	
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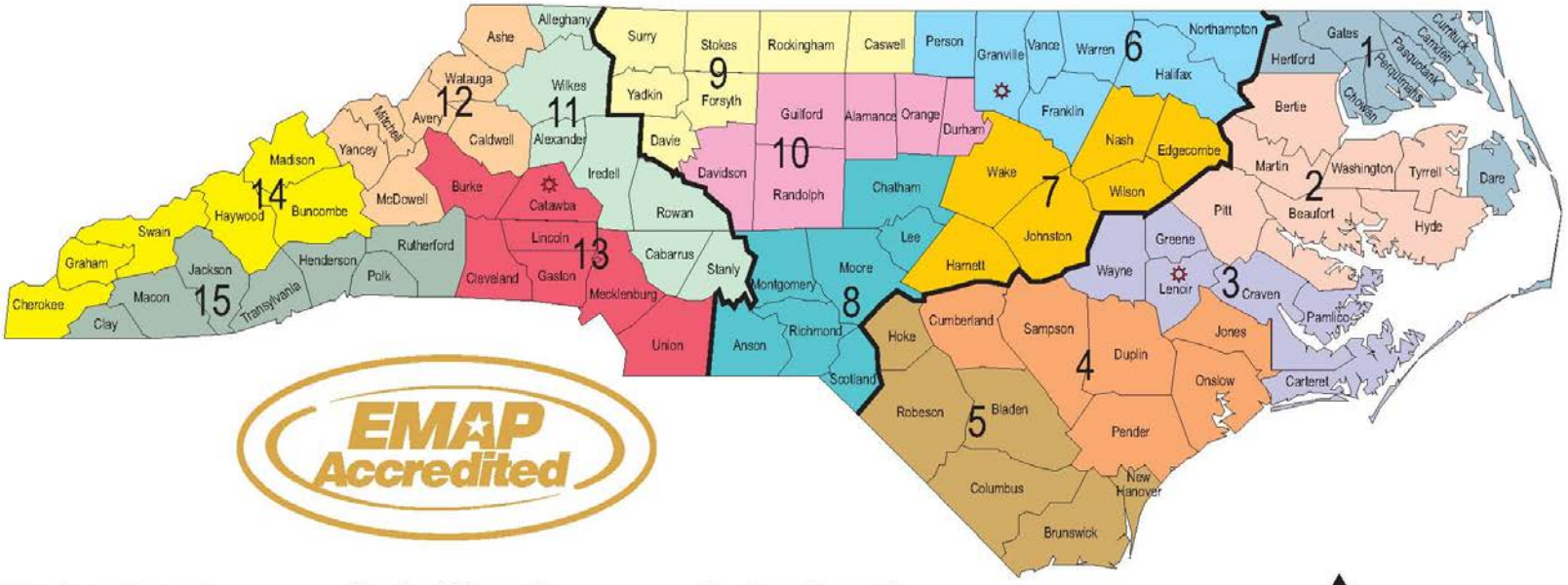
D. Attachment 1D: Coalition Partner Contacts

State of North Carolina
Division of Emergency Management



EMAP Accredited

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EMERGENCY MANAGEMENT
NORTH CAROLINA

NCEMbranches.cdr 03March16 abrown

F. Attachment 2B: State OEMS and Emergency Management Contacts

G. Attachment 3: Requesting NC SMRS Assets During an Emergency

Overview: North Carolina is fortunate to have significant ESF 8 resources that have been funded by HRSA and ASPR within the State Medical Response System (SMRS). These ESF 8 resources are housed with various agencies across the state in a number of organizations that include, but are not limited to: EMS agencies, local emergency management, healthcare organizations, and state agencies. With this in mind, this document is intended to serve as guidance for accessing these resources in a timely fashion during an event. Assets and resources maintained at each of the eight Healthcare Preparedness Regions may be deployed during an emergency or disaster to meet the immediate needs of the healthcare infrastructure or provide health and medical support.

Process: Requests for immediate assistance will be made in accordance with the **Health and Medical Resource Request Algorithm**. For local agencies and healthcare organizations, the initial point of contact should always be the respective local emergency management agency. Based on the request and needs for support, the local coordinator through NCEM will contact the appropriate Regional Healthcare Preparedness Coordinator to assist with ESF 8 needs. Assets and resources can be provided as single resources or as packages and may be accompanied by a Unit Leader unless transferred to the requesting agency or jurisdiction.

Administration and Reimbursement:

1. **Pre-planned or special events:** Federal HPP funding may not be utilized. The requesting jurisdiction or organization will be invoiced based on the established agreement with that healthcare preparedness region. That specific healthcare preparedness region must have:
    a. A plan in place to maintain the capability of that specific asset utilizing other assets or resources across the system, or
    b. A plan to recover the asset in the event the capability is needed to address an emergent event within the region or state.
2. **Emergent events:** The requesting jurisdiction or organization should be prepared to incur the following expenses related to request and deployment of an asset or resource locally:
    a. For fuel for those assets or resources that utilize fuel for operation,
    b. For any damage sustained by asset or resource,
    c. For usage of disposable medical supplies or goods.

For events that require deployment of personnel packages in excess of the HPP-funded program or healthcare preparedness regional staffs, approval and activation will be made by ESF 8/NCOEMS.

Note: An emergency declaration is often not made immediately and as such, the requesting organization or jurisdiction should be prepared to reimburse the above mentioned items. For events that escalate to state or federal declarations, reimbursement may not be required by the requesting organization or jurisdiction. Additionally, establishment of a mission number through North Carolina Division of Emergency Management does not automatically trigger SMRS activation, nor does an activation order automatically have a mission number associated.

H. Attachment 4: Situation Report (Sitrep)

Health and Medical Situational Report Template

1. Incident Name	2. Report Number	3. Period Covered
4. Prepared By	5. Position	6. Date/Time Prepared
7. Situation Summary:		

8. Status Reports
8a. Organization
NC Emergency Management:
NC OEMS/ESF#8:
NC Triangle Coalition:
NC PHP&R:
Other:

8b. Jurisdiction/Area	EM	EMS	Hospital(s)	Other
Alamance County				
Caswell County				
Chatham County				
Cumberland County				
Durham County				
Franklin County				
Granville County				
Harnett County				
Hoke County				
Johnston County				
Lee County				
Moore County				
Montgomery County				
Orange County				
Person County				
Richmond County				

Robeson County				
Sampson County				
Vance County				
Warren County				
Wake County				
9. Notes/Comments:				

I. Attachment 5: Public Health Preparedness