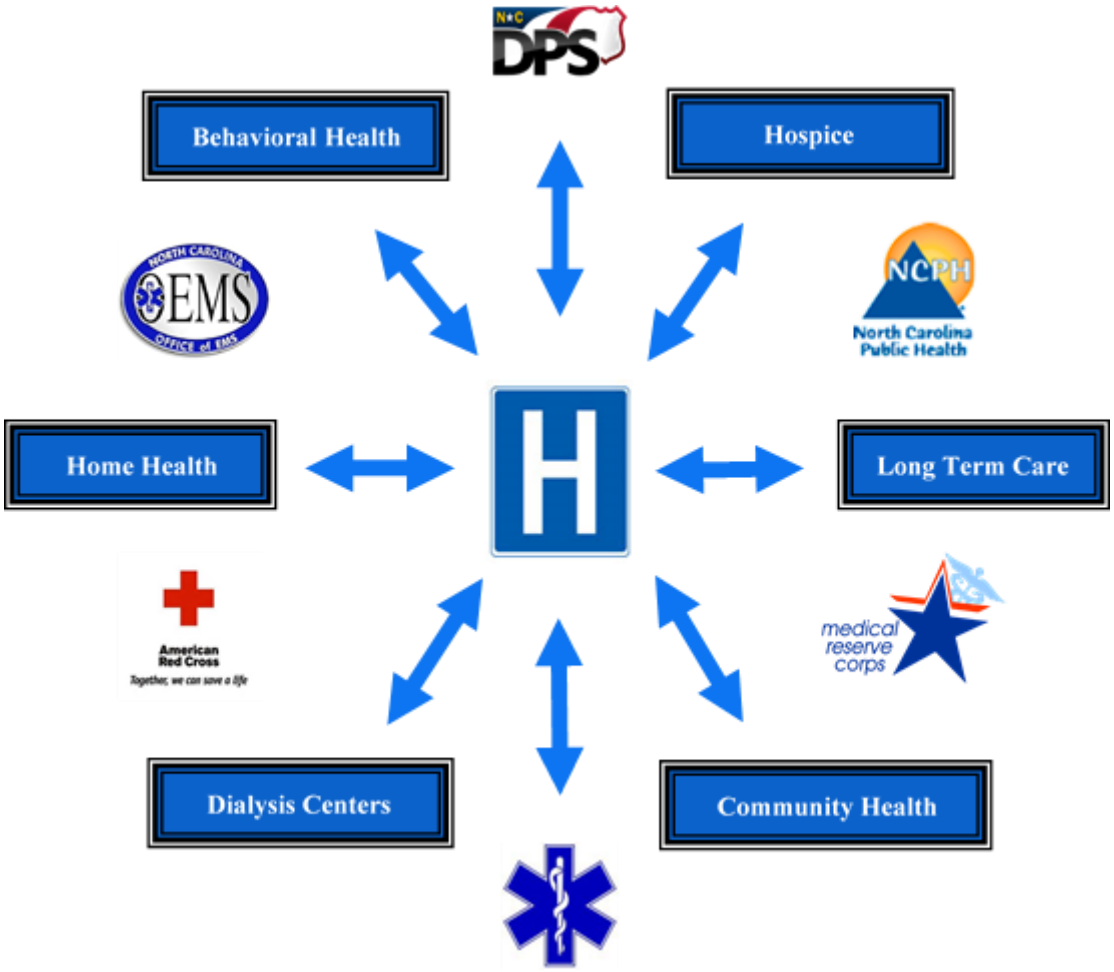

Mid Carolina Regional Healthcare and Partner Coalitions Infectious Disease Response Annex 2021

ESF-8 HEALTHCARE PREPAREDNESS, RESPONSE, & RECOVERY PROGRAM

NC Triangle Coalition HEALTHCARE PREPAREDNESS

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Forward

The Federal Healthcare Preparedness Program (HPP), managed by the Assistant Secretary for Preparedness and Response (ASPR), provides funding and other direct assistance to States to enable healthcare systems to save lives during emergencies that exceed the daily capacity of health and emergency response systems.

In North Carolina, this program is managed by the NC Department of Health and Human Services, Office of Emergency Medical Services, in partnership with the NC Department of Public Safety, Division of Emergency Management. Within the NC HPP, there are eight (8) Healthcare Preparedness Coalitions (HPCs) strategically located across the State and managed and coordinated by eight (8) lead hospitals.

The mission of the HPP in North Carolina is to be:

> "…..a partner to healthcare and emergency response organizations working to prepare for, mitigate, respond to, and recover from emergencies and disasters affecting the residents and guests of North Carolina." (*Source - nchpp.com*)

As a requirement of the 2019-2023 HPP Funding Opportunity Announcement (FOA), this Infectious Disease Surge Annex is created in conjunction with and for all Healthcare Preparedness Coalitions in the State.

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Endorsements

HPC Coordinator

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Caucus Leader

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Distribution List

The agencies and departments listed below have received a copy of the NC Healthcare Preparedness Coalitions Infectious Disease Surge Annex and agree to the responsibilities assigned to them. The Healthcare Preparedness Coordinator for each Coalition will maintain a record of signatures and plan receipt.

NC Healthcare Coalition - Infectious Disease Annex Distribution List		
Agency	**Person/Signature**	**Date**

Record of Changes

NOTE: This should be completed upon any major changes to the Plan. Major changes include any item that changes the intended action/guidance of the plan.

Date	Section/Page Number	Change Made	Person Completing Change

Basic Plan

Purpose

The purpose of this annex is to provide guidance and to outline the concept of operations for the Healthcare Preparedness Coalitions (HPCs) in North Carolina during a range of known and emerging infectious disease outbreaks. It aims to improve capacity and capabilities to manage a small number of patients with high-consequence pathogens or a large number of patients during a major epidemic or pandemic and can be used to ensure an effective response to a variety of disease agents with various severity scenarios.

Scope

This annex is created to address the common planning and coordination requirements of all eight (8) HPCs across the State as related to Highly Infectious Diseases (HID). The concept of operations outlined here applies to HID which typically are highly transmissible and/or have a high case-fatality rate. Diseases covered under this annex may be considered novel, emerging or re-emerging, may include weaponized biologic agents, may or may not have effective prophylaxis or treatments available, and may be difficult to readily recognize or diagnose.

This annex, as a part of the HPCs' Regional Response Plans, is intended to compliment, not replace, existing facility surge plans or applicable State-level infectious disease plans.

Situation and Assumptions

Situation

According to the 2020 US Census, North Carolina has a population of 10.5 million residents, with significant seasonal increases due to tourism and other economically incentivized events and opportunities. Based on the diversity of its population with communities of international origin, national and international travelers, and a globalized workforce, the State is considered a high-risk jurisdiction for infectious disease.

Highly infectious diseases pose a risk to the residents and guests of North Carolina and may adversely affect the ability of public health organizations, hospitals, and other healthcare infrastructure to effectively resolve the threats. A rapid surge in disease cases could easily overwhelm the healthcare capacity if not quickly mitigated. Early recognition of the potential as well as a coordinated response to infectious disease outbreaks are essential to managing such events and preventing that overload.

In North Carolina, state and local resources work in concert to protect the public health. On a day-to-day basis the Division of Public Health's (DPH) Epidemiology Section and the State Laboratory of Public Health (SLPH) work to reduce health risks across North Carolina and respond to outbreaks of disease.

Within the Epidemiology Section of DPH are two Branches that have shared roles and responsibilities for highly infectious disease outbreak response: Public Health Preparedness & Response (PHP&R), and the Communicable Disease Branch (CDB). Investigation and control of communicable diseases are coordinated by the State Epidemiologist and the CDB.

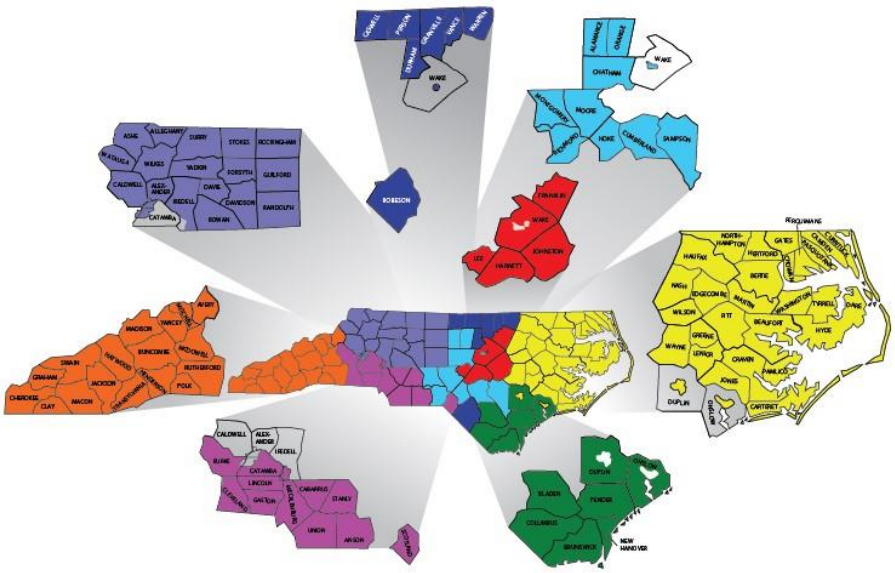
Local Health Departments and districts in the State are responsible (and have legal authority) to investigate cases and outbreaks, and to identify and require control measures. *(NCGS§ 130A-144, "Investigation and Control Measures)*

The North Carolina Office of Emergency Medical Services (NCOEMS) sits within the Department of Health and Human Service's Division of Health Service Regulation. Its mission is to foster emergency medical systems, trauma systems and credentialed EMS personnel to improve in providing responses to emergencies and disasters which will result in higher quality emergency medical care being delivered to the residents and visitors of North Carolina. According to the North Carolina Emergency Operations Plan, NCOEMS is responsible for Disaster Medical Services as part of the State Emergency Response Team.

The North Carolina Healthcare Preparedness Program (HPP) sits within the Division of Health Service Regulation's Office of Emergency Medical Services. HPP's mission is to partner with healthcare and emergency response organizations working to prepare for, mitigate, respond to, and recover from emergencies and disasters.

As a part of the NC HPP, there are eight Healthcare Preparedness Coalitions (HPCs) or Regions across North Carolina, each based within a lead hospital:

- Mountain Area Healthcare Preparedness Coalition (Mission Health)
- Triad Healthcare Preparedness Coalition (WFU Baptist)
- Metrolina Healthcare Preparedness Coalition (Atrium Health)
- Duke Healthcare Preparedness Coalition (Duke Health)
- Mid Carolina Regional Healthcare Preparedness Coalition (UNC Health)
- Capital RAC (Wake Med)
- Eastern Healthcare Preparedness Coalition (Vidant Medical Center)
- Southeastern Healthcare Preparedness Region (Novant Health New Hanover Regional)



Each HPC includes representation from all jurisdictions of emergency response organizations, to include Hospitals, Emergency Medical Services, Emergency Management, Fire, Rescue, Law Enforcement, Public Health, Dialysis Centers, Long-Term and Continual Care Facilities, Home Health & Hospice Agencies, Durable Medical Equipment Agencies, Pharmacies, ancillary Healthcare organizations, Volunteer Organizations Active in Disasters (VOADs), and other relevant members.

Each of these HPCs have similar responsibilities during a highly infectious disease outbreak response to include:

- Provide situational awareness and information sharing to the Coalition and State partners
- Support continuity of operations
- Augment medical surge
- Coordinate healthcare resource allocation

North Carolina has licensed acute care hospitals, many of which are part of larger healthcare systems which include hospitals, urgent care centers, specialty transport entities, physician offices, home health & hospice, skilled nursing facilities etc. Healthcare systems and hospitals have well-developed surge plans and crisis-standards process plans that allow them to manage significant medical surge incidents without any external support.

In North Carolina, Emergency Medical Services (EMS) Systems are the responsibility of county governments. (*10A NCAC 13P .0201(a) "EMS System Requirements"*) Additionally, each EMS System must have a written Infectious Disease Control Policy which describes how the EMS system will protect and prevent against exposure and illness from infectious diseases to include all patients and EMS Providers *(10A NCAC 41A .0206 "Infection Prevention – Health Care Settings")* Prehospital EMS Systems and all associated providers should be prepared to evaluate patients for many different highly infectious diseases. The best approach for prehospital management of all these diseases is strong prevention habits which includes a respiratory protection program and effective communication between prehospital providers and receiving healthcare facilities.

North Carolina Emergency Management (NCEM) has the delegated responsibility and authority to respond to emergencies and disasters in North Carolina. Chapter 166A of the North Carolina General Statutes (NCGS) establishes the authority and responsibilities of the Governor, state agencies, and local government for emergency management. To accomplish this responsibility, NCEM utilizes an organizational structure referred to as the State Emergency Response Team (SERT) to provide, coordinate and arrange for emergency assistance to the counties. The Emergency Services Group is the functional lead for Disaster Medical Response within the SERT and serves as the primary point of contact for situational awareness, support requests and response coordination.

Assumptions

For the purposes of this annex, the following planning assumptions are made:

- All infectious disease outbreaks pose an increased risk for healthcare workers.
- Susceptibility to the disease will be universal, although increased susceptibility may be present among specific populations (age, gender, race, co-morbidities).

- Persons under investigation (PUI) may present to any healthcare access point including hospitals, clinics, EMS, and private physicians; however, only some facilities will be equipped to manage the care and treatment of a confirmed case.
- Supplies such as Personnel Protective Equipment (PPE), medication, and ventilators may not necessarily be available from the Strategic National Stockpile (SNS).
- Cases will require laboratory testing to confirm diagnoses until the appropriate authorities no longer deem laboratory confirmation necessary.
- Initially, local and state labs may not be equipped to perform necessary testing, and patient samples may need to be sent to the U.S. Centers for Disease Control and Prevention (CDC).
- Most novel and several emerging diseases do not have known cures or vaccines, and the treatment may be largely supportive.
- Major public health emergencies will require federal Centers for Medicare and Medicaid Services (CMS) waivers, Food and Drug Administration (FDA)-issued Emergency Use Authorization (EUA), and other authorities that may affect healthcare operations and affect coalition options.
    - Experimental treatments and vaccines may be used under an Emergency Use Authorization (EUA) granted by the Food and Drug Administration (FDA). Large scale vaccinations, specifically with a new vaccine, will require a multiagency collaborative effort to administer.
- Staffing may be challenged by illness, fear of illness, or family obligations (e.g. child/family care if schools are out). Healthcare workers are a high-risk population during most infectious disease incidents; the implementation of effective infection prevention measures and associated training are necessary for workforce protection across the coalition.

Annex Development and Maintenance

Each Coalition is responsible for the development of specific standard operating guidelines in support of this annex.

Maintenance, as required, of the general sections of this annex will be done by consensus of all Coalition Healthcare Preparedness Coordinators. The Coalitions' collective leadership will have authority to make changes as needed to ensure this annex remains functional, efficient, and meets its objectives as outlined. However, maintenance to the Coalition-specific sections of the annex is the responsibility of the respective Coalition Healthcare Preparedness Coordinator.

This annex will be reviewed annually and revised as needed based on after-action reviews of actual incidents or exercises.

The Coalition Healthcare Preparedness Coordinator directs the development and annual review of this annex by all Coalition representatives and will coordinate necessary revision efforts. This will include a critique of the actions taken in support of the annex following any event requiring its implementation.

This annex should be exercised in coordination with HPP guidance in lieu of actual response to real emergency events.

Concept of Operations

Activation

The Healthcare Systems in North Carolina manage many patients daily and are typically capable of managing patient surges and high acuity cases without assistance, as demonstrated during normal flu seasons. Healthcare systems have various methods of managing temporary surges to coordinate patient flow during these times. However, certain scenarios involving highly infectious diseases, which can rapidly spread and/or cause a significant, extended burden above the daily expected capabilities, require additional support and resources.

Due to specific needs unique to each HPC region, exact triggers for activation of this annex will vary and are outlined in the individual HPC's internal protocols.

In general, this annex should be activated by the Healthcare Coalition Coordinator or a designee when any of the following conditions occur:

- **Trigger 1 (Advisory)** – Notification of the spread of a highly infectious disease or emerging/novel disease internationally but not nationally.
- **Trigger 2 (Alert)** – Notification of the spread of a highly infectious disease or emerging/novel disease nationally, but not locally.
- **Trigger 3 (Activation)** – Notification of the spread of a highly infectious disease or emerging/novel disease regionally or locally.

Each relative trigger will initiate certain actions to be taken, and, based on the trigger level, should progressively increase the anticipated actions within the HPC Regions. These include situational awareness, alerting and notifications, resource identification and procurement, and monitoring of daily hospital capacity metrics.

Trigger	Recommended Actions
Trigger 1 (Advisory) - Notification of International Event	1. Actively monitor the event. 2. Provide situational awareness information to partners in standard HPC Regional communications at least weekly. 3. Review readiness plans. 4. Review logistical supply chains including verification of existing procurement contracts. 5. Review alternate care sites, plans and facility agreements.
Trigger 2 (Alert) - Notification of National Event	1. Actively monitor the event. 2. Provide dedicated situational awareness information to partners when available. 3. Consider regional coordination calls with partner agencies if potentially impacted. 4. Review Operations and Logistics Plans. 5. Review status of Coalition resources and supplies.

	6. Suggest agencies review procurement contracts and distribution procedures. 7. Monitor and plan for support of resource gaps such as medical equipment, consumables, and transportation support services. 8. Monitor Healthcare System capacities to include daily hospital metrics.
Trigger 3 (Activation) - Notification of Regional or Local Event	1. Actively monitor the event. 2. Provide dedicated situational awareness information to partners when available, or as requested. 3. Hold regional coordination calls with partner agencies. 4. Begin direct logistical coordination and support for resource gaps, as appropriate, by partner agencies. 5. Monitor daily hospital surge metrics and assist with the establishment of alternate care sites as required.

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Alerting/Notifications

Alerting

North Carolina Healthcare Preparedness Coalitions, in general, may receive health alerts from multiple sources including NCDHHS, peer notifications, and national, regional, and local media reports. The most common method of alerting is through NCOEMS.

Notifications

Once a public health alert has been received by the Coalition, the Preparedness Coordinator or designee will relay appropriate information to healthcare facilities, providers, and partner agencies within the respective region. Information may be shared through several means of communication including email, SMS texting, telephone, NCVIPER and in-person delivery.

Information provided may include but is not limited to:

- Nature and summary of the threat including location
- Date/time of issuance of alert
- Recommended actions
- How to receive additional information
- Availability of specific resources to support the event

Assignment of Responsibilities

Within each HPC are varying levels of internal staffing based on the daily operational needs of the individual Coalition Region. However, the primary purpose of the HPC is to provide partner agency participation and coordination within the Healthcare Preparedness Program. As such, the HPC represents a collaborative effort in providing for the overall preparedness program.

Within each HPC Region exists multiple healthcare providers, each assuming specific duties in a Statewide approach to managing a surge due to an infectious disease. This section outlines the general roles and responsibilities of agencies represented within the Coalitions.

All individuals, departments, divisions, and agencies identified here have common responsibilities. These are:

- Develop Standard Operating Guidelines in support of their respective assignments
- Maintain training on policies and procedures related to the assignment, as well as the National Incident Management System (NIMS) and the Incident Command System (ICS)
- Inventory departmental/agency response assets and resources, and identify shortfalls that may inhibit the full delivery of duties as assigned
- Delegate authority as allowed by policy to maintain lines of succession and support for activation of the Annex, as well as to maintain continuity of normal operations during emergencies and disasters
- Establish, maintain, and coordinate mutual-aid agreements and contracts necessary to support the assigned responsibilities

Surveillance

Surveillance and identification of trends associated with highly infectious diseases is vital to the management and eventual control of the event and is primarily the function of Public Health. Nationally and Internationally, the CDC and the WHO provide surveillance information to state and local public health entities.

Coalitions coordinate with Public Health and other healthcare delivery system information portals such as NC Detect, to get information on laboratory reporting, test ordering, fatality reporting, staff absenteeism rates, hospital bed counts, and syndromic surveillance as it relates to the submission of emergency department visit data to collect, analyze and interpret critical information and inform healthcare system decision-making.

Safety, Infection Control and Prevention

With any emerging disease, especially novel pathogens, infection control measures become critical to the safety of healthcare workers, and the overall delivery of healthcare to the public.

The Coalitions' objectives for Infection Control and Prevention during a highly infectious disease event can include:

- Research and provide guidance on appropriate infection control practices for the healthcare system
  - Deconflict, and disseminate guidance on restricted access to healthcare facilities/emergency departments
  - Deconflict, and disseminate information on patient visitation
  - Provide specific information on disinfecting/safety procedures, including type and level of disinfectant; deconflict State and Federal Guidance as necessary
  - Provide tools/resources to support hospital administration decision making
  - Provide deconflicted, cohesive, tiered guidance on:
    - PPE
    - Workplace practices
    - Facility infrastructure
    - Waste Management
    - Standardization of care
    - Precaution options (tiered for facilities and capacity)
  - Provide vetted guidance on healthcare vendors
    - Waste management
    - Environmental services
    - Linen services
    - Delivery
    - Points of access
    - PPE
- Distribute infection control guidance to all applicable entities
  - Distribute information broadly to healthcare Coalition stakeholders and partners.

    - Provide regular outreach and communication through conference calls to discuss any changes in guidelines and state of outbreak
- Work with facilities to support staff training efforts in appropriate infection control measures
    - Define clinical concern levels – categorize risk
    - Send teams/resources/supplies for training as needed
- Provide just-in-time training based on appropriate and current guidelines.
- Research and provide guidance for appropriate engineering controls and surge modification of facility infrastructure (e.g., Patient Care Areas, Alternate Care Sites, and Waste Treatment areas)
- Provide guidance for facility workflow, safe patient care, and healthcare worker safety
    - Research and provide guidance/protocols on movement of patients in/out of healthcare treatment areas
    - Assist with Business Continuity Planning at healthcare facilities
    - Assist with bed limit waiver with federal/ state regulatory agencies when appropriate.

Non-pharmaceutical Interventions

Non-pharmaceutical intervention refers to actions, practices, and efforts, apart from medicines or vaccinations, to control the spread and limit the effects of a highly infectious disease. These are also known as community mitigation strategies and may involve actions such as isolation/quarantine, face-covering in public, social distancing, encouraging more frequent handwashing and sanitizing, and other methods of preventing the spread of a disease. In some cases, these measures may become mandatory for the general public as allowed by under public health orders consistent with authorities under North Carolina General Statutes.

In addition to preventive vaccines and effective treatments for a disease, the Coalitions will work together with healthcare facilities, providers, and partner agencies to develop and promote consistent mitigation strategies as well as joint policy and strategy coordination to distribute information related to them. As the CDC provides recommendations and guidance, the Coalitions will distribute it to appropriate partners.

Strategies may include:

- Public communication and promotion of personal protective actions
    - Face coverings
    - Handwashing
    - Hand sanitizing
    - Covering coughs and sneezes
    - Self-monitoring for symptoms
    - Home self-isolation/quarantine
    - Social distancing
- Recommendations for quarantine operations and isolation protocols
- Restrictions on facility visitors, including adaptations that allow for continuation of critical services such as Emergency Medical Services (EMS) handoffs, supply deliveries, off-site laboratory processing, and waste management
- Restrictions on mass gatherings in public and private spaces
- Public transport guidance

Surge Staffing

During an HID event, one goal of the Coalitions is to ensure that adequate healthcare staff are available to meet surging demands. The following objectives to achieve this goal are common to all Coalitions in the State:

- Support readiness plans in place at all healthcare agencies and facilities, including both clinical and non-clinical staff that last throughout the course of an HID event.
    - Assess healthcare system staff needs
    - Develop and disseminate information to healthcare system regarding staff risks
    - Ensure healthcare facilities have up to date outbreak info.
- Coordinate the fulfillment of critical staffing resources throughout the course of an HID event
    - Activate Coalition emergency operations to assist with surveillance of staffing ratios
    - Research and provide staffing guidelines to healthcare facilities
    - Establish communication with healthcare facilities regarding staffing needs and facility status
    - Assist with coordination of mutual aid as needed.

Due to the unique characteristics of each Coalition region, exact triggers for surge levels will vary and are reflected in the Coalition Specific sections of this annex. However, the NC Office of Emergency Medical Services generally categorizes surge in three (3) phases. These are:

- **Phase 1 - Conventional Capacity**
- **Phase 2 – Contingency Capacity**
- **Phase 3 – Crisis Capacity**

Each phase of surge is further defined by healthcare facilities' available in-patient bed space and ICU capacity, as compared to staffing, and is described in the table below along with recommended actions.

Surge Phases
Medical Surge Phases

Phase	Phase Name	Regional Trigger	Statewide Trigger	Key Actions
Phase 1	Healthcare System operating at Conventional Capacity	Known local spread of highly infectious disease or newly emerged disease	Known regional spread of highly infectious disease or newly emerged disease	• Assess availability of assets & resources • Procurement of additional resources • Monitor metrics
Phase 2	Healthcare System operating at Contingency Capacity	≤7.5% Total Staffed Adult and/or Child ICU Capacity Available	Three or more regional triggers	• Increased monitoring of daily metrics • Regular cadence regional coordination call • Healthcare situation reports
		≤10% Total Staffed Inpatient Bed	≤30% Total Staffed Inpatient Bed	

		Capacity Available	Capacity Available	
Phase 2.5	Healthcare System operating at Contingency Capacity	≤5% Total Staffed Adult and/or Child ICU Capacity Available	≤15% Total Staffed Adult and/or Child ICU Capacity Available	• Regular cadence statewide patient capacity coordination calls • Mobilize State Coordinated Alternate Care Sites
		≤0% Total Staffed Inpatient Bed Capacity Available	≤10% Total Staffed Inpatient Bed Capacity Available	
Phase 3	Healthcare System operating at Crisis Capacity	Use of inpatient temporary space (using tents, mobile facility, or other alternate care space outside facility)	Use of inpatient temporary space (using tents, mobile facility, or other alternate care space outside facility) in two or more regions	• Activate State Coordinated Alternate Care Sites • Activation of statewide patient movement team • Recommend suspension of non-urgent surgeries

Phase 1: Healthcare system operating at conventional capacity

During this phase it is important that the Healthcare Preparedness Program (HPP) is providing situational awareness, partner communication, healthcare system guidance and support, and is beginning to prepare for the potential medical surge that can result from a highly infectious disease outbreak response by assessing the statewide status of assets, equipment, personnel and determining potential gaps in resource availability. Phase 1 is triggered when there is known local or regional spread of a highly infectious disease or a newly emerged disease to ensure proper preparedness efforts have occurred to begin preparing for a potential medical surge.

The following actions are expected during this phase:

- Assess availability of existing assets & resources:
  - Alternate Care Site Locations
  - Medical Equipment Status and Availability for Alternate Care Site locations
  - Personnel Availability
- Procurement of additional resources:
  - Assist with vendor research based on the assessment of existing assets and resources for noted gaps such as medical equipment and consumables, staffing support, transportation support etc.
- Monitor metrics
  - Begin collecting and monitoring daily metrics for hospital capacity and operational triggers.

Phase 2: Healthcare System operating at contingency capacity

Phase 2 is based on the initial healthcare surge that is expected during any large disaster that puts strain on the healthcare system and is triggered when the available hospital capacity is noted to be sustained at or below 7.5% Adult or Pediatric ICU Capacity (this can be triggered for either adult or pediatric available

capacity within the region as the HID outbreak may be impacting one population group more so than the other) and/or below 10% Total Staffed Inpatient Bed Capacity available over a 7 day timeframe. This is determined by the daily reported staffed capacity from the hospital and is not based on licensed capacity. It is anticipated that hospital bed capacity waivers will be available to support the medical surge response within the healthcare system. Hospitals have the best visibility of their own capacity and ability to surge based on staffing, physical space and equipment and supplies. The day-to-day capacity is noted to change quickly due to small surges within the healthcare system and as such capacity is monitored over a 7-day period to determine if potential triggers are being met.

An operational triggers dashboard is monitored daily to ensure the hospital capacity criteria are being watched closely for potential triggers. It is expected that during this phase the healthcare system will be able to be manage the surge of patients internally with minimal support needed from regional or state entities through the activation of their internal medical surge plans. During this phase the actions implemented are to ensure that the situation is monitored closely, support provided quickly when needed and that actions are being taken to prepare to move into the next phase when necessary. Phase 2.5 indicates triggers that have been identified to denote when NC OEMS should request support from the State Emergency Response Team Unified Command to begin mobilizing State Coordinated Alternate Care Sites, Statewide Patient Movement Coordination, and staffing support resources.

- Increased monitoring of daily metrics
  - Daily review of operational triggers should begin to ensure that the set hospital capacity metrics are monitored closely.
- Regular cadence regional coordination call
  - A regular cadence should be set for the regional coordination call between NC HPP & the NC Healthcare Preparedness Coalitions (HPCs) to ensure good situational awareness of the response, potential gaps, requests for support and information sharing (cadence is expected to change based on response activities). Each HPC should also set a regular cadence for their regional coordination call with partners to ensure good situational awareness of the response, potential gaps, requests for support and information sharing (cadence is expected to change based on response activities).
- Healthcare situation reports
  - Regional healthcare situation reports (sit-rep) or Essential Elements of Information (EEI) should be collected on a regular basis from the healthcare system (daily, weekly etc.) to ensure good visibility of the healthcare system status. The initial elements have been set by the Assistant Secretary of Preparedness and Response (ASPR) Healthcare Preparedness cooperative agreement. However, the elements collected may change frequently based on the evolving situation as required by federal regulatory and response agencies. Elements are expected to include general operating status, indication of impact to normal services, capacity, anticipated needs and current unmet needs.
- Regular cadence statewide patient capacity coordination calls
  - A regular cadence should be set for the statewide patient capacity coordination calls with the large healthcare systems (cadence is expected to change based on response activities) to support situational awareness of hospital capacity and provide open lines of communications to support the movement of patients across regions and the state to help manage the medical surge.

- Mobilize State Coordinated Alternate Care Sites

- It is anticipated to take a minimum of 7 days lead time to activate a state coordinated alternate care site during a highly infectious disease outbreak response due to the already increased strain on the healthcare system. Once the decision has been made to mobilize state coordinated ACS, plans should be activated to physically move the equipment and supplies into the Alternate Care Sites and begin assessing staffing resources and contractual needs (oxygen, environmental services, transportation, staff, supplies, feeding etc.) as outlined in the State Medical Support Shelter (SMSS) plan.

Phase 3: Healthcare System operating at crisis capacity

This phase indicates that the healthcare system is being significantly impacted regionally or statewide to the point that crisis capacity standards are being utilized to manage the patient volume, indicating significant support from regional and state partners may be required. This phase is triggered by any hospital within a region needing to manage their surge in a temporary space (using tents, mobile facility, or other alternate care space outside facility) for inpatient capacity. Use of temporary space for outpatient diagnostic or patient flow management does not trigger this phase although should be considered an early warning sign for potential capacity concerns. Any two regions experiencing crisis capacity will trigger a statewide response. Expected actions during this phase are focused on supporting the movement of patients, activating alternate care sites and determining statewide policy decisions to ensure the healthcare system can continue to provide the level of care expected.

- Activate State Coordinated Alternate Care Sites
- Activate statewide patient movement team
- Recommend suspension of non-urgent surgeries
  - A recommendation from the NC DHHS Secretary on the need to suspend non-urgent (elective) procedures and surgeries regionally or statewide is expected to be considered during this phase. The recommendation would outline the expectations for healthcare systems (hospitals and ambulatory surgery centers) regarding the suspension of elective and non-urgent procedures and surgeries. Elective and non-urgent are defined as any procedure or surgery that if delayed would not cause harm to the patient.

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Supply Chain

HID events will require the dedicated use of personal protective equipment (PPE) to aid in the prevention of disease spread. Without proper PPE, healthcare workers are especially susceptible to infection and its consequent escalation. During a widespread HID event, PPE supplies will become limited and as such, it becomes inherent on healthcare facilities and providers to maintain adequate supplies on-hand and to closely manage inventories.

This section describes and outlines the development and dissemination of Personal Protective Equipment (PPE) guidance for healthcare facilities and organizations. It also includes methodologies and resources for determining burn rates, maintenance and location of logistical stockpiles, and other essential supplies for response to an HID event.

Historically, once agency efforts to obtain supplies have been exhausted, during HID and other events the Coalitions have provided supply chain coordination and support to partner agencies and providers within their regions. This has been accomplished through:

- Information-sharing
- Regional trainings
- Provide established guidance on the best type and consistent use of PPE for the emerging HID.
- Establishing standard supply request protocols
- Mutual-aid assistance between other facilities and regions to obtain resources
- Coordination with state and federal agencies for supplies
- Assisting with supplies from the Strategic National Stockpile (SNS)
- Assist agencies in developing inventory management techniques

In order to effectively manage inventory and ensure PPE availability, the Coalitions work together with their partner agencies to closely determine required supplies. Past events should be used as examples along with burn rate calculations for daily use and surge events caused by HIDs. This determination can be made by utilizing basic inventory management techniques of "supply-in versus supply-out" to identify demand. Based on the COVID-19 event, ASPR/TRACIE and the Centers for Disease Control (CDC) have provided a spreadsheet to aid in burn rate calculation and forecast of PPE usage. This can be found at:

- https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/burn-calculator.html

Once a burn rate has been established for daily operations as well as HID surge operations, it is recommended that agencies maintain an adequate supply of required PPE. From this inventory, supplies should be rotated and maintained current by using the oldest stock first and restocking with new.

During widespread events such as a pandemic, the probability of disruption to facilities' and agencies' normal supply chains exists. The Coalitions have developed strategies to manage this potential which include:

- Burn Rate Calculator
- Maintain adequate supplies
- Share information on appropriate use of PPE including reuse and quality control
- Recommendation for agencies to maintain MOUs with alternate suppliers

All Coalitions maintain a minimal inventory of supplies that can be distributed in the event of supply chain disruptions. Distribution of Coalition stockpiles during an HID event is governed by internal policies developed by each Coalition in conjunction with its partners.

Support Services

Support Services may include healthcare and non-healthcare staff or material resources required to support the care of infectious disease patients, such as respiratory care, dialysis, blood banks/ blood product providers, laboratory, waste and material management, food and dietary services, pharmacy, radiology, and environmental services.

Support service providers will work with local healthcare and partner agencies to prepare and respond by assisting healthcare organizations in the care of acute infectious disease patients.

Laboratory

The timely diagnosis of an acute infectious disease patient is critical to a coordinated and efficient response. Healthcare organizations should coordinate with appropriate laboratories to test specimens and communicate results of laboratory testing. Based on the suspected pathogen, the North Carolina State Laboratory may be responsible for testing specimens and/or coordinating the provision of specimens to the Centers for Disease Control and Prevention (CDC). Healthcare organizations and laboratories should coordinate closely concerning specimen collecting and timing of testing needs. If a healthcare organization's incident command structure has been activated, laboratories should report all testing results through the healthcare organization's response structure, as well as to the patient's attending physician directly. Additionally, laboratories should communicate testing results to the local health department. (https://slph.ncpublichealth.com)

Waste Management/Decon

The North Carolina Medical Waste Management rules regulate the packaging, storage, transportation, treatment, and disposal of medical waste. The medical waste management rules are located at NCAC, Title 15A, Chapter 13, Subchapter B, (Medical Waste Management [Rules] 15A NCAC 13B .1201 - .1204) The medical waste management rules regulate non-hazardous solid waste.

Medical waste is subject to the requirements for solid waste found in the solid waste management regulations (https://deq.nc.gov/about/divisions/waste-management/solid-waste-section). The North Carolina Medical Waste Management rules are administered by the North Carolina Department of Environmental Quality, Division of Waste Management - Solid Waste Section. (*Source – deq.nc.gov*)

Healthcare organizations should work through their normal vendors and channels to ensure all waste produced in the screening and care of HID patients will be handled and disposed of appropriately. If needed, the Coalitions will assist in providing guidance on waste handling and disposal. Where necessary, healthcare providers may coordinate or contract with specific waste management contractors for the safe handling and removal of waste associated with healthcare for acute infectious disease patients as well as coordinating with the appropriate utilities as needed. Waste management agencies will maintain protocols for the handling of waste from acute infectious disease patients.

Patient Care/Management

The Coalitions will play a support role to healthcare providers for patient care and management during an HID event. HPCs may provide the following:

- Assess healthcare system resource needs for patient care
- Information Dissemination
    - Best practices from Federal, State and Local healthcare authorities
    - Procedures for recourse requests including available resource types
    - Procedures for decontamination and disinfection procedures for various types of facilities and departments such as acute care, emergency department and skilled nursing.
    - Guidance on disease containment and intra-facility transfer of HID patients.
- Request and deploy additional healthcare resources to support patient care and management needs.
- Survey partners for issues including but not limited to the following:
    - Patient census
    - Morgue capacity
    - PPE supplies and requirements
    - Staffing

Medical Countermeasures

Medical countermeasures, or MCMs, are life-saving medicines and medical supplies regulated by the U.S. Food and Drug Administration (FDA) that can be used to diagnose, prevent, protect from, or treat conditions associated with chemical, biological, radiological, or nuclear (CBRN) threats, emerging infectious diseases, or a natural disaster. In the event of emerging infectious diseases, state, local, tribal, or territorial health departments may need medicines and medical supplies from the Strategic National Stockpile (SNS) if local supplies are depleted. Through the Public Health Emergency Preparedness (PHEP) program, CDC collaborates with states and local jurisdictions to ensure they have plans and processes in place to receive and provide life-saving medicines and supplies. (*Source – www.cdc.gov*)

As a part of the PHEP, HPCs in NC may assist in coordination of medical countermeasures. Once an SNS request has been made through Public Health and Emergency Management, HPCs may also assist in regional distribution of supplies during an HID event.

Community-based Testing

During an HID event, widespread testing of the population is essential to gauging the extent of disease spread and consequently the appropriate selection and application of prevention and treatment measures. At the onset of the COVID-19 outbreak in 2020 and throughout the event, widespread testing was offered and performed by various organizations including public health and hospitals, as well as private entities and laboratories.

Due to the complex nature of community testing events, several considerations should be made by a sponsoring organization, including:

- Type and Nature of the Event
    - Walk-in
    - Drive-through
    - Appointment or Walk-up
    - Homebound appointments
- Location
- Weather
- Site Access and Facility Agreements
- Required Logistics
    - Testing and sampling equipment/supplies
    - Staffing
    - Personnel support (food, beverage, restrooms)
    - Computers
    - Site power and communications requirements
    - Security
    - PPE
    - Traffic control
    - Signage
    - Informational brochures and flyers
- Publicity of the Event
- Target Population/Demographics

As requested, HPCs may assist member organizations and regional stakeholders with community testing events by providing the following:

- Planning
- Partner Collaboration and Mutual Aid Brokerage
- Information Sharing
- Public Information
- Test Site logistics
    - Supply Coordination
    - Staffing
    - Site Location
    - Facility Agreements
- Testing/Reporting

Patient Transport

Facilities within each region have normal operating guidelines for interfacility transports and will follow established procedures whenever possible. An HID event may cause additional requirements for patient transports based on the actual disease, as well as regional surges in the numbers of patients. HPCs may assist during times of increased demand for services in various ways including the coordination of mutual aid resources, and review of critical triage procedures for transfer prioritization.

Each HPC has varying levels of patient transport support services available, and specifics are included in the Coalition-Specific SOGs, as well as regional and State patient transport plans, according to capabilities.

Mass Fatalities

An HID event has the potential to cause mass fatalities, overwhelming medical facilities' short-term decedent storage and handling capacities. During an HID event, HPCs may support regional partners in planning for and responding to mass fatality events through:

- Identification of human-remains storage availability throughout the region.
- Direct provision of temporary storage facilities and morgue units (refrigerated trailers).
- Provision of decedent-care supplies.
- Research and provision of guidance on safe handling of potentially infectious human remains.

Training and Exercises

Initial and on-going training for healthcare providers at all levels is essential for the management of HID events. In many cases, special considerations must be made at the onset of an event that may not have been previously relevant to daily operations. HPCs play a significant role in assisting in the provision of training classes within their respective regions, including:

- Respiratory Protection
- Personal Protective Equipment (PPE)
    - Rules, regulations, and guidelines for use
    - Selection of proper PPE for the situation
    - Proper donning and doffing
    - Sanitation and Disposal
- Operational Coordination
    - National Incident Management System (NIMS)
    - Incident Command System (ICS)
- Specialty training as requested by stakeholders and partners

HPCs also play an active role in assisting with and/or coordinating an Exercise program within the region, along with Emergency Management and other partners. Exercises provide participants the opportunity to practice and test plans and procedures without the pressures of actual consequences. The Homeland Security Exercise and Evaluation Program (HSEEP) is the general guide to develop, design, execute, evaluate and recommend corrective actions and improvement plans. Various forms of exercises may be designed and utilized, depending on the needs of the region. In some cases, real world events may be reviewed, and the response evaluated, to create after action reports identifying strengths, corrective actions, and improvement plans. A progressive series of exercises should be used to ensure thorough testing of plans, procedures, and capabilities. HSEEP categorizes exercises as:

1. Discussion-based exercises
    - Seminars
    - Workshops
    - Tabletop Exercises
    - Games
2. Operations-based exercises
    - Drills

- Functional Exercises
- Full-Scale Exercises (FSE)

Each exercise in a multi-year approach should build off the previous exercise, based on modifications made to plans and procedures as a result of lessons-learned during the exercises.

HPCs may assist regional partners with the following:

- Integrated Preparedness and Planning Workshop (IPPW)
- Integrated Preparedness Plan (IPP)
- Exercise planning and design
- Exercise evaluation and observation
- Exercise logistical support

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Deactivation and Recovery

As with any event, deactivation, recovery, and demobilization planning should begin at the onset of the event. This Surge Annex may be deactivated once it is determined by the authorities having jurisdiction that returning to normal operating procedures is safe and that the crisis phase of the event is complete.

HPCs should plan for the following deactivation activities:

- Return of surge personnel to normal service
- Recovery of all durable equipment owned or leased by the HPC
- Repair/replacement of damaged or lost durable equipment owned or leased by the HPC
- Inventory and replacement of expended consumable supplies
- Recovery of reimbursable expenditures
- After action reviews and reporting
- Corrective Action and Improvement Planning

Special Considerations

Behavioral/Mental Health

HPCs primarily exist as preparedness and support entities for other healthcare and response organizations. As such the HPCs may provide behavioral and mental health support programs such as Critical Incident Stress Management (CISM) for healthcare workers and responders during an HID event.

At-Risk/Marginalized Populations

Each HPC region has certain demographics that are considered to be at a higher risk for the effects of an HID event. These may include but are not necessarily limited to:

- Children
- Communities of color
- Older adults
- People with access and functional needs
- Individuals with challenges to accessing medical care
- Socio-economically disadvantaged
- Communication barriers
- Homelessness
- Congregate care living
- Religious or cultural limitations to medical care

Issues regarding the fair and unbiased treatment for any or all of these categories will be addressed individually by facilities and agencies. As requested by the ESF-8/OEMS branch or a partner organization, HPCs may coordinate and share resources (language services, ADA equipment, etc.) and will coordinate with Public Health to assist with addressing recognized critical gaps.

It should be noted that some infectious diseases may affect specific ethnicities, children, older adults, those in congregate living centers, or those with difficulty accessing healthcare more significantly. During these incidents education, health screenings, and vaccines may be more specifically directed to the demographic.

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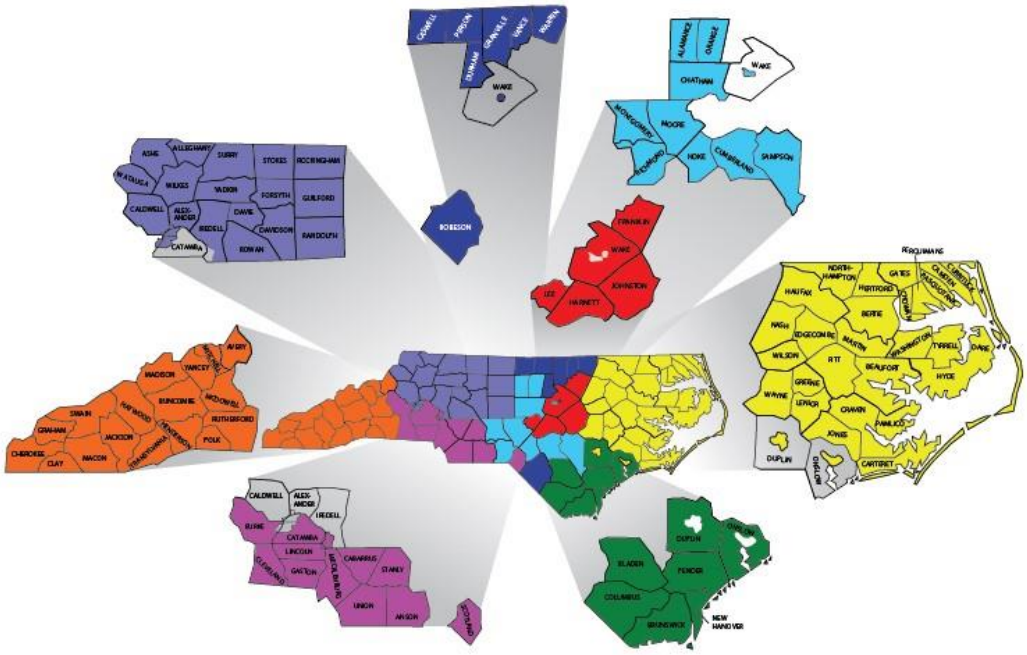
Coalition-Specific

The following pages contain information specific to each HPC and/or HPC sub-region. Although there are many similarities addressed earlier in this document, due to the inherent differences in population density, tourism, and even physical terrain and weather characteristics, each region is individually addressed to reflect certain characteristics and requirements that may not be present in the other regions. Contained in each region-specific section are descriptions and diagrams of the regions, their lead hospitals and hospitals served, counties served, and coalition membership caucuses.

Subsequent individual sections are categorized as follows:

- Mountain Area Healthcare Preparedness Coalition (MAHPC)
- Triad Healthcare Preparedness Coalition (THPC)
- Metrolina Healthcare Preparedness Coalition (MHPC)
- NC Triangle Coalition (NCTC)
    - Duke Healthcare Preparedness Coalition (DHPC)
    - Mid Carolina Regional Healthcare Coalition (MCRHC)
    - Capital RAC (CapRAC)
- Eastern Healthcare Preparedness Region (EHPR)
- Southeastern Healthcare Preparedness Coalition (SHPC)



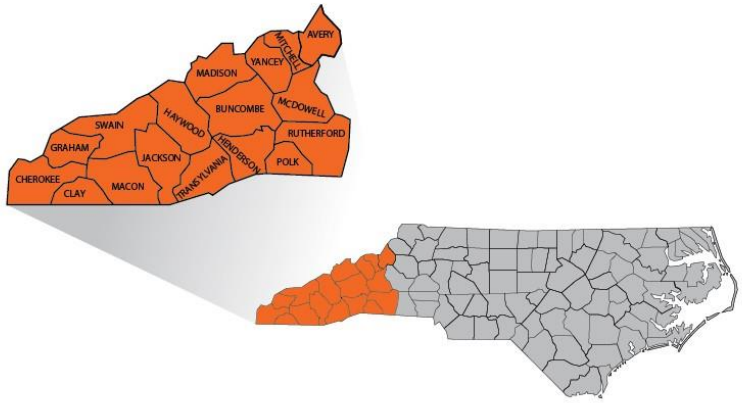
Mountain Area Healthcare Preparedness Coalition (Mission Health System)

Situation and Assumptions

Situation

The Mountain Area Healthcare Preparedness Coalition (MAHPC) office is located at 518 South Allen Road, Flat Rock, NC, in the western portion of the state. The region covers the following counties, including the Eastern Band of The Cherokee Indian (Qualla Boundary):

- Avery
- Buncombe
- Cherokee
- Clay
- Graham
- Haywood
- Henderson
- Jackson
- Macon
- Madison
- McDowell
- Mitchell
- Polk
- Rutherford
- Swain
- Transylvania
- Yancey



The lead hospital for the MAHPC is Mission Health System, based in Asheville, NC. In addition to Mission Health System, the region includes the following hospitals:

- Avery-Cannon Hospital (Appalachian Regional Healthcare System)
- Mission Hospital
- Charles George VA Medical Center
- Erlanger Western Carolina Hospital
- Cherokee Indian Hospital
- Haywood Regional Medical Center
- Advent Hendersonville
- Henderson-Park Ridge Hospital
- Jackson-Harris Hospital
- Macon-Highlands-Cashiers Hospital
- Macon-Angel Medical Center
- McDowell Hospital
- Mitchell-Blue Ridge Regional Hospital
- Polk-St. Luke's Hospital

- Rutherford Regional Hospital
- Swain Hospital
- Transylvania Regional Hospital

The MAHPC supports its Emergency Response and Public Safety partners from each of the region's counties to provide essential services such as response resources, and planning for public health issues, healthcare, and related emergencies and disasters. Within the region exists multiple Emergency Medical Services agencies, Emergency Management offices, and Public Health Departments each of which are represented in the Coalition through Regional Partner and Stakeholder leaders. Each leader is responsible to maintain contact with and represent, to the general Coalition membership, the respective agencies' needs and concerns within the specific discipline or group.

The following Regional Partners and Stakeholders makeup the MAHPC:

- Hospital
- Emergency Medical Services
- Public Health
- Emergency Management
- Continuing Care
- Mental Health
- Law Enforcement
- Other Emergency Services Organizations – entities with a vested interest in healthcare emergency preparedness

Assignment of Responsibilities

Healthcare Coalition Preparedness Coordinator

- Notifications, Communication and Coordination with State/Regional partners
- Assist in the location of appropriate resources
- Coordination of load management in regional hospitals
- Assist in maintaining situational awareness

Assistant Healthcare Preparedness Coordinator

- Planning documentation
- Volunteer management
- Other duties as assigned

Regional Logistics Specialist

- Maintain inventory and ensure stock rotation
- Work with partners and stakeholders to locate appropriate resources
- Other duties as assigned

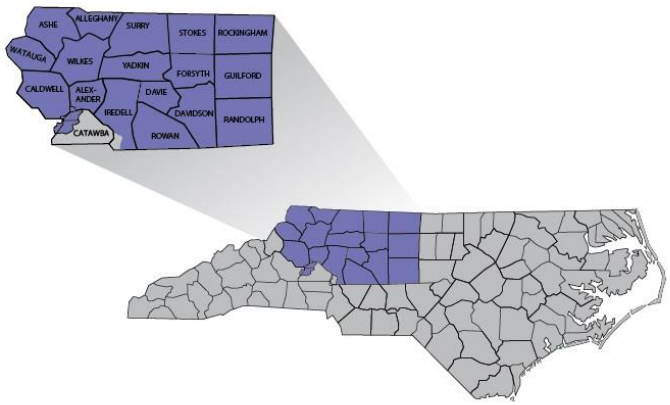
Triad Healthcare Preparedness Coalition (WFU Baptist/Moses Cone)

Situation and Assumptions

Situation

The Triad Healthcare Preparedness Coalition (THPC) office is located at 315 Bethel Church Rd, Mocksville NC, in the Triad portion of the state. The region covers the following counties:

- Alexander
- Alleghany
- Ashe
- Caldwell
- Catawba
- Davie
- Davidson
- Forsyth
- Guilford
- Iredell
- Randolph
- Rockingham
- Rowan
- Stokes
- Surry
- Watauga
- Wilkes
- Yadkin



The lead hospital for the THPC is Wake Forest Baptist Medical Center, a division of Atrium Health, in Winston-Salem, NC. In addition to Wake Forest Baptist Medical Center, the region includes the following hospitals:

- Alleghany Memorial Hospital
- Ashe Memorial Hospital
- Caldwell UNC Health Care
- Catawba Valley Medical Center
- Cone Health
    - Annie Penn Hospital
    - The Moses H. Cone Memorial Hospital
    - Wesley Long Hospital
- Davis Regional Medical Center
- Frye Medical Center
- Hugh Chatham Memorial Hospital
- Iredell Memorial
- LifeBrite Community Hospital of Stokes

- Northern Hospital of Surry County
- Novant Health
    - Kernersville Medical Center
    - Rowan Medical Center
    - Thomasville Medical Center
    - Clemmons Medical Center
    - Forsyth Medical Center
- Randolph Hospital
- UNC Rockingham Health Care
- Wake Forest Baptist Health
    - Davie Medical Center
    - Lexington Medical Center
    - Wake Forest Baptist Hospital
    - High Point Medical Center
    - Wilkes Regional Medical Center
- Watauga Medical Center
- VA Hospital - Salisbury

The THPC supports its Emergency Response and Public Safety partners from each of the region's counties to provide essential services such as response resources, and planning for public health issues, healthcare, and related emergencies and disasters. Within the region exists multiple Emergency Medical Services agencies, Emergency Management offices, and Public Health Departments each of which are represented in the Coalition.

The following Stakeholder groups, represented through a core planning committee, are part the THPC:

- Hospital
- Emergency Medical Services
- Public Health
- Emergency Management
- Long-Term and Continual Care Facilities
- Mental Health
- Law Enforcement

Assignment of Responsibilities

The THPC has internal policies and procedures that guide its operations according to certain triggers and make specific assignments of responsibilities based on the event. In general, the following assignments are made:

<u>Healthcare Coalition Preparedness Coordinator (Planning)</u>

- Notifications, Communication and Coordination with State/Regional partners
- Assist in the location of appropriate resources
- Coordination of load management in regional hospitals
- Assist in maintaining situational awareness

Healthcare Coalition Finance/Administrative Coordinator

- Grant Management, Finance and Coalition Administration
- Serves as Preparedness Coordinator in absence of primary Coordinator

Healthcare Coalition Operations Coordinator

- Planning documentation
- Volunteer management

Healthcare Coalition Logistics Coordinator

- Maintain inventory and ensure stock rotation
- Work with partners to locate appropriate resources

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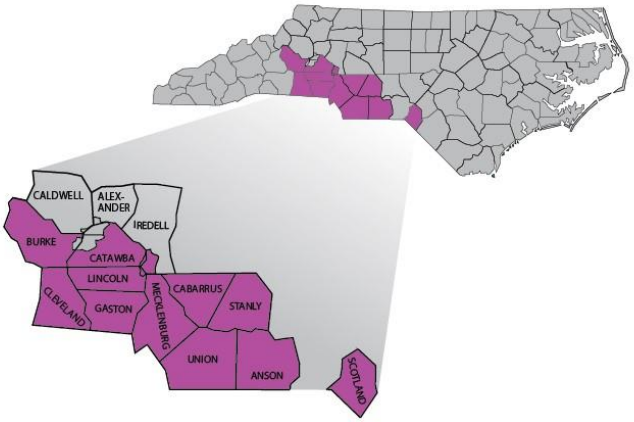
Metrolina Healthcare Preparedness Coalition (Carolinas Medical Center)

Situation and Assumptions

Situation

The Metrolina Healthcare Preparedness Coalition (MHPC) office is located at 3311-A Beam Rd, Charlotte, NC 28217, in the southwestern portion of the state. The lead hospital for the MHPC is Carolinas Medical Center in Charlotte, NC. The region covers the following counties:

- Burke
- Cleveland
- Catawba
- Lincoln
- Gaston
- Iredell
- Mecklenburg
- Cabarrus
- Union
- Stanly
- Anson
- Richmond
- Scotland



The lead hospital for the MHPC is Carolinas Medical Center in Charlotte, NC. In addition to Carolinas Medical Center, the region includes the following hospitals:

- Atrium - Anson
- Atrium – Carolinas Medical Center
- Atrium - Cleveland
- Atrium - Huntersville
- Atrium - Lincoln
- Atrium - Mercy
- Atrium - Cabarrus
- Atrium - Pineville
- Atrium - Providence
- Atrium - Steele Creek
- Atrium - Union
- Atrium - Union West
- Atrium - University
- Atrium - Kings Mountain
- Atrium – Stanly
- Atrium - Waxhaw

- CaroMont Regional Medical Center
- CaroMont – Mount Holly
- Catawba Valley Medical Center
- Frye Regional Medical Center
- Lake Norman Regional Medical Center
- Novant Health – Presbyterian
- Novant Health – Huntersville
- Novant Health – Matthews
- Novant Health – Mint Hill
- Scotland Memorial Hospital

The MHPC supports its Emergency Response and Public Safety partners from each of the region's counties to provide essential services such as response resources, and planning for public health issues, healthcare, and related emergencies and disasters. Within the region exists multiple Emergency Medical Services agencies, Emergency Management offices, and Public Health Departments each of which are represented in the Coalition through Stakeholder leaders. Each Stakeholder leader is responsible to maintain contact with and represent, to the general Coalition membership, the respective agencies' needs and concerns within the specific discipline or group.

The following Stakeholders makeup the MHPC:

- Hospital
- Emergency Medical Services
- Public Health
- Emergency Management
- Long-Term and Continual Care Facilities
- Mental Health
- Auxiliary
    - Law Enforcement
    - Medical Examiner
    - Fire

The MHPC has developed a separate HID Surge Annex to address the specific requirements for the region. The document entitled "MHPC Highly Infectious Disease Plan" is adopted here, in this annex, by reference, and is maintained on file in the main MHPC office.

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NC Triangle Coalition

Situation and Assumptions

Situation

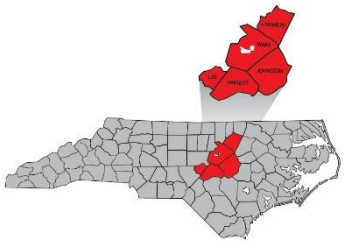
The NC Triangle Coalition (NCTC) is a collaboration of three (3) individual HPCs with similar characteristics. Duke Healthcare Preparedness Coalition (DHPC), Mid-Carolina Regional Healthcare Coalition (MCRHC), and Capital Regional Advisory Committee (CapRAC) makeup the NCTC. The NCTC is located and generally represents a region in the Piedmont of North Carolina that is known as the Research Triangle. The Research Triangle is described as the region developed when extending lines from Chapel Hill to Durham to Raleigh, creating a triangle and encompassing an economical region involving technological, industrial, and medical research and manufacturing. It is considered to be anchored by three (3) universities in the referenced cities, those being the University of NC at Chapel Hill, Duke University in Durham, and NC State University in Raleigh.

The CapRAC has developed a separate HID Surge Annex to address the specific requirements for the region. The document entitled "CapRAC Healthcare Preparedness Coalition, Highly Infectious Disease Medical Surge Plan" is adopted here, in this annex, by reference, and is maintained on file in the main CapRAC office.

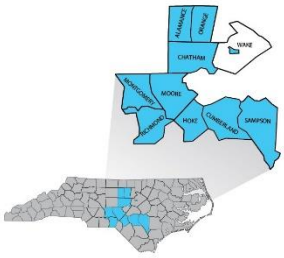
The NCTC region represents twenty-one (21) counties in Central NC as follows:

- Alamance (MCHPC)
- Caswell (DHPC)
- Chatham (MCHPC)
- Cumberland (MCHPC)
- Durham (DHPC)
- Franklin (CapRAC)
- Granville (DHPC)
- Harnett (CapRAC)
- Hoke (MCHPC)
- Johnston (CapRAC)
- Lee (CapRAC)
- Montgomery (MCHPC)
- Moore (MCHPC)
- Orange (MCHPC)
- Person (DHPC)
- Richmond (MCHPC)
- Robeson (DHPC)
- Sampson (MCHPC)
- Vance (DHPC)
- Wake (CapRAC, MCHCP, and DHPC)
- Warren (DHPC)

Duke



CapRAC



Mid-Carolina

The lead hospitals for the NCTC are Duke Health (DHPC), in Durham, UNC Health (MCHPC), in Chapel Hill, and Wake Med (CapRAC), in Raleigh. In addition to the lead hospitals the region includes the following hospitals:

- Maria Parham Franklin (CapRAC)
- Harnett Health System – Betsy Johnson Hospital (CapRAC)
- Harnett Health System – Central Harnett Hospital (CapRAC)
- Johnston Health Smithfield (CapRAC)
- Johnston Health Clayton (CapRAC)
- Central Carolina Hospital (CapRAC)
- WakeMed Raleigh (CapRAC)
- WakeMed North Hospital (CapRAC)
- WakeMed Cary Hospital (CapRAC)
- Duke Raleigh Hospital (DHCP, CapRAC secondary Coalition)
- UNC REX Hospital (MCHC, CapRAC secondary Coalition)
- Person Memorial (DHPC)
- Granville Health (DHPC)
- Central Regional Hospital (DHPC)
- Mariah Parham Henderson (DHPC)
- Duke Regional (DHPC)
- Duke University (DHPC)
- Durham VA (DHPC)
- NC Specialty Hospital (DHPC)
- UNC South Eastern Hospital (DHPC)
- Alamance Regional Medical Center (MCHPC)
- UNC Hospitals Medical Center (MCHPC)
- UNC Hillsborough Hospital (MCHPC)
- UNC Rex Hospital (MCHPC)
- UNC Chatham Hospital (MCHPC)
- First Health Moore Regional Hospital (MCHPC)
- First Health Moore Regional Hospital, Hoke Campus (MCHPC)
- First Health Montgomery Memorial Hospital (MCHPC)
- First Health Richmond Memorial Hospital (MCHPC)
- Cape Fear Valley Medical Center (MCHPC)
- Cape Fear Valley, Hoke Hospital (MCHPC)
- Highsmith Rainey Memorial Hospital (MCHPC)
- Fayetteville VAMC (MCHPC)
- Womack Army Medical Center (MCHPC)
- Sampson Regional Medical Center (MCHPC)

The NCTC supports its Emergency Response and Public Safety partners from each of the region's counties to provide essential services such as response resources, and planning for public health issues, healthcare,

and related emergencies and disasters. Within the region exists multiple Emergency Medical Services agencies, Emergency Management offices, and Public Health Departments each of which are represented in the Coalition through Caucus and Stakeholder leaders. Each leader is responsible to maintain contact with and represent, to the general Coalition membership, the respective agencies' needs and concerns within the specific discipline or group.

Throughout the region, the following Caucuses and/or Stakeholders makeup the NCTC:

- Hospital
- Emergency Medical Services
- Public Health
- Emergency Management
- Long-Term and Continual Care Facilities
- Mental Health
- Law Enforcement
- Federally Qualified Health Centers
- Home Health and Hospice
- Dialysis
- American Red Cross
- NC Baptists on Mission
- Wake Interfaith Disaster Team
- Universities/Student Health

Assignment of Responsibilities

Each Coalition within the NCTC has various authorized positions and stakeholders. Specific positions and duties of full and part-time positions are reflected within the individual Coalitions' internal operations and personnel systems. In general, the following assignments of responsibilities are made across all common positions and stakeholders as they relate to HID Surge:

<u>Healthcare Coalition Preparedness Coordinator</u>

- Notifications, Communication and Coordination with State/Regional partners
- Assist in the location of appropriate resources
- Coordination of load management in regional hospitals
- Assist in maintaining situational awareness

<u>Healthcare Coalition Assistant Preparedness Coordinator</u>

- Grant Management, Finance and Coalition Administration
- Serves as Preparedness Coordinator in absence of primary Coordinator

<u>Healthcare Coalition Planner</u>

- Planning documentation
- Volunteer management

Healthcare Coalition SMAT Coordinator

- Maintain inventory and ensure stock rotation
- Work with partners to locate appropriate resources

Hospitals

- Track and coordinate patient movement
- Maintain accurate census for patient placement
- Initiate planning and response activities related to changes in daily operations
- Request Coalition resources and staff as needs are identified

Emergency Medical Services

- Serve as lead for the coordination of the movement of suspected infected patients to the most appropriate healthcare facility
- Coordinate mutual aid requests related to movement of patients to the most appropriate healthcare facility
- Provide staffing and resources as available in support of Coalition Ambulance Strike Teams
- Request Coalition resources and staff as needs are identified

Emergency Management

- Coordinate SNS Requests
- Assist with logistical needs
- Assist with planning efforts
- Assist with information sharing
- Assist with the coordination of mutual aid as requested

Public Health

- Serve as lead agency in directing and coordinating resources in response to an HID outbreak
- Serve as lead agency for public information
- Coordinate and disseminate information to regional partners related to the HID
- Receive all case reports related to confirmed infected patients from healthcare facilities in the respective counties
- Coordinate mass testing
- Coordinate mass vaccinations
- Conduct contact tracing associated with infected individuals
- Request Coalition resources and staff as needs are identified

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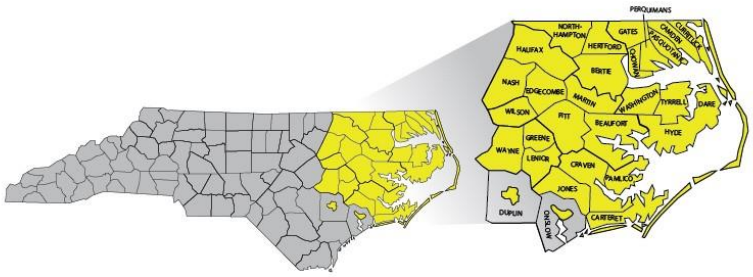
Eastern Healthcare Preparedness Coalition (Vidant Medical Center)

Situation and Assumptions

Situation

The Eastern Healthcare Preparedness Coalition (EHPC) office is located at 2100 Stantonsburg Rd Greenville, NC 27834 in the Eastern portion of the state. The region covers the following counties:

- Beaufort
- Bertie
- Camden
- Carteret
- Chowan
- Craven
- Currituck
- Dare
- Duplin
- Edgecombe
- Gates
- Greene
- Halifax
- Hertford
- Hyde
- Jones
- Lenoir
- Martin
- Nash
- Northampton
- Onslow
- Pamlico
- Pasquotank
- Perquimans
- Pitt
- Tyrell
- Washington
- Wayne
- Wilson



The lead hospital for the EHPC is Vidant Medical Center in Greenville, NC. In addition to Vidant Medical Center, the region includes the following hospitals:

- Carolina East Medical Center
- Carteret Health Care
- Martin General Hospital

- Nash UNC Healthcare
- Onslow Memorial Hospital
- Outer Banks Hospital
- Sentara Albemarle Hospital
- UNC Lenoir Healthcare
- Vidant Health System
    - Beaufort Hospital
    - Bertie Hospital
    - Chowan Hospital
    - Duplin Hospital
    - Edgecombe Hospital
    - Multi-Specialty Clinic
    - Roanoke-Chowan Hospital
    - Vidant Medical Center
    - Vidant North Hospital
- Washington Regional Medical Center
- Wayne UNC Healthcare
- Wilson Medical Center

The EHPC supports its Emergency Response and Public Safety partners from each of the region's counties to provide essential services such as response resources, and planning for public health issues, healthcare, and related emergencies and disasters. Within the region exists multiple Emergency Medical Services agencies, Emergency Management offices, and Public Health Departments each of which are represented in the Coalition through Stakeholder leaders. Each leader is responsible to maintain contact with and represent, to the general Coalition membership, the respective agencies' needs and concerns within the specific discipline or group.

The following Stakeholders makeup the EHPC:

- Hospital
- Emergency Medical Services
- Public Health
- Emergency Management
- Long-Term and Continual Care Facilities
- Mental Health
- Law Enforcement
- Dialysis
- Rural Health
- Home Health
- Private Providers

The EHPC has developed a separate HID Surge Annex to address the specific requirements for the region. The document entitled "EHPC Highly Infectious Disease and Biohazard Surge Annex Plan" is adopted here, in this annex, by reference, and is maintained on file in the main EHPC office.

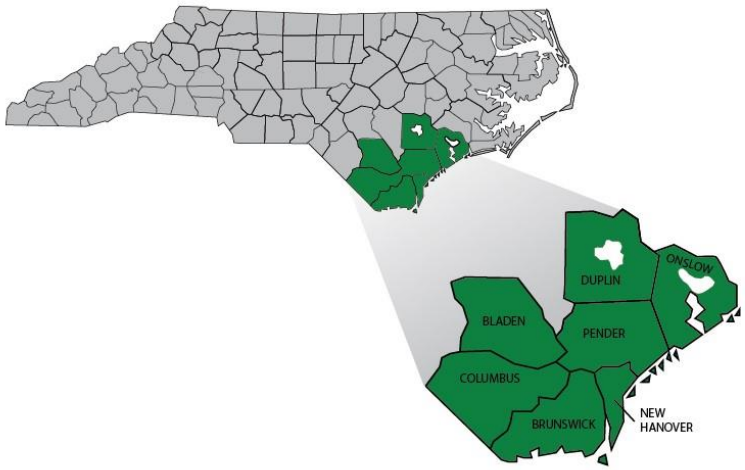
Southeastern Healthcare Preparedness Region (New Hanover Regional)

Situation and Assumptions

Situation

The Southeastern Healthcare Preparedness Region (SEHPR) office is located at 312 Raleigh Street, Suite #11, Wilmington NC, in the southeastern portion of the state. The region covers the following counties:

- Bladen
- Brunswick
- Columbus
- Duplin
- New Hanover
- Onslow
- Pender



The lead hospital for the SEHPR is New Hanover Regional Medical Center in Wilmington, NC. In addition to New Hanover Regional, the region includes the following hospitals:

- Cape Fear Valley Hospital-Bladen
- Novant Health-Brunswick Medical Center
- Columbus Regional Healthcare System
- Naval Medical Center Camp Lejeune
- Pender Memorial Hospital

The SEHPR supports its Emergency Response and Public Safety partners from each of the region's counties to provide essential services such as response resources, and planning for public health issues, healthcare, and related emergencies and disasters. Within the region exists multiple Emergency Medical Services agencies, Emergency Management offices, and Public Health Departments each of which are represented in the Coalition through Stakeholder leaders. Each Stakeholder leader is responsible to maintain contact with and represent, to the general Coalition membership, the respective agencies' needs and concerns within the specific discipline or group.

The following Stakeholders makeup the SEHPR:

- Hospital
- Emergency Medical Services
- Public Health
- Emergency Management
- Long-Term and Continual Care Facilities
- Mental Health
- Law Enforcement

Assignment of Responsibilities

(To be completed by Coalition)

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Hazard-Specific Appendices

Although the general duties of the Coalitions during an HID event will remain consistent, certain disease outbreaks may require additional considerations. For the purposes of the hazard-specific appendices, the following planning scenarios will be used:

- **Planning Scenario 1 - "Low Healthcare Burden – High Acuity" (Ebola-like scenario)**. Although Ebola or EVD patients require a substantial amount of resources per patient, it is unlikely for one facility to receive a large number of persons under investigation (PUI). Once a PUI is deemed positive they would be transferred to the closest treatment facility.
- **Planning Scenario 2 - "Moderate Healthcare Burden – High Acuity" (SARS-like scenario).** SARS is more likely to produce a larger number of affected patients than Ebola due to its mode of transmission. While Ebola requires direct contact with bodily fluids, SARS can be spread via respiratory droplets.
- **Planning Scenario 3 - "High Healthcare Burden - High Acuity" (Pandemic Influenza-like scenario).** Pandemic Influenza is more likely to produce a large number of patients than both Ebola and SARS due to the ease of transmission. This scenario would lead to over-crowding in hospitals as well as a likely shortage in PPE.

LOW	MODERATE	HIGH
Direct transmission. Overall low case numbers resulting in very few admissions. Resource-intensive care expected.	Indirect or direct transmission. Moderate rates of hospitalization (20-50%). Case fatality rates (5-10%).	Widespread rates of infection. High rates of hospitalization (>80-90%). Case fatality rate of >10%.

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Bioterrorism

Bioterrorism may be categorized under all the aforementioned planning scenarios, based on the level of threat and/or actual consequences of the biologic agent used. The actual intended nature of terrorism itself is to instill fear in the general public. As such, bioterrorism involving an HID will likely create mass panic and generate additional healthcare surges as a result of actual infections as well as the "worried well" who will seek care when not affected.

Situation

Bioterrorism may potentially involve many different pathogens and, consequently, different transmission methods. The effects may be limited to a specific population or may target large-scale infections. Biological agents are organisms or toxins that can kill or disable people, livestock and crops. A biological attack is the deliberate release of germs or other biological substances that can cause illness.

There are three basic groups of biological agents that could likely be used as weapons: bacteria, viruses and toxins. Biological agents can be spread by spraying them into the air, person-to-person contact, infecting animals that carry the disease to humans and by contaminating food and water. (*Source – ready.gov*)

Assumptions

- Little or no warning will be received prior to a bioterrorism attack.
- Attack area(s) will likely be geographically small to maximize the effects of the biologic agent.
- Exact biologic agents used in an attack may not be known until well after symptoms appear.
- The general public will likely react in panic.
- Media attention will be high.
- All scenarios will have high visibility, regardless of the biologic agent used.

Concept of Operations

In addition to their general roles during an HID event , Coalitions may assist partner agencies and stakeholders with the following:

- Implementing screening
- SNS assets (storage/dissemination)
- Logistical support
- Risk communications
- Critical Incident Stress Management (CISM)
- Alternate care sites
- MCM distribution and use
- Fatality management
- Waste management

Additional Support Resources

- 42nd Civil Support Team, NC National Guard
- NC HazMat Regional Response Teams (RRTs)
- SMAT III

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High Consequence Pathogens (HCP)/Ebola

HCP/Ebola is categorized under Planning Scenario 1, Low Healthcare Burden – High Acuity. Although significant numbers of patients causing overwhelmed capacities as a result of surge are not anticipated due to the mode of transmission, PUIs will require a high degree of specialized/dedicated patient care and potential isolation measures, as well as specialized waste and decedent handling to manage outbreaks.

Situation

High Consequence Pathogens (HCP) may be defined as highly lethal viral, bacterial, prion, and/or related infections and diseases of unknown origin. (*Source – cdc.gov*) HCPs may be transmitted through direct contact with an infected individual, contact with bodily fluids pre and postmortem, contact with contaminated medical waste, airborne exposure, or any combination of these transmission modes. These pathogens may pose generalized risks to laboratory personnel through direct clinical specimens. All forms of HCP medical waste (including patient excreta, secreta, blood, tissue, tissue swabs, and specimens in transport media) are classified as "Category A, or B, Infectious Substances" (UN2814) by the U.S. Department of Transportation (*Source - www.phmsa.dot.gov*).

Ebola, also known as Ebola Virus Disease (EVD), is a viral hemorrhagic fever of humans and other primates caused by filoviruses. Signs and symptoms typically start between two (2) days and twenty-one (21) days after contracting the virus with a fever, sore throat, muscular pain, and headaches. Vomiting, diarrhea, and rash usually follow, along with decreased function of the liver and kidneys, while some patients begin to bleed both internally and externally. The disease has a high risk of death, killing 25% to 90% of those infected, with an average of about 50%. This is often due to shock from fluid loss, and typically follows six to 16 days after symptoms appear.

The virus spreads through direct contact with body fluids, such as blood from infected humans or other animals. Spread may also occur from contact with items recently contaminated with bodily fluids. Spread of the disease through the air between primates, including humans, has not been documented in either laboratory or natural conditions.

Control of outbreaks requires coordinated medical services and community engagement. This includes rapid detection, contact tracing of those who have been exposed, quick access to laboratory services, care for those infected, and proper disposal of the deceased through cremation or burial. Samples of body fluids and tissues from people with the disease should be handled with special caution.

Other diseases that are also classified as an HCP:

- Lassa Fever
- Marburg Virus Disease
- Middle Eastern Respiratory Syndrome (MERS)
- Severe Acute Respiratory Syndrome (SARS)
- Nipah Virus
- Other emerging infections that require special containment measures

Assumptions

- Warning, and information will be readily available based on known international outbreaks.
- Information will be exchanged rapidly as it becomes available.
- Media attention will be high.
- Management of an HCP outbreak will require intensive resources.
- Specialized biocontainment facilities may not be readily available.
- All urgent care and emergency departments are expected to screen for PUIs with HCPs

Concept of Operations

State and local health departments are the lead agencies for outbreaks of this nature. Healthcare organizations should refer to specific plans developed for HCP/Ebola outbreaks, located within each healthcare region.

In general, Coalitions may assist partner agencies and stakeholders with the following, as they relate to HCP outbreaks:

- Information sharing
- Implementing screening
- Testing/sampling coordination
- Regional patient movement coordination
- SNS assets (storage/dissemination)
- Logistical support
- Risk communications
- Critical Incident Stress Management (CISM)
- Alternate care sites
- MCM distribution and use
- Fatality management
- Waste management

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Highly Pathogenic Respiratory Viral Infection

Highly Pathogenic Respiratory Viral Infections are categorized under Planning Scenario 2, Moderate Healthcare Burden – High Acuity, due to the primary mode, respiratory droplets, and ease of transmission. It is anticipated that this category would result in a higher-than-average surge at healthcare facilities.

Situation

New viral respiratory pathogens are emerging with increasing frequency and have potentially devastating impacts on the population worldwide. Recent examples of newly emerged threats include severe acute respiratory syndrome coronavirus, the 2009 H1N1 influenza pandemic, Middle East respiratory syndrome coronavirus, and the SARS CoV-2, better known as "COVID-19," pandemic outbreak in 2020. The increase in rate of emergent respiratory viral infections in the past 15 years is driven by the convergence of various global factors, including growth in the human population, urbanization, changes in the interactions between human and animal populations, and increases in international travel and trade. In recent years, novel zoonotic coronavirus outbreaks have required new approaches in surveillance and containment. (*Source* - *www.ncbi.nlm.nih.gov*)

Assumptions

- Warning, and information may not be readily available.
- Information will be exchanged rapidly as it becomes available.
- Affected individuals may shed transmissible virus before becoming symptomatic.
- Diagnosis based on symptoms may not be readily discernible from other similar respiratory diseases with lower morbidity rates.
- Specific testing may not be immediately available for novel diseases.
- Effective treatments and vaccines will likely not be readily available.
- Media attention will be high.
- There will likely be a high influx of "worried well" at healthcare facilities.

Concept of Operations

State and local health departments are the lead agencies for outbreaks of this nature. Healthcare organizations should refer to specific plans developed for influenza or other viral respiratory diseases, located within each healthcare region.

In general, Coalitions may assist partner agencies and stakeholders with the following, as they relate to surges from HCP outbreaks:

- Information sharing
- Implementing screening
- Testing site coordination
- Regional patient movement coordination
- SNS assets (storage/dissemination)
- Logistical support
- Risk communications
- Critical Incident Stress Management (CISM)
- Alternate care sites

- MCM distribution and use
- Fatality management
- Waste management

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Pandemic

Pandemic is categorized under Planning Scenario 3, High Healthcare Burden – High Acuity due to the ease of and rapid transmission rates, as well as global spreading of the specific disease.

Situation

A pandemic is an epidemic of an infectious disease that has spread across multiple continents or worldwide, affecting a substantial number of people. Throughout human history, there have been a number of pandemics of diseases such as smallpox and tuberculosis. The most fatal pandemic in recorded history was the Black Death (also known as The Plague), which killed an estimated 75–200 million people in the 14th century. The term was not used yet but was for later pandemics including the 1918 influenza pandemic (Spanish flu). Current pandemics include HIV/AIDS, and COVID-19 (SARS-CoV-2).

Assumptions

- Warning, and information will be readily available based on known international outbreaks.
- Information will be exchanged rapidly as it becomes available.
- Media attention will be high.
- Management of a pandemic outbreak will require intensive resources.
- Due to increased risk of infection, healthcare staffing will be compromised.

Concept of Operations

State and local health departments are the lead agencies for outbreaks of this nature. Healthcare organizations should refer to specific plans developed for pandemic influenza or other global disease outbreaks, located within each healthcare region.

In general, Coalitions may assist partner agencies and stakeholders with the following, as they relate to surges from HCP outbreaks:

- Information sharing
- Implementing screening
- Testing site coordination
- Regional patient movement coordination
- SNS assets (storage/dissemination)
- Operations and Logistical support
- Risk communications
- Critical Incident Stress Management (CISM)
- Alternate care sites
- MCM distribution and use
- Fatality management
- Waste management

General Appendices

Legal Authorities

NCGS 130A-144, “Investigation and Control Measures”

10A NCAC 41A .0206 “Infection Prevention – Health Care Settings”

NCGS 166A, “Emergency Management Act”

References

“North Carolina Office of Emergency Medical Services, Highly Infectious Disease Concept of Operations,” October 2020

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Glossary of Terms and Acronyms

ASPR, Assistant Secretary for Preparedness and Response – A division of the US Department of Health and Human Services (HHS), the mission of the HHS Office of the Assistant Secretary for Preparedness and Response (ASPR) is to save lives and protect Americans from 21st century health security threats. ASPR leads the nation's medical and public health preparedness for, response to, and recovery from disasters and public health emergencies. ASPR collaborates with hospitals, healthcare preparedness coalitions, biotech firms, community members, state, local, tribal, and territorial governments, and other partners across the country to improve readiness and response capabilities.

ACS, Alternate Care Site - An ACS is a building or structure of opportunity that is temporarily converted for health care use during a public health emergency to provide additional health capacity and capability for an affected community, outside the walls of a traditional established health care institution. The safety of patients, care providers, and the general public is the main priority. (*Source - asprtracie.hhs.gov*)

Bioterrorism - Terrorism involving the intentional release or dissemination of biological agents. These agents are bacteria, viruses, insects, fungi or toxins, and may be in a naturally occurring or a human-modified form, in much the same way as in biological warfare.

CBRN, Chemical, Biological, Radiological, Nuclear - Events involving weapons of mass destruction incidents, spills or fires involving HAZMATs, and/or accidents involving radiological/nuclear materials.

CDB, Communicable Disease Branch - The Communicable Disease Branch of the NC Division of Public Health primarily deals with infectious diseases that are reportable by law to the state health department, as well as a few other communicable diseases of public health significance, such as influenza, norovirus infection and certain healthcare-associated infections. (*Source - epi.dph.ncdhhs.gov*)

CDC, Centers for Disease Control and Prevention – A division of the US Department of Health and Human Services charged with the responsibility of protecting the Nation's citizens from health, safety and security threats from both foreign and domestic sources. Whether diseases start at home or abroad, are chronic or acute, curable or preventable, human error or deliberate attack, CDC fights disease and supports communities and citizens to do the same. (*Source - CDC.gov*)

CISM, Critical Incident Stress Management - Critical Incident Stress Management, or CISM, is an intervention protocol developed specifically for dealing with traumatic events. It is a formal, highly structured and professionally recognized process for helping those involved in a critical incident to share their experiences, vent emotions, learn about stress reactions and symptoms and given referral for further help if required. It is not psychotherapy. It is a confidential, voluntary, and educative process, sometimes called "psychological first aid." (*Source - criticalincidentstress.com*)

CMS, Centers for Medicare and Medicaid Services – A division of the US Department of Health and Human Services, charged with oversight of Medicare and Medicaid services. (*Source - cms.gov*)

DPS, Division of Public Health – A division of the NC Department of Health and Human Services, North Carolina Public Health (NCPH) works to promote and contribute to the highest possible level of health for the people of North Carolina. (*Source - publichealth.nc.gov*)

Ebola – Ebola virus disease (EVD) is a deadly disease with occasional outbreaks that occur mostly on the African continent. EVD most commonly affects people and nonhuman primates (such as monkeys, gorillas, and chimpanzees). It is caused by an infection with a group of viruses within the genus Ebolavirus. The virus first spreads to people through direct contact with the blood, body fluids and tissues of animals. Ebola virus then spreads to other people through direct contact with body fluids of a person who is sick with or has died from EVD. This can occur when a person touches these infected body fluids or objects that are contaminated with them. (*Source – CDC.gov*)

EMS, Emergency Medical Services – Prehospital medical services. Typically provides basic and advanced life support measures in response to emergency situations, in addition to emergency transportation of the sick and injured to a medical facility for definitive medical care.

Emergency Support Functions (ESF), ESF-8 – Emergency Support Functions are federal coordinating structures that group resources and capabilities into functional areas most frequently needed in a national response. ESF-8, Public Health and Medical Services, provides the mechanism for Federal assistance to supplement local, state, tribal, territorial, and insular area resources in response to a disaster, emergency, or incident that may lead to a public health, medical, behavioral, or human service emergency, including those that have international implications. ESF-8 provides planning and coordination of public health, healthcare delivery, and emergency response systems to minimize and/or prevent health emergencies from occurring; detect and characterize health incidents; provide medical care and human services to those affected; reduce the public health and human service effects on the community; and enhance community resiliency to respond to a disaster.

EUA, Emergency Use Authorization - A mechanism to facilitate the availability and use of medical countermeasures, including vaccines, during public health emergencies, such as during the COVID-19 pandemic. Under an EUA, the Federal Food and Drug Administration (FDA) may allow the use of unapproved medical products, or unapproved uses of approved medical products in an emergency to diagnose, treat, or prevent serious or life-threatening diseases or conditions when certain statutory criteria have been met, including that there are no adequate, approved, and available alternatives. (*Source - fda.gov*)

FDA, Food and Drug Administration – A division of the US Department of Health and Human Services, the FDA is charged with the responsibility of protecting the public health by ensuring the safety, efficacy, and security of human and veterinary drugs, biological products, and medical devices; and by ensuring the safety of our nation's food supply, cosmetics, and products that emit radiation. (*Source – fda.gov*)

FSE, Full-Scale Exercise – Part of the Homeland Security Exercise and Evaluation Program, a Full-Scale Exercise is an Operations-based exercise. These exercises validate plans, policies, procedures, and agreements; clarify roles and responsibilities; and identify resource gaps. Operations-based exercises include a real-time response such as initiating communications or mobilizing personnel and resources.

High Consequence Pathogen (HCP) – A highly lethal viral, bacterial, prion, and/or related infections and diseases of unknown origin. (*Source – cdc.gov*)

Healthcare Preparedness Coalition (HPC) - A healthcare preparedness coalition (HPC), as defined in the HHS ASPR 2017-2022 Health Care Preparedness and Response Capabilities, is a group of individual healthcare and response organizations (e.g., hospitals, emergency medical services [EMS], emergency management organizations, and public health agencies) in a defined geographic location that play a critical role in developing healthcare system preparedness and response capabilities. HPCs serve as multiagency coordinating groups that support and integrate with ESF-8 activities in jurisdictional incident command systems (ICS).

Homeland Security Exercise and Evaluation Program (HSEEP) - A set of guiding principles for exercise and evaluation programs, as well as a common approach to exercise program management, design and development, conduct, evaluation, and improvement planning.

ICS, Incident Command System - A standardized approach to the command, control, and coordination of on-scene incident management, providing a common hierarchy within which personnel from multiple organizations can be effective. ICS is the combination of procedures, personnel, facilities, equipment, and communications operating within a common organizational structure, designed to aid in the management of on-scene resources during incidents. It is used for all kinds of incidents and is applicable to small, as well as large and complex, incidents, including planned events. (*Source – fema.gov*)

Infectious Disease - A disease (such as influenza, malaria, meningitis, rabies, or tetanus) caused by the entrance into the body of pathogenic agents or microorganisms (such as bacteria, viruses, protozoans, or fungi) which grow and multiply there, and is capable of being spread to others through one or more means of transmission. (*Source - merriam-webster.com*)

IPP, Integrated Preparedness Plan – Part of the Homeland Security Exercise and Evaluation Program, the IPP is a plan for combining efforts across the elements of the Integrated Preparedness Cycle to make sure jurisdictions/organizations have the capabilities to handle threats and hazards. (*Source – fema.gov*)

IPPW, Integrated Preparedness Planning Workshop - Part of the Homeland Security Exercise and Evaluation Program, the IPPW is a periodic meeting that establishes the strategy and structure for an exercise program, in addition to broader preparedness efforts, while setting the foundation for the planning, conduct, and evaluation of individual exercises. The IEPW is used to prepare the Integrated Preparedness Plan (IPP). (*Source – fema.gov*)

MCM, Medical Countermeasures - FDA-regulated products (biologics, drugs, devices) that may be used in the event of a potential public health emergency stemming from a terrorist attack with a biological, chemical, or radiological/nuclear material, or a naturally occurring emerging disease. (*Source – fda.gov*)

NCAC, North Carolina Administrative Code - Rules adopted by state agencies, boards, and commissions. (*Source – nc.gov*)

NCEM, North Carolina Emergency Management – A division of the NC Department of Public Safety, NCEM is governed by North Carolina General Statute 166A and is charged with disaster preparedness, response, recovery, and mitigation efforts within the state.

NCGS, North Carolina General Statute – The governing laws and regulations of the State of North Carolina.

NCOEMS, North Carolina Office of Emergency Medical Services – A division of the NC Department of Health and Human Services, NCOEMS is charged with the responsibility of fostering and oversight of Emergency Medical Systems as well as credentialing emergency medical services personnel within the state of North Carolina.

NIMS, National Incident Management System – A guides for all levels of government, nongovernmental organizations and the private sector to work together to prevent, protect against, mitigate, respond to and recover from incidents. NIMS provides stakeholders across the whole community with the shared vocabulary, systems, and processes to successfully deliver the capabilities described in the National Preparedness System. NIMS defines operational systems that guide how personnel work together during incidents. (*Source – fema.gov*)

Pandemic – A global epidemic, where "epidemic" is defined as a certain percentage of infections of a particular disease over and above what is considered normal for that period.

PHEP, Public Health Emergency Preparedness - The Public Health Emergency Preparedness (PHEP) cooperative agreement is a critical source of funding for state, local, and territorial public health departments. The program helps health departments build and strengthen their abilities to effectively respond to a range of public health threats, including infectious diseases, natural disasters, and biological, chemical, nuclear, and radiological events. (*Source – cdc.gov*)

PUI, Person Under Investigation – A person or patient being medically followed as a result of direct infection or being suspected of contact with an infectious disease.

RRT, Regional Response Team - The NC Hazardous Materials Regional Response program is a system of seven teams strategically located in the state to provide hazardous materials response services to the citizens of North Carolina. The RRTs are available to respond whenever an incident exceeds local capabilities with technical support, manpower, specialized equipment and/or supplies.

SERT, State Emergency Response Team - State and federal agencies, nonprofit relief organizations, faith-based organizations and some private sector companies working to protect the people of North Carolina under the command of the SERT leader, the North Carolina Emergency Management Director.

SLPH, State Laboratory of Public Health - The State Laboratory of Public Health provides certain medical and environmental laboratory services (testing, consultation and training) to public and private health provider organizations responsible for the promotion, protection and assurance of the health of North Carolina citizens. (*Source – slph.ncpublichealth.com*)

SMAT, State Medical Assistance Team - A multidisciplinary volunteer team of medical and non-medical professionals established to provide medical support for short- and long-term disasters or catastrophic events. Roles in which the SMAT can provide support include set up and provision of a mobile treatment facility, regional and state logistics support, and community alternate care site support.

SMSS, State Medical Support Shelter – Managed by the NC Office of Emergency Medical Services, the SMSS is established to provide medical care and support for sheltering of disaster victims when general population shelters are not capable of providing for their needs. (*Source - nchpp.com*)

TRACIE - Technical Resources, Assistance Center, and Information Exchange (TRACIE) was created to meet the information and technical assistance needs of regional ASPR staff, healthcare preparedness coalitions, healthcare entities, healthcare providers, emergency managers, public health practitioners, and others working in disaster medicine, healthcare system preparedness, and public health emergency preparedness.

VOAD, Voluntary Organizations Active in Disasters - National VOAD is a coalition of 70+ of the nation's most reputable national organizations (faith-based, community-based and other non-profit organizations) and 56 State/Territory VOADs, which represent Local/Regional VOADs and hundreds of other member organizations throughout the country. (*Source - nvoad.org*)

WHO, World Health Organization - The directing and coordinating authority on international health within the United Nations system. (*Source - who.int*)

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