



REGIONAL HEALTHCARE SYSTEM EMERGENCY RESPONSE PLAN ANNEX

Regional Acute Infectious Disease Response Plan

Version 2, August 2017



Record of Changes

Version No.	Description of Change	Date Entered	Posted By
1.	Plan development and review by partner agencies	January 2016	Rebecca Lis
2.	Plan updated based on after action and improvement plan from April 2016 tabletop exercise	January 2017	Rebecca Lis Aaron Resnick
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Introduction

In a globalized society, emerging and acute infectious diseases are easily transported and transmitted around the world. The Puget Sound region is an international hub for travel, commerce, and tourism as well as numerous humanitarian organizations with staff that travel overseas. Therefore, our region could be exposed to numerous infectious diseases locally or through introduction by international travelers, including Ebola, Marburg, pandemic and avian influenza, Middle East Respiratory Syndrome Coronavirus (MERS-CoV), Severe Acute Respiratory Syndrome (SARS), or other unknown emerging infectious diseases as well as outbreaks of established diseases such as measles.

Definition: For the purposes of this plan an “acute infectious disease response” is a response to any new, emerging, or severe infectious disease situation that goes above and beyond routine infectious disease investigation, coordination, and response; and likely requires significant multi-agency response.

The Regional Acute Infectious Disease Response Plan defines roles and responsibilities of regional response agencies to an acute infectious disease response including the coordination of healthcare, Local Health Jurisdictions (LHJs), and other regional and State partners. It is based on the experience of local and regional partners in healthcare, infectious disease, LHJs, and emergency management and will serve as a template for infectious disease outbreak response. Acute infectious disease preparedness is a fluid planning environment and this plan will be updated as work progresses on other planning fronts.

Purpose

The purpose of this plan is to provide a concept of operations for a coordinated regional response in King and Pierce Counties related to the potential consequences of an acute infectious disease outbreak. The plan describes the coordination of decision making, operations, and communication for an acute infectious disease response. Specifically, the purpose of the plan is to:

1. Describe the decision making structure to be used to determine healthcare and coordination of LHJ response actions and priorities.
2. Describe procedures for creating or updating protocols for patient placement, movement, and care.
3. Describe procedures for sharing and/or prioritizing scarce resources.
4. Define roles and responsibilities for healthcare, the Northwest Healthcare Response Network (NWHRN), LHJs, local response agencies, emergency management, community, non-governmental, and local, state, federal and tribal partners in an acute infectious disease response in the region.
5. Describe procedures for communications and coordination among public health, healthcare agencies and other local partners during a response.
6. Describe procedures for the coordination of local healthcare system planning and response efforts to respond to an acute infectious disease.

Scope

The Regional Acute Infectious Disease Response Plan is an Annex to the larger King and Pierce County Healthcare System Emergency Response Plan and is applicable for any incident in which an



individual or population with confirmed or suspected acute infectious disease. This plan outlines the concept of coordination and operations for incidents wherein the complexity or duration requires regional coordination of information, resources and/or response activities. This plan is not applicable for the routine management of infectious diseases such as tuberculosis, measles, foodborne illness, and other sexually transmitted diseases (STDs) within our community, unless the situation requires urgent regional coordination.

The information in this plan applies to the roles and responsibilities of healthcare organizations (including hospitals, ambulatory care, long-term care, home health/home care, and support services) and the relationship of healthcare organizations with other emergency preparedness partners. It includes a general concept of operations for the response to acute infectious disease patients. Broader health, medical and mortuary response activities are covered in the King and Pierce County Healthcare Emergency Response Plan, the King County ESF 8 plan and Annexes (including Isolation and Quarantine and Communicable Disease), the Pierce County ESF 8 plan and Annexes, or in relevant functional response plans. This plan is compatible with federal, state, and local emergency response plans, promotes the coordination of an efficient and effective response by utilizing the concepts outlined in the National Incident Management System and it establishes common goals, strategies and terminology with other regional and local plans (See References).

This plan applies to:

- Acute infectious disease response to any new, emerging, or severe infectious disease situation that goes above and beyond routine infectious disease investigation, coordination, and response; and likely requires significant multi-agency response.
- Healthcare organizations, NWHRN, LHJs, and all partner agencies with whom there are established memoranda of agreement, procedures, or protocols for acute infectious disease incidents.
- Acute infectious disease incident within or impacting King and/or Pierce Counties.

Planning Assumptions

Planning assumptions for this plan include:

1. This plan is meant to provide an overview of healthcare system response to an acute infectious disease outbreak, and will coordinate with other relevant regional plans and partners.
2. Acute infectious disease outbreaks may be anticipated and provide the ability to plan in advance, or there may be no notice and require immediate response.
3. Patients with an acute infectious disease could present to healthcare organizations in the region through two modes:
 - a. A patient presents with symptoms with or without a history of exposure and no advance notification to the healthcare facility.
 - b. A patient being monitored or treated for a disease/exposure and is directed to a healthcare facility for evaluation or treatment in the region.
4. Not all healthcare facilities in the region may be able to care for all acute infectious disease patients.



5. All healthcare facilities must be able to maintain a base level of preparedness to safely screen (in-person or remotely), stabilize, isolate if necessary, and arrange for the transport of a possible acute infectious disease patient.
6. Resources such as personnel, equipment, and personal protective equipment may be in short supply throughout the region, state, country, or the globe depending on the severity and nature of the acute infectious disease.
7. The objectives of public health and hospitals may differ in an acute infectious disease response: public health is primarily concerned with community disease control and healthcare facilities are focused on the clinical care of patients.
8. This plan does not apply to routine disease responses such as tuberculosis, measles, STD, and foodborne illness cases or outbreaks, unless the response requires coordination above and beyond normal operational procedures.
9. LHJs maintain plans for pandemic/avian influenza as well as isolation and quarantine. This plan is meant to complement other local planning efforts.
10. Responses to large scale acute infectious disease response may require coordination with other regional, state and federal partners.
11. Local Health Officers (LHOs) have the authority to change or implement procedures to protect the public's health, including isolation and quarantine.
12. Healthcare organizations and systems throughout the region will commit their own resources to address internal challenges prior to releasing resources to other healthcare organizations.
13. Pediatric, obstetric and other specialty care patients, including those that are critically ill, may present to ANY healthcare facility during an acute infectious disease response.
14. Healthcare organizations will rely on existing contracts with medical suppliers and pharmaceutical vendors to the maximum extent possible.
15. Hospitals and healthcare systems have, or are in the process of completing, internal plans and systems for an acute infectious disease response.

Concept of Operations

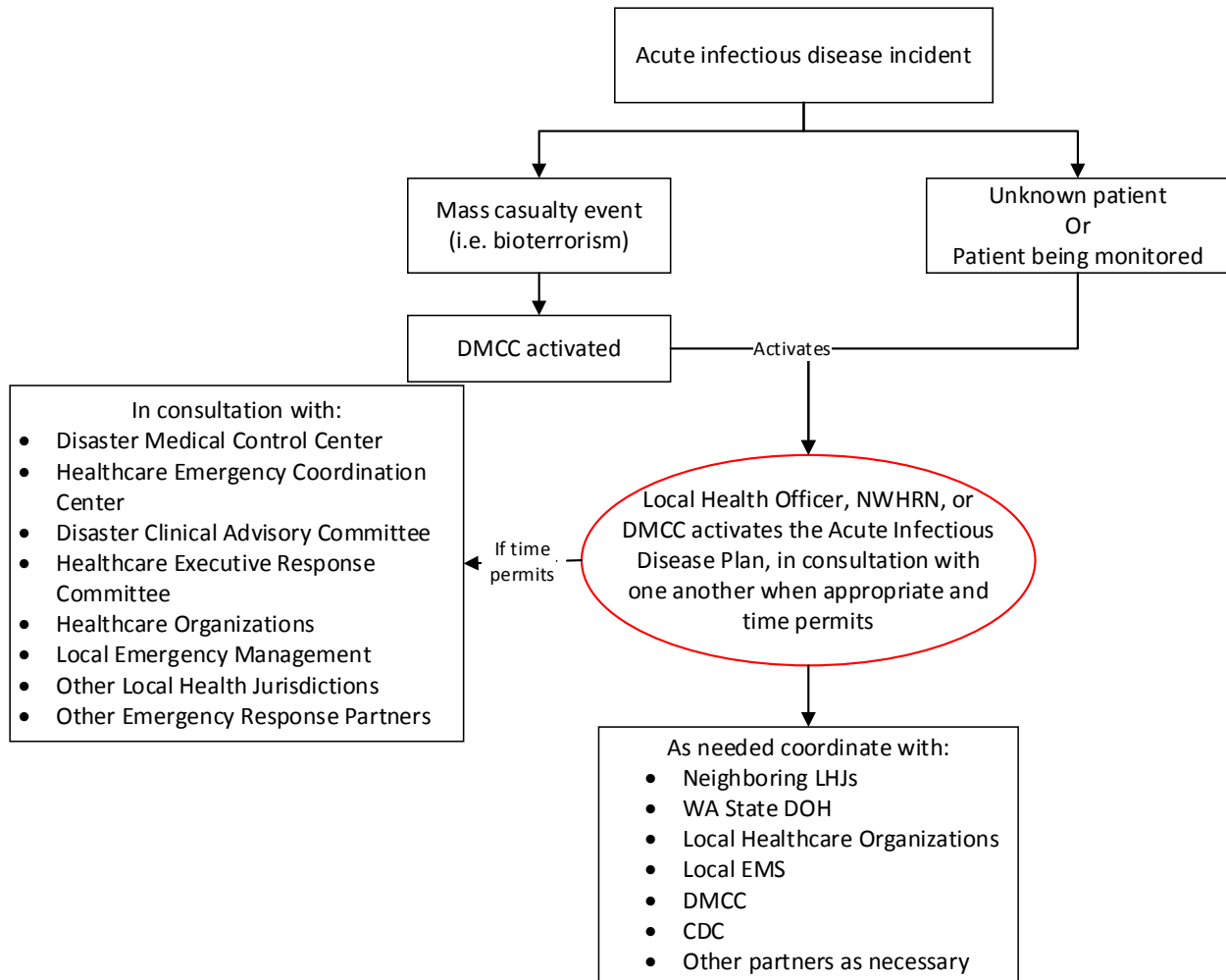
A. Activation of the Plan

- This plan may be activated during any acute infectious disease scenario that warrants coordination between healthcare organizations when the day-to-day resources and plans are insufficient to address the current or anticipated acute infectious disease response needs. This may occur concurrently with activation of other plans.
- This plan is meant to facilitate a need to activate a response quickly. Therefore, this plan can be activated by the LHO (or their designee), NWHRN, or the local Disaster Medical Control Center (DMCC), where appropriate and time permitting, parties should consider consulting with one another prior to activation. If time permits, parties may consult with local healthcare organizations, the Healthcare Executive Response Committee, the Disaster Clinical Advisory Committee (DCAC), other Local Health Jurisdictions (LHJs), local Emergency Operations Centers (EOCs), or any other regional entities or emergency response partners.
- Following activation LHJs and NWHRN should notify each other, if not already notified prior to activation.



- NWHRN will notify the Washington State Department of Health (DOH) Preparedness Duty Officer; the LHJs will notify the DOH Epidemiology Duty Officer and may additionally notify the DOH Preparedness Duty Officer concerning regional response.
- If the plan is only activated to support operations in one county, NWHRN and the activated LHJ will communicate with the other LHJ and DOH regarding the situation and potential need for wider activation.

Figure 1: Plan activation and notification diagram



- Plan activation triggers may include (but are not limited to):
 - One or more suspected or laboratory confirmed acute infectious disease patients identified in the region.
 - Regional coordination required to assist with monitoring, laboratory testing, patient care, patient movement, etc.
 - Multiple counties affected by an acute infectious disease requiring a coordinated response.
 - Regional coordination required for risk communication, public information, and/or media response.

B. Notification and Warning

- The NWHRN, Public Health – Seattle & King County (PHSKC), and the Tacoma-Pierce County Health Department (TPCHD) each maintain a 24/7 contact numbers for healthcare providers, as well as a duty officer phone line. LHJs are the first line of contact for healthcare organizations in the event of an acute infectious disease response. See Attachment A for Duty Officer contact information
 - In the event of an acute infectious disease response of an unannounced patient that presents to a healthcare organization, healthcare providers should contact their LHJ, who will then contact the DOH duty officer(s) and NWHRN duty officer.
 - In the event of an “announced” acute infectious disease emergency in a patient being monitored locally or transferred into the region, healthcare providers should contact their LHJ, who will then contact the NWHRN duty officer.
 - In the event of a mass causality incident (e.g. an act of bioterrorism) when the DMCC is activated, the DMCC will notify the LHJ duty officer and/or the NWHRN duty officer.
- Following notification, the NWHRN and the LHJs will identify the appropriate partners to further notify. Partners may include:
 - Neighboring LHJs
 - DOH (preparedness and communicable disease)
 - Local healthcare organizations/providers
 - Local EMS
 - DMCC
 - CDC/Assistant Secretary for Preparedness and Response (ASPR)
 - Local emergency management
 - Other health partners as necessary

C. Command, Control, and Coordination

It is recognized that there are overlapping roles and responsibilities for acute infectious disease responses between LHJs, healthcare organizations, and the NWHRN. It is recommended that all parties use Incident Command System (ICS) to coordinate internal and multiagency responses to an acute infectious disease incident.

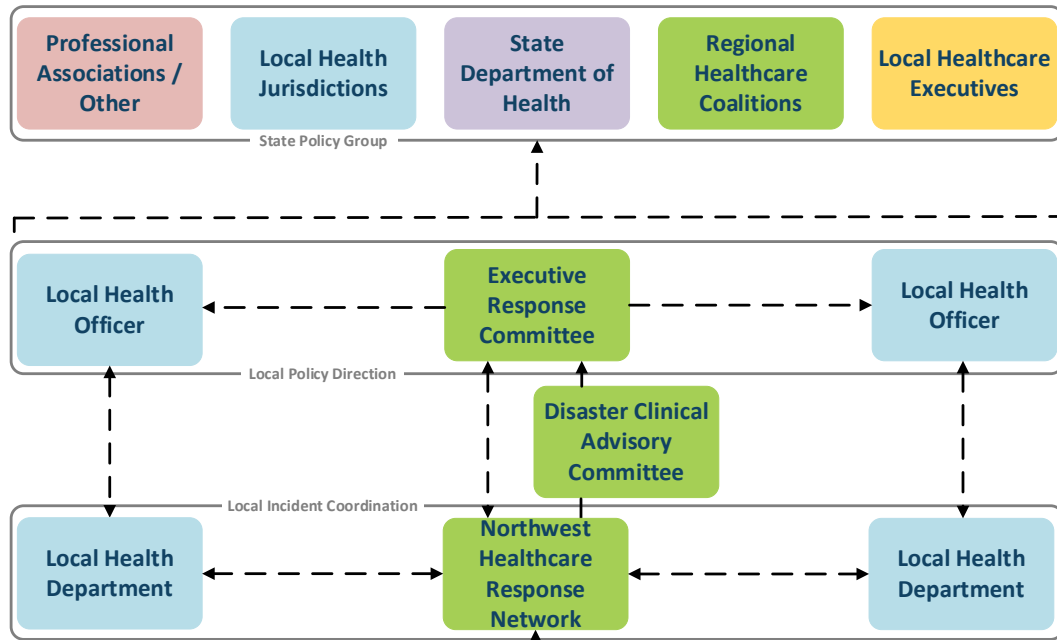
- The NWHRN will activate the Healthcare Emergency Coordination Center (HECC) to support the coordination for an acute infectious disease response.
- The NWHRN may activate the DCAC to advise the NWHRN Executive Response Committee on clinical and healthcare operations, protocols, policies and response an acute infectious disease response. Additionally, the NWHRN may activate the Executive Response Committee in coordination with LHJs to advise the LHO on policy level decisions in an acute infectious disease response (See Figure 2, p. 10).
- LHJ may activate their ESF-8 response to assist in coordination for an acute infectious disease response. PHSKC will activate Health and Medical Area Command (HMAC) to support ESF-8 response in King County. TPCHD will activate their EOC to support ESF-8 response in Pierce County.



- The LHO may also work through defined public health channels to coordinate with the DOH.
- If conditions warrant multi-jurisdictional coordination, the DOH will be the lead agency to coordinate healthcare, LHJ, and non-medical response to an acute infectious disease. In this capacity, the DOH will consider establishing a policy group that may include but not limited to the following organizations:
 - Local Health Jurisdictions and Health Officers
 - Northwest Healthcare Response Network and other Regional Healthcare Coalitions
 - Washington State Hospital Association
 - Washington State Nurses Association
 - Washington State Medical Association
 - Washington State Pharmacy Association
- Coordination among regional partners for acute infectious disease response should follow the tiered communications approach outlined in Attachment D: Regional Acute Infectious Disease Decision-Making and Communications Protocol. Attachment D outlines key decision points concerning acute infectious disease patients, and outlines the process and partners that should be involved in decision making communications.
 - Public information and risk communication specialists should be incorporated into communication discussions early in the response to ensure appropriate public messaging and media coordination.



Figure 2: WA State and King and Pierce county general emergency response coordination diagram. Clinical coordination may occur directly between healthcare organization and LHJs.



D. Categories of Acute Infectious Response

Acute infectious disease responses can fall into the following four general categories based on the characteristics of the pathogen, as well as the healthcare and public health response required to control and ensure the safety of care provided. The following pathogens listed are examples of those that fall into each category and are not an exhaustive list. Emerging pathogens can be categorized by their characteristics and risk to healthcare procedures, healthcare workers, and other patients.



Table 1: Acute Infectious Disease Response Categorization¹

Acute Infectious Disease Category	Pathogen Examples	Requires Category A waste Management for all medical waste	Generalized Laboratory risk from raw specimen	Risk of transmission to healthcare workers providing direct care	Other need for robust institutional response
Category 1	Ebola, Marburg, Lassa, Crimean-Congo, Smallpox <u>Note: low prevalence only – if high prevalence then these pathogens might be Category 2</u>	Yes	Yes	Yes	Yes

¹ Adapted from, Tosh Pritish, MD (Mayo Clinic). *A Preparedness/Response Model & Computer Simulation Modeling for High Consequence Infectious Disease*. National Healthcare Coalition Preparedness Conference. December 2016.

Category 2	MERS-CoV, SARS-CoV, Avian Influenza, Measles	No	Yes	Yes	Yes
Category 3	Pneumonic Plague, Cutaneous Anthrax, Antibiotic Resistant Infections	No	No	Yes	Yes
Category 4	Botulism, Tularemia, Glanders, Melioidosis	No	No	No	Yes

E. Three-Tiered Hospital Model

DOH has identified, assessed, and designated hospitals in Washington State to serve as Treatment Centers and Assessment Hospitals for acute infectious disease responses. These facilities, along with Frontline Facilities, encapsulate the three-tiered framework that may be employed in Category 1 type acute infectious disease responses. Additionally, the three-tiered model may be activated to support lower level (category 2-4) acute infectious disease responses if required to ensure appropriate care and safety of healthcare staff and patients.

These facilities maintain a higher level of capability and preparedness to handle a high level acute infectious disease patient and provide care through the continuum of testing and care. Below is an outline of the three-tiered hospital model and their corresponding roles

1. Treatment Centers - Treatment Centers are facilities that can care for and manage a patient with a confirmed acute infectious disease for the duration of the patient's illness.
2. Assessment Hospitals - Assessment Hospitals are facilities prepared to receive and isolate PUIs and care for the patient until a diagnosis of acute infectious disease can be confirmed or ruled out and until discharge or transfer is completed.
3. Frontline Facilities - Frontline healthcare facilities should, in coordination with local and state health authorities, be able to:
 - Rapidly identify and triage patients with relevant exposure history and signs and symptoms of an acute infectious disease.
 - Immediately isolate any patient with relevant exposure history and signs and symptoms of an acute infectious disease, and take appropriate steps to adequately protect staff caring for the patient. A patient meeting this criteria should be placed in a private room with an in-room bathroom or covered bedside commode.²
 - Immediately notify the facility infection control program, appropriate staff, and LHJs.
 - Coordinate with LHJs to possibly transfer the patient to an assessment or treatment facility.
 - Decontaminate and perform environmental cleaning.
 - Identify exposed staff and patients.

² "Hospital Preparedness: A Tiered Approach", Centers for Disease Control & Prevention, Accessed Jan. 6, 2017: <https://www.cdc.gov/vhf/ebola/healthcare-us/preparing/frontline-healthcare-facilities.html>.



The following hospitals have been designated Treatment and Assessment facilities.

Treatment Centers:

- Harborview Medical Center (Adult) (Seattle)
- Seattle Children’s Hospital (Pediatrics) (Seattle)
- Providence Sacred Heart Medical Center and Children’s Hospital (Spokane) – Regional Treatment Center

Assessment Hospitals:

- Swedish Issaquah (King)
- EvergreenHealth Medical Center (King)
- Harrison Medical Center (Kitsap)
- Providence Regional Medical Center – Everett (Snohomish)
- PeaceHealth St. Joseph Medical Center (Bellingham)
- Providence St. Mary Medical Center (Walla Walla)

F. Patient Triage

1. EMS may provide additional phone screening for individuals before EMS arrival on the scene to ensure proper personal protective equipment and infection control steps are taken.
2. In the event of a mass casualty incident (MCI), the DMCC will coordinate the distribution of patients.
3. LHJs and/or DOH will provide clinical guidance on acute infectious disease patient management and infection control measures when necessary.
4. Healthcare organizations should consider providing phone and/or in-person screening/triage during an acute infectious disease response.
5. During an emergency, LHJs (in coordination with Emergency Management as appropriate) may activate a Public Information Contact/Call Center (PICC). If conditions warrant, the PICC will provide public information and medical triage by nurses or in coordination with external agency nurse lines. LHJs will work with specific external agencies to provide support on a case by case basis.

G. Transportation

Local EMS agencies in King and Pierce Counties will have internal guidelines and protocols for responding to possible acute infectious disease patients within the community. This includes protocols for patients who have been identified as possibly exposed and are being monitored by LHJs as well as patients who have not been previously identified. As information is made available, EMS will incorporate and follow current Occupational Health and Safety Administration (OSHA) and Center for Disease Control and Prevention (CDC) guidelines for personal protective equipment and infection control associated with the current acute infectious disease response. EMS has plans established to coordinate the identification, management, and cleaning of an appropriate transport vehicle for patient transport (See Attachment B for Ebola Transport Plans for King and Pierce Counties). If



cross-jurisdictional support is required, EMS will work through existing memorandums of agreement/understanding to address their needs.

Transportation method/mode considerations must take into account the number of patients, acuity level, and confirmed or suspected acute infectious disease. The U.S. federal government has recognized the Phoenix Air Group, Inc. as the air transport vendor for patients suspected of or confirmed to have acquired Ebola Virus Disease. For non-Ebola patients, healthcare organizations and public health agencies should use standard transport protocols and mechanisms and for arranging transport to appropriate facilities.

H. Local Hospitals

All local hospitals are expected to maintain baseline preparedness levels for early-encounter screening to identify, and isolate (when necessary), individuals suspected of having an acute infectious disease. This includes utilizing appropriate administrative, environmental and infection control measures, personal protective equipment, and staffing.

In the event patients with an acute infectious disease require a level of care that cannot be achieved at all hospitals, the region will designate specific facilities that have appropriate capability and capacity (E.g., infection control practices, personal protective equipment, isolation units or patient care area, equipment and staffing). Hospitals may be designated as treatment, assessment, or frontline facilities.

Hospitals may be designated by the LHO in coordination with NWHRN, the Healthcare Executive Response Committee, and healthcare executives/administrators; or by the DOH in coordination with its policy group and LHOs in a multi-jurisdictional response. The NWHRN will be responsible for engaging with regional healthcare executives/administrators in a multi-jurisdictional response.

- **Triaging and Transferring Patients:** if hospitals are designated as treatment, assessment or frontline facilities, protocols will establish criteria and procedures for transferring patients to assessment and treatment facilities. An example guideline for Ebola triage transfer criteria is provided in Attachment C: Interim Guidance for Ebola Virus Disease (EVD) Triage and Transfer. In the event a patient needs to be transferred, the LHJ in coordination with the NWHRN will contact receiving hospitals to identify an available facility for care (See Attachment D).

I. Support Services

Support services may include any healthcare or non-healthcare staff or material resources required to support the care of acute infectious disease patients. This may include dialysis providers, blood banks/blood product providers, laboratory services, infection prevention/control, waste and material management, food and dietary services, and environmental services.

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



- LHJs will work with healthcare organizations to coordinate testing of acute infectious disease patients with the WA State Public Health Laboratory and/or the CDC Laboratories.
- The DCAC will work with the NWHRN, LHJs, and healthcare organizations to provide recommendations on standardized patient care protocols, practices, and support services across the region. LHJs will issue guidance to healthcare organizations and providers concerning these issues.

J. Ambulatory Care

Ambulatory care organizations are expected to plan and provide baseline screening for infectious diseases as early as possible in the clinical encounter whether over the phone or in person, isolate the patients (if necessary) and when necessary, coordinate with LHJs, EMS, and other healthcare organizations to appropriately transfer the patient to a receiving facility for further screening, testing, and treatment. Ambulatory care facilities are not expected to provide full testing and care for all acute infectious disease patients, but should maintain protocols to ensure the ability to promptly identify and safely evaluate, stabilize and isolate if necessary, suspected infectious disease patients and implement guidance for transfer of patients to designated facilities when indicated. Ambulatory care facilities should be able to decontaminate and identify exposed staff or patients, if an acute infectious disease patient were evaluated onsite. Ambulatory care will coordinate with the NWHRN, LHJs, and other healthcare organizations for updated guidance during response. (Attachment E: Ambulatory Care Planning for Ebola)

K. Laboratory Testing

The timely diagnosis of an acute infectious disease patient is critical to a coordinated and efficient response. Relevant healthcare organizations, LHJs, and DOH should coordinate with appropriate laboratories to test specimens and communicate results of laboratory testing. Based on the suspected pathogen, the Washington 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 LHJ.

L. Palliative Care and Behavioral Health

In coordination with direct medical care, palliative care may be necessary to support patients with an acute infectious disease. Plans should be enacted early in an acute infectious disease response to address and plan for palliative care needs as appropriate based on the pathogen. Additionally, due to impact of being infected, exposed, or treating individuals with an acute infectious disease, plans may be required to support a surge in behavioral health needs of patients, family members, community members, healthcare staff and employees during an acute infectious disease incident. LHJs, healthcare organizations, and the NWHRN should



work together to facilitate information coordination and standardizations of resources provided to address palliative care and behavioral health concerns based on the incident. Palliative care and behavioral health response may need to continue long after an acute infectious disease response is demobilized.

M. Mortuary Services

A death due to a diagnosed acute infectious disease is considered a natural death and does not fall under the jurisdiction of the Medical Examiner's Office, unless the death is in connection to an act of bioterrorism. A death due to an unknown cause is under the Medical Examiner's jurisdiction. Healthcare organizations are therefore expected to work through their normal channels for the care of the deceased. LHJs, and the DOH will coordinate any changes in guidance or reporting associated with deaths due to an acute infectious disease. If healthcare organizations need assistance in coordinating the care of the deceased, local officials will communicate with local mortuary services to provide guidance on protocols and handling. Local mortuary services have internal plans and protocols to handle the remains of acute infectious disease patients. For an example of guidelines for the handling of human remains, see the CDC Ebola human remains guidelines and PHSKC guidelines for handling Ebola deaths in Attachment F.

N. Waste Management

Healthcare organizations will work through their normal vendors and channels to ensure all waste produced in the screening and care of acute infectious disease patients will be handled and disposed of appropriately. If needed, the NWHRN will coordinate with LHJs and/or DOH to provide guidance on waste handling and disposal. Where necessary, LHJs and DOH 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. For guidance on the handling of Category A solid waste see the Interim Planning Guidance for Handling Category A Solid Waste

O. Monitoring, Isolation, and Quarantine

Monitoring of cases and contacts of cases during an acute infectious disease response will be led by LHJs in collaboration with healthcare organizations (E.g., infection control and/or occupational health professionals). Individuals will be monitored according to national, state, and/or local standardized procedures. Monitoring procedures and movement restrictions are situation and disease specific and could vary from one response to the next. An example of monitoring procedures for Ebola is provided in Attachment H. LHJs may work with healthcare organizations to pre-identify healthcare facilities that monitored individuals should be directed to if they develop symptoms and are in need of medical evaluation.

LHJs will typically rely on voluntary compliance by individuals who require monitoring. In the event that large scale isolation or quarantine is required for any of the cases or contacts of the acute infectious disease cases, LHJs will activate their isolation and quarantine plans. LHJs are the lead agency for coordinating operations, resources, and services associated with



the voluntary or involuntary isolation and/or quarantine of individuals. The NWHRN will work with healthcare organizations to provide support to LHJs when necessary. For additional information on isolation and quarantine procedures, please see the PHSKC Isolation and Quarantine Response Plan (<http://www.kingcounty.gov/healthservices/health/preparedness/isoquarantine.aspx>) and the TPCHD Isolation and Quarantine Plan.

Table 2: Potential Monitoring Leads by Facility and Person Type

Healthcare Person Type	Inpatient Facility	Outpatient Facility	EMS Agency
Patient	Facility Infection Prevention/Control	Facility Infection Prevention/Control (resources permitting)	Agency Occupational Health and/or Infection Prevention/Control
Staff	Facility Occupational Health and/or Infection Prevention/Control	Facility Occupational Health and/or Infection Prevention/Control (resources permitting)	Agency Occupational Health and/or Infection Prevention/Control
Other (visitor, general public, etc.)	Local and/or State Health Jurisdiction	Local and/or State Health Jurisdiction	N/A

Demobilization

When the NWHRN in consultation with local healthcare organizations, LHJs, and DOH determine that the need for advanced coordination with healthcare for the acute infectious disease response has passed, the decision will be made to demobilize and transfer any outstanding coordination back to normal operational channels.

Triggers and indicators for ending acute infectious disease response and monitoring:

- If the level of regional coordination necessary to manage existing patients is comparable to that of normal operating procedures
- If the immediate danger has passed and there is no longer a threat
- Completion of the monitoring period for all exposed persons.
- The passage of at least two incubation periods without reported cases.
- The healthcare system has sufficient resources and capacity to resume normal operations
- Healthcare emergency department volume decreases in general, or decreases to usual census levels (social and clinical measure of change)
- Syndromic surveillance markers indicate a return to baseline
- School/childcare attendance return to ‘normal’
- Call center volume (911 and other call centers) return to ‘normal’ threshold



- EMS call reports (type and volume) return to 'normal' threshold
- Community and social media concerns decrease
- Media requests for information decrease

The NWHRN and the LHJs will lead in notifying staff and partners of the demobilization. At that time:

- All activations are demobilized.
- Final situational awareness information is sent to all partners.
- All partners notified of the demobilization.
- A debrief and after action process is established for internal operations and all partners.

The following activities should be considered:

- Return of any borrowed assets
- Debrief, local, regional, and/or state partners with after action report and improvement plan and coordinated approach to incorporating recommendations into future planning
- Communication concerning payment and reimbursement for the response
- Communication of any screening or surveillance activities that need to be revised or maintained longer term.

Communications

A. Public Information/Risk Communications

- The LHJ will coordinate public information and risk communications messaging and education. NWHRN, LHJs, and DOH will coordinate to ensure consistency of messaging.
- LHJs will lead in planning (including communications plan development) and providing risk communication and official guidance to all healthcare organizations.
- NWHRN and LHJs will participate in any Joint Information System (JIS) established for the acute infectious disease incident. NWHRN and LHJs will involve their Public Information Officer (PIO) to coordinate on public messaging.

B. Communicable Disease

- Healthcare providers will continue to coordinate directly with LHJs (communicable disease programs) for guidance on acute infectious disease patient management.

C. Situational Awareness

- The NWHRN will coordinate situational awareness information sharing with healthcare organizations throughout the region during an emergency response. The NWHRN will work with the LHJs on all communication to local partners as well as the DOH. The NWHRN HECC will:
 - Provide situational awareness on healthcare operations to all healthcare, local and state partners.
 - Assist healthcare organizations with communications.



Responsibilities

A. Primary Agencies

1. Northwest Healthcare Response Network (NWHRN)
 - Establish the HECC to support acute infectious disease response.
 - Coordination of regional healthcare in the response to acute infectious disease for local response and surge.
 - Distribution of situational awareness information to and from healthcare organizations.
 - Coordination of medical and non-medical resource needs for healthcare organizations.
 - Provide communications materials and support for healthcare information and communications needs.
 - Convene the DCAC and Executive Response Committee to support clinical/healthcare guidance and policy decisions, respectively.
 - DCAC: When activated the DCAC will provide clinical guidance to local healthcare organizations, the NWHRN, and the Executive Response Committee, on patient care protocols, practices, and procedures to provide standardization in practice across the regions.
 - Executive Response Committee: When activated the Executive Response Committee will provide guidance to the LHO on policy decisions that affect local healthcare organizations and public health response.
2. Local Health Jurisdictions (Public Health)
 - Management of a communicable disease outbreak.
 - Lead policy decision making for healthcare and public health response.
 - Assess the public health threat, evaluate potential consequences based on established criteria and determine whether isolation and/or quarantine other measures to protect the public are necessary in any given response situation.
 - Monitoring of cases and contacts of cases of acute infectious disease.
 - Coordination of services required for isolation and quarantine.
 - Activate Public Health emergency response structure (e.g. ICS).
 - Coordinate public information and media communications concerning an acute infectious disease response.
 - Coordinate communications with healthcare providers concerning an acute infectious disease response.
 - Coordinate EMS transportation needs for acute infectious disease cases (King County only).
 - Advise healthcare organizations on laboratory testing processes and environmental cleaning and decontamination.



- Coordinate the transfer of patients to a treatment or assessment facility with the NWHRN and appropriate partners.
3. Healthcare Organizations
 - Provide medical care for patients during an acute infectious disease response.
 - Communicate with LHJs regarding patient placement, movement, and care.
 - Communicate with the NWHRN all medical and non-medical resource needs.
 - Provide timely situational awareness information regarding the acute infectious disease response to the NWHRN.
 - Achieve a base level of preparedness to be able to appropriately screen, manage and/or transfer patients with acute infectious diseases.
 - Provide assistance to other healthcare organizations during a response in line with signed mutual aid agreements.
 - Coordinate EMS transportation needs for acute infectious disease cases (Pierce County only).
 4. Disaster Medical Control Center (DMCC)
 - Notify local hospitals and LHJs in the event that a suspected acute infectious disease response occurs requiring regional coordination of healthcare. NWHRN will be notified by DMCC or LHJs.
 - In a no notice mass casualty incident due to an acute infectious disease the DMCC may collaborate with the NWHRN in the coordination of patient distribution.
 5. Local Emergency Management
 - The NWHRN will work with local emergency management on behalf of area healthcare partners to coordinate non-medical resource requests and needs.
 6. Other Primary Agencies (may include):
 - Private EMS
 - Local Law Enforcement
 - Community Based Organizations

B. Support Agencies

1. State Government
 - Coordinate multi-jurisdictional response to an acute infectious disease, establishing the policy group if warranted.
 - Policy group: The DOH will lead a policy group in coordination with the LHJs, the NWHRN, and other partners as necessary to provide guidance to the WA State Health Officer on policy decisions that affect healthcare organizations and public health response.
 - Coordinate with federal and neighboring state partners if the response exceeds local and state resources.



- Provide support for patient monitoring, movement, and care as necessary.
 - Provide support for medical and non-medical resource needs of local healthcare providers, including the coordination of local and national stockpiles of resources.
 - Provide direction on legal and statutory regulations and modifications.
 - Standardize infectious disease and care guidance throughout Washington State as warranted.
 - Support implementation of large scale isolation and quarantine.
2. Federal Government
- Coordinate with DOH when a response exceeds local and state resources.
 - Provide standardized infectious disease guidance throughout the nation as warranted.
 - Coordinate federal level resource requests and any national stockpiles of resources.
 - Coordinate monitoring, screening, and isolation protocols at ports of entry with local and state jurisdictions.

Administration, Finance, and Maintenance

A. Mutual Aid Agreements

As seen in previous acute infectious disease responses, resources including personal protective equipment, durable resources (i.e. ventilators), and trained staff, may be in short supply. In an effort to provide a structure for coordination and sharing, area hospitals have signed a mutual aid plan (MAP) to share resources across facilities in an emergency; including staff and durable and disposable resources. This MAP is not specific to an acute infectious disease response and is applicable for resource sharing between all King and Pierce County hospitals. It is assumed that all healthcare organizations will exhaust internal resources and all normal channels for resupply before activating the MAP agreement. Medical and non-medical resource requests will be handled by the NWHRN in coordination with LHJs and emergency management partners. A copy of the MAP agreement is provided in Attachment I. Additionally the DOH maintains a state-wide mutual aid agreement for hospitals to facilitate sharing of resources during an emergency response.

Authorities and References

A. Review Process and Plan Update

1. Sections of this plan will be updated, in collaboration with LHJs, as needed based on the evolution of planning activities and partnerships or in coordination with the Regional Improvement Plan after exercises or real world incidents.
2. The plan will be provided to the LHJs, healthcare organizations, and regional partners for review and input.
3. Following review, modifications will be made and a copy will be provided to regional partners. Healthcare organizations are expected to share the updated plan internally within their appropriate committees and with their leadership.
4. The NWHRN Board of Directors will be briefed when updates to this plan are completed.



B. Maintenance

The plan will be reviewed every three years or as needed following the process outlined above.

C. References

King and Pierce County Healthcare System Emergency Response Plan
King County Emergency Support Function 8 – Health, Medical, and Mortuary Services
Pierce County Emergency Support Function 8 – Health, Medical, and Mortuary Services
PHSKC Pandemic Influenza Response Plan
TPCHD Pandemic Influenza Response Plan
PHSKC All Hazards Mass Fatality Management Plan
TPCHD All Hazards Mass Fatality Management Plan
PHSKC Isolation and Quarantine Emergency Response Plan
TPCHD Isolation and Quarantine Emergency Response Plan
Regional Disaster Plan

Definitions & Acronyms

A. Definitions

Northwest Healthcare Response Network (NWHRN) – Is a regional Healthcare Coalition that leads a regional effort to build a disaster-resilient healthcare system through collaboration with healthcare providers, public health agencies and the community partners they depend on. NWHRN works to keep hospitals and other healthcare facilities open and operating during and after disasters, enabling them to continue serving the community.

Healthcare Emergency Coordination Center (HECC) – In the event of an emergency the NWHRN will activate the Healthcare Emergency Coordination Center (HECC) to facilitate situational awareness, resource matching, communications, and coordination among regional healthcare providers and partner agencies.

Disaster Clinical Advisory Committee (DCAC) - Is an integral component of an ethical, responsive, transparent and clinically responsible health emergency decision-making structure for King and Pierce counties. This multi-disciplinary committee meets quarterly and as necessary in an emergency to provide expert clinical advice on issues such as regional medical surge and crisis standards of care. The DCAC also advises the local health officers and other policymakers during health emergencies.

Executive Response Committee – Is the committee that advises the LHO on healthcare related policy issues during an emergency. The committee is made up of members of the NWHRN Board of Directors and representatives from the LHJs. The Executive Response Committee meets as needed in an emergency.

B. Acronyms

CDC – Center for Disease Control and Prevention

DCAC – Disaster Clinical Advisory Committee

DMCC – Disasters Medical Control Center



DOH – Department of Health
EMS – Emergency Medical Services
EOC – Emergency Operations Center
ESF-8 – Emergency Support Function-#8
EVD – Ebola Virus Disease
HECC – Healthcare Emergency Coordination Center
HMAC – Health and Medical Area Command
I&Q – Isolation and Quarantine
JIS – Joint Information System
LHJ – Local Health Jurisdiction
LHO – Local Health Officer
MAC – Multi-agency Coordination
MAP – Mutual Aid Plan
MCI – Mass Casualty Incident
MERS-CoV - Middle East Respiratory Syndrome Coronavirus
NIMS – National Incident Management System
NWHRN – Northwest Healthcare Response Network
OSHA – Occupational Safety and Health Administration
PHSKC – Public Health – Seattle & King County
PICC – Public Information Contact Center
PIO – Public Information Officer
SARS – Severe Acute Respiratory Syndrome
STDs – Sexually Transmitted Diseases
TPCHD – Tacoma-Pierce County Health Department
WAC – Washington Administrative Code
WA State DOH – Washington State Department of Health



Attachments

- A. Attachment A: Emergency Contact Information
- B. Attachment B: Ebola Transport Plans for King and Pierce Counties
- C. Attachment C: Interim Guidance for EVD Triage and Transfer
- D. Attachment D: Regional Ebola Decision-Making and Communications Protocol
- E. Attachment E: Ambulatory Care Planning for Ebola
- F. Attachment F: Guidelines for Safe Handling of Human Remains of Ebola Patients
- G. Attachment G: Interim Planning Guidance for Handling Category A Solid Waste
- H. Attachment H: Monitoring procedures for Ebola
- I. Attachment I: Hospital Mutual Aid Plan for Resource Sharing

