NORTHWEST HEALTHCARE
Response Network.

REGIONAL HEALTHCARE SYSTEM EMERGENCY RESPONSE PLAN ANNEX

Regional Patient Movement Response Plan

Version 1, February 2018

Plan Template Creation

The Northwest Healthcare Response Network (NWHRN) leads the local healthcare coalition, which is an affiliation of private and public partners working together to prepare for, respond to, and recover from emergencies and disasters. The Network's coalition encompasses King, Kitsap and Pierce counties, but it has been contracted by the Washington State Department of Health to also lead preparedness initiatives for all of Western Washington.

The Regional Patient Movement Response Plan template, was used to create this plan and, had been created by the Network in coordination with the following Western Washington and state-level partners:

Region 1 Healthcare Coalition (North Region)
Lead: Katie Curtis
Snohomish Health District

Clallam/Jefferson Healthcare Collaborative
Lead: Jessica Guidry
Kitsap Public Health District

Region 3 Healthcare Coalition (West Region)
Leads: Anne Benoist and Sue Poyner
West Region EMS & Trauma Care Council and Thurston County Public Health and Social Services

Region 4 Healthcare Preparedness Alliance
Lead: Robin Albrandt
Clark County Public Health

King/Pierce/Kitsap Counties (Central Puget Sound)
Leads: Susan Pelaez and Aaron Resnick
Northwest Healthcare Response Network

Washington State Department of Health

Record of Changes

Version No.	Description of Change	Date Entered	Posted By
1.	Regional Patient Movement Response Plan Created	February 2018	Rebecca Lis (NWHRN)

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Introduction

Patient movement is a vital component of a coordinated healthcare response to a Mass Casualty Incident (MCI) nationally and locally, such as the recent shootings in Las Vegas Nevada, the Pulse Nightclub in Orlando, Florida, the Aurora Bridge crash in Seattle, Washington, and the Amtrak train derailment in DuPont, Washington; or healthcare facility evacuations in response to the 2017 Hurricanes Harvey (Texas), Irma (Florida and the Virgin Islands), and Maria (Puerto Rico and the Virgin Islands). Successfully coordinated and efficient patient placement, tracking, and movement can save lives and bolster family reunification processes. Effective patient movement requires the coordination of multiple community partners including Emergency Medical Services (EMS), hospitals, long-term care facilities (nursing homes), healthcare coalitions, health departments, emergency management, and other supporting partners.

For the purposes of this document the term "Region" is defined as the geographic area contained within the boundaries of the NWHRN footprint. The Regional Patient Movement Response Plan defines roles and responsibilities of regional response agencies and organizations for patient movement including the coordination of healthcare, NWHRN, Local Health Jurisdictions (LHJs), and other regional and State partner response. The plan is based on the expertise of local, regional, and national guidance and will serves as a template for patient movement in King, Kitsap and Pierce Counties.

Purpose

The purpose of this plan is to provide a concept of coordination for regional response related to the movement of patients during an emergency response in King, Kitsap, and Pierce Counties. The plan describes the coordination of decision making, operations, and communication for patient movement during a response. Specifically, the purpose of the plan is to:

1. Describe the coordination and procedures of a patient movement process within the region for all MCIs and healthcare facility (hospital and long-term care) evacuations.
2. Describe the process to support placement, tracking, and movement of patients in an MCI or healthcare facility evacuation.
3. Define roles and responsibilities for healthcare facilities, the Northwest Healthcare Response Network (NWHRN), LHJs, local response agencies, emergency management, EMS, non-governmental, and local, state, federal, and tribal partners in patient movement response in the region.
4. Describe procedures for communications and coordination among LHJ, healthcare organizations and other partners during a response.

Scope

The Regional Patient Movement Response Plan is an Annex to the larger Regional Healthcare Systems Emergency Response Plan and is applicable for any incident in which patients are moved due to an MCI or a healthcare facility evacuation that requires regional coordination. This plan provides a framework of coordination for patient placement, tracking, and movement of patients during an emergency response. This plan is not applicable for the daily/routine movement of patients by EMS or healthcare facilities. This plan does not address in detail, but connects to, multi-

regional and catastrophic patient movement plans maintained in Western Washington (in development) and the State (in development) respectively.

The information in this plan applies to the roles and responsibilities of healthcare organizations (including hospitals and long-term care) and the relationship of healthcare organizations with other emergency preparedness partners. It includes a general concept of operations for the response to patient movement needs. Broader health, medical, and mortuary response activities are covered in the local ESF-8 plans maintained by LHJs, or in relevant functional response plans. This plan is compatible with federal, state, and local emergency response plans, and promotes the coordination of an efficient and effective response by utilizing the concepts outlined in the National Incident Management System. Additionally, this plan establishes common goals, strategies, and terminology with other regional and local plans.

Planning Assumptions

Planning assumptions for this plan include the following:

1. This plan is meant to provide a concept of operations to support regional patient movement operations and coordinates with other relevant regional plans and partners.
2. This plan does not replace or supersede healthcare facility internal plans and existing community and fire/EMS MCI plans. All healthcare systems, hospitals, and long-term care facilities are expected to maintain plans for the following components:
   a. Full-facility evacuations
   b. Receiving a surge/influx of patients
   c. Communications with regional partners, particularly about their current bed availability
   d. Processes to support resource needs and requesting resources
3. Patient movement operations may be slow moving and provide ample notice for partners to support evacuation operations, or fast moving and require immediate coordination and movement to save lives. Many full-facility evacuations can take hours or days to place and move all patients to receiving facilities.
4. Resources to support patient movement and surge may be in short supply, or delayed, in the county, region, or state (e.g. transportation).
5. The definition of MCI varies in scale between regions and is dictated by local resources and available support for MCI response.
6. Healthcare organizations and partners should consider activating their emergency response structure to support this plan and response.
7. Healthcare organizations and systems throughout the region will commit their own resources and rely on existing agreements with vendors to the maximum extent possible to address internal challenges prior to requesting resources from other healthcare organizations or regional partners.
8. Specialty care patients, including pediatrics, behavioral health, and critically ill, may be transferred to any healthcare facility based on the incident (e.g., bed availability, transport issues, etc.).

9. Patients may arrive by non-traditional means, such as private vehicle, law enforcement, etc., and patients may arrive at healthcare facilities with little to no notice and with little to no clinical information.
10. Response to large scale disasters may require coordination with other regional, state, and federal partners.
11. Routine methods of communications may be strained and disrupted during the emergency response.
12. To best accommodate care needs, patients may be moved across regional boundaries to receiving facilities. Disaster Medical Control/Coordination Centers (DMCCs) and the NWHRN should consider notifying neighboring regions and healthcare organizations during a patient movement scenario in case patients are transported beyond regional boundaries.
13. Healthcare facilities and response partners may need to coordinate with appropriate receiving facilities for their patient population beyond regional, or even state boundaries.

Concept of Operations

A. Activation, Notification and Warning

- This plan may be activated prior to or during any event in which there is a current or potential need to move patients throughout a region including an MCI, hospital evacuation, or long-term care facility evacuation. This activation may occur concurrently with activation of other plans.
- This plan can be activated by a DMCC, the NWHRN, a LHJ, or an evacuating or potentially evacuating facility. Additional partners, such as EMS, emergency management, and receiving facilities, may request the activation of this plan through the DMCC, the NWHRN, or the LHJ.
  - MCI: the DMCC[1] should be notified of the incident by EMS or dispatch.
  - Hospital evacuation: the DMCC should be notified by the currently, or potentially, evacuating facility. The DMCC (optionally with the support of NWHRN) will notify regional hospitals of a potential patient movement incident.
  - Long-Term Care evacuation: NWHRN should be notified by the currently or potentially evacuating LTC facility. Following notification, the Long-Term Care Response Team[1] will notify potential receiving facilities within the region, or neighboring regions if appropriate. See Attachment B (in development) for detailed information and team protocols.
- If the plan is activated by only one of the above entities (DMCC, NWHRN, or LHJ) all parties must ensure the other partners are notified immediately following activation.
- In a hospital evacuation, due to its licensing role in healthcare facilities, the Department of Health (DOH) must be notified. In a long-term care facility evacuation, the State Department of Social and Human Services (DSHS) and/or DOH must be notified. Notification to these entities will be completed by the evacuating facility or the NWHRN, if requested.

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[1] See Patient Placement section on page 13-14 for full description

- Following activation, the NWHRN and/or LHJ will notify local EMS, and identify other appropriate partners to further notify. Partners may include:
  - Neighboring Healthcare Coalitions, LHJs, or DMCCs
  - DOH/DSHS
  - Other local healthcare organizations
  - Local emergency management
  - Other partners as appropriate

B. Patient Movement Concepts

1. Mass Casualty Patient Movement

All MCIs, by definition, result in a significant number of patients. The basic concept of patient movement in an MCI is to triage the patient as accurately as possible and move them efficiently to facilities that can best accommodate their care needs. Due to severe injuries, changes in a patient's status on the way to facilities, the length of time required to transport patients, or patients self-transporting, hospitals may receive patients that are outside their normal scope of care. For example, a non-trauma hospital may receive trauma patients, or a non-pediatric facility may receive pediatric patients. Therefore, all receiving facilities are expected to maintain a baseline readiness to receive all potential patients even if they are outside their day-to-day scope of care. If patients require specific support (e.g. antidotes, vaccines, trauma, neonatal care, etc.), it is important to consider the location of necessary care moving patients to receiving facilities.

2. Facility Evacuation Patient Movement

Healthcare facility (hospital or long-term care) evacuations should be considered a last resort once all other response options, such as sheltering-in-place, lateral/vertical movement within the facility, and providing additional resource or staff support, are exhausted or deemed insufficient. The basic facility evacuation concept is that patients will be evacuated from like-to-like levels of care or up a level of care, if possible. For example, adult patients in an intensive care unit at an evacuating hospital will be evacuated to a similar level of care, if possible.

If it is necessary to evacuate to a healthcare facility that does not provide the equivalent level of care, staff from the evacuating facility may accompany patients to the receiving facility, or teams from other healthcare facilities with the required levels of training may be deployed as necessary. This action may require waivers (which may be retroactively enacted) from the DOH or other regulatory agencies, such as the Center for Medicare & Medicaid Services (CMS). Requests for waivers will be made through normal request chains at the local and state level.

Teams may be deployed from the evacuating facility or a non-affected hospital to support the configuration and set-up of a unit to provide care for the evacuating patient population. Teams should be pre-designated by hospitals and include at least two clinicians (e.g. nurses, physician assistants, physicians, etc.) with knowledge of the level of care being provided.

3. Specialty Patient Movement

There are several groups of specialty patients that to consider during healthcare facility (both hospital and long-term care) evacuations: pediatrics, behavioral health, and intensive care patients (including ventilation, burn, high-risk obstetric, and complex surgical patients). Many of these specialty patients are concentrated in a few facilities. If those facilities were required to evacuate, it could cause significant stress on surrounding healthcare facilities to accommodate these patients. If possible, facilities with specialty patient populations may consider pre-identify facilities capable of receiving these specialty patients. In a response, DMCCs/Long-Term Care Response Team might call upon subject matter experts to support identifying appropriate receiving facilities for specialty patients (e.g., subject matter experts from Seattle Children's Hospital to support pediatric or neonatal patient placement). If possible, advanced preparation should be considered for these patients that may include:

- Moving entire patient units with their staff to a receiving facility to better support care for those patients
- Sending advanced teams to receiving facilities to prepare space and staff for receiving specialty patients
- Placing patients using pre-identified partner facilities that could accommodate the appropriate care needs
- Moving patients beyond regional boundaries to accommodate patient care needs
- Establishing telehealth capabilities to support care at non-traditional receiving facilities

C. Command, Control, and Coordination

Any patient movement scenario that requires regional coordination will involve multiple organizations. Tasks to accomplish include: alert partners, identify placement for patients, identify transportation assets, coordinate and move patients, and track their destination. Figures 1 and 2 below outline the coordinated effort required in an MCI and single facility evacuation or multiple facility evacuation event. The following sections on patient placement, transportation, and tracking outline the key components and processes required to execute this general concept of coordination.

- Key regional response entities will activate their incident command structures to support patient movement including: any evacuating facilities, NWHRN, LHJs, local emergency management, EMS, DMCC/Long-Term Care Response Team, and receiving facilities. ESF-8: Public Health and Medical Services operations is led by the LHJs. The NWHRN, in support of ESF-8, serves as the lead for healthcare preparedness, response, and recovery.
- DMCCs/Long-Term Care Response Team will primarily be communicating with Unified Command at the scene or evacuating facility. Additionally, they will communicate with receiving facilities for placement of patients.
- Additional coordination may be required with neighboring jurisdictions, DMCCs/Long-Term Care Response Team, EMS, healthcare facilities, Coalitions, LHJs, State partners (DOH/DSHS) and federal entities including the Department of

Health and Human Services (HHS), Department of Defense (DOD), and other state and federal partners.

- In addition to hospitals and long-term care facilities, receiving facilities could include alternate care facilities or field treatment sites based on current situation and local/regional plans. This may be part of secondary movement or coordination and may not be coordinated by the DMCC/Long-Term Care Response Team directly.

Figure 1: Mass Casualty or Single Facility Evacuation Command and Control
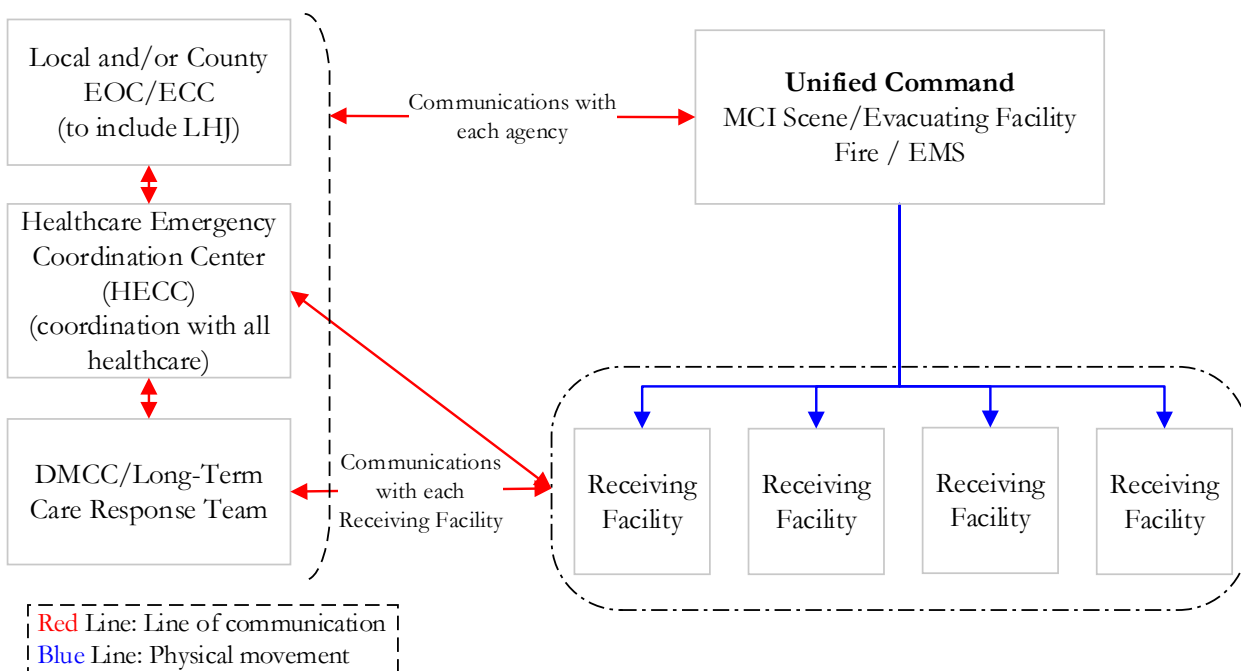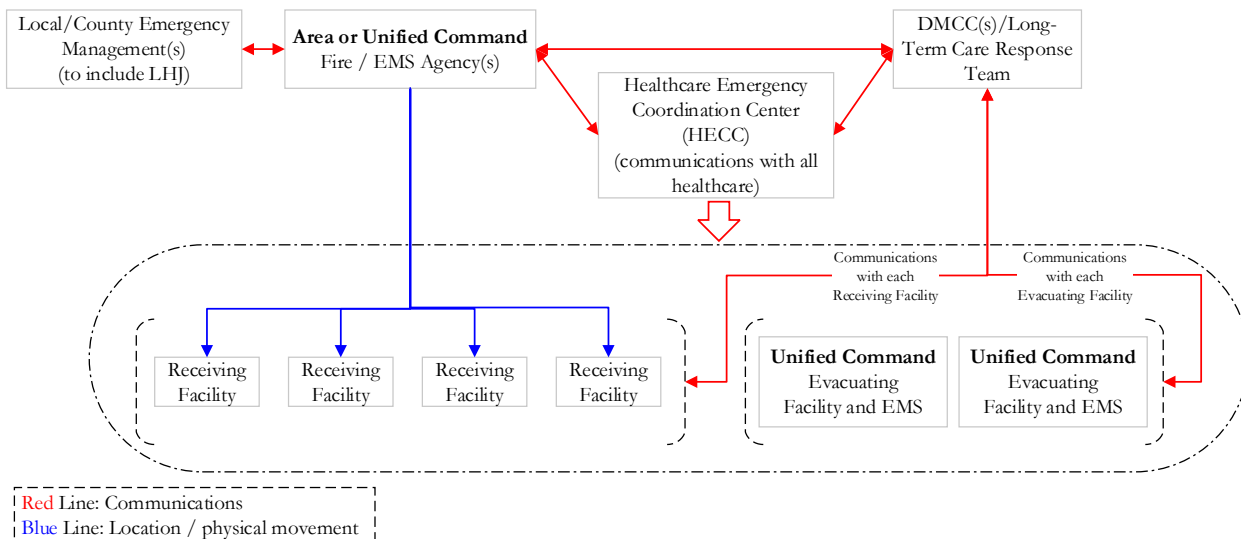

Figure 2: Multiple Facility Evacuation Command and Control

In a multiple facility evacuation scenario, there will need to be coordination among regional partners to support prioritization of facility evacuation timing, if possible. Depending on the incident, there might be impacts to transportation infrastructure, EMS/transportation resources or receiving facilities that may preclude the movement of all evacuated patients at once. In this scenario, the DMCC/Long-Term Care Response Team along with the NWHRN, LHJs, EMS, and local emergency management will coordinate to determine the appropriate sequencing of patient evacuation and movement. Facilities that have more damage or are unable to sustain patient care in the interim would be prioritized. Additional facilities that may be able to sustain care and move patients in subsequent cycles will be supported in place until appropriate resources and receiving facilities can be identified. Additional resources from neighboring jurisdictions, states or federal partners may be required to support this patient movement, but resources may take several hours or days to be available.

D. Evacuating and Receiving Facilities

1. Evacuating Facility

When a healthcare facility is considering evacuation, it should prepare by:

- Activating facility evacuation plan, activating internal notification processes for staff and leadership, establishing appropriate ICS positions, and supporting coordination with outside partners and resources. Coordinate directly with Area or Unified Command, when established.
- Assessing if there are resources, staff, or support that could prevent, slow, or mitigate a possible evacuation. An evacuation should always be considered a last resort as it is better to support the care of patients in place, if possible. Notifying the NWHRN or local emergency management if there is resource support that can prevent or slow an evacuation.
- Notifying the DMCC (hospital evacuation) or NWHRN (to notify the Long-Term Care Response Team).
- Implementing all census reductions procedures to minimize the number of patients that are required to be moved to another healthcare facility.
- Identifying transport needs for all patients within the evacuating facility. See the patient transportation section of this plan (p. 14) for additional details.
- Identifying staff, resources, equipment and medications that can go with evacuating patients.
- Identifying, contacting, and moving to a stop-over point or interim evacuation location if immediate evacuation is required (e.g. evacuation due to fire).
- Designate and coordinate with EMS and transportation partners the location that patients will be evacuated from within/outside the facility.
- Coordinating with EMS and any other relevant patient transportation resources at the facility.
- Readying medical records (hard copy) documentation to be sent with evacuating patients. Place a unique identifier band on each patient as they leave the facility.

Begin patient tracking process if time allows. See patient tracking section for more details.

- Readying any resource, medications, or supplies that will be transported with the patient. See equipment/supplies/staff section for more details.
- Notifying appropriate regulating authority (DOH and/or DSHS) if the facility will be evacuating.
- Notifying patient's family or responsible party of evacuation. See patient information and documentation section for more details.

2. Receiving Facility

When notified of an MCI or healthcare facility evacuation(s), potential receiving facilities should prepare to receive patients by:

- Communicating their bed availability via radio, WATrac or appropriate bed tracking process.
- Activating internal processes to create additional beds and space (e.g., early discharge, census reduction, internal surge plans, staff call backs, etc.).
- Activating internal command structures to support possible patient surge.
- Determining and communicating receiving area to incoming transport vehicles. If time and resources allow, this communication could be coordinated with support of the NWHRN.
- Readying staff and receiving area(s) for patient arrival.
- Reading internal processes to receive healthcare staff from evacuating facility or other regional facilities.
- Communicating actual or potential resource needs to support the additional patients with the NWHRN and/or local emergency management.
- Participating in patient tracking processes for all patients received via WATrac, or appropriate paper-based back-up process. Specifically taking note of the unique identifier present on the patient's band. See patient tracking section for more details.

E. **Patient Placement**

Patient placement refers to connecting patients with the appropriate destination facility. Every attempt will be made to move patients to appropriate receiving facilities; but in a no notice or larger event, specialty patients (e.g., pediatrics, critically ill, burns, etc.) may be placed at any facility. For a hospital or long-term care facility evacuation, this placement means identifying the appropriate receiving facility that can accommodate the patient's needs, which most often is a like facility (e.g., nursing home patient moves to another nursing home) with a like level of care (e.g., ventilator patients move to a ventilator capable facility). The coordination of this effort can be complex based on the patient's needs, the scale of the emergency response, the speed required for movement (e.g., slow vs. fast evacuation), and the availability of receiving facilities.

In a mass casualty or hospital evacuation situation, patient placement is coordinated by the DMCC. The DMCC will provide clinical support to identify appropriate receiving facilities

for mass casualty or hospitalized patients. In a slower moving, single hospital evacuation the evacuating hospital may support the identification of receiving facilities with the support and coordination of the DMCC. The role of the DMCC is to:

- Receive notification from evacuating facility and/or EMS on scene to activate the DMCC.
- Notify the NWHRN duty officer of an incident leading to possible or actual DMCC activation.
- Distribute alerts, or request distribution to area healthcare organizations with information pertaining to an incident.
- Request hospital bed availability information from area hospitals prior to and/or during an incident.
- Determine appropriate patient destination and advise EMS agencies (and transportation entities) and healthcare organizations on these destination(s) prior to, during, and/or following an incident.
- Communicate with receiving facilities on the patients they will be receiving
- Seek assistance, as necessary, from public safety agencies, the NWHRN, LHJs, neighboring local DMCCs, and/or State DMCCs.

If a local DMCC is overwhelmed and/or requires assistance in their operations they can request support from their back-up facility or a neighboring county/region's DMCC. In addition to the county-level DMCCs, the DOH has established two state-wide DMCCs, Western: Harborview Medical Center (Seattle) and Eastern: Providence Sacred Heart Medical Center & Children's Hospitals (Spokane). Any local DMCC can request support to place hospitalized patients from the state-wide DMCC if it is overwhelmed or unable to complete its functions.

The local DMCC(s) within this region are as follows:

- <u>King:</u> Harborview Medical Center (primary), Overlake Medical Center (back-up)
- <u>Kitsap:</u> Harrison Medical Center (primary)
- <u>Pierce:</u> Good Samaritan Medical Center (primary), Madigan Army Medical Center (back-up)

The local DMCC does not typically support the placement of patients from evacuating behavioral health facilities and long-term care facilities. Primary responsibility for the placement of these patients lies with the evacuating facility and any parent organization to identify appropriate local receiving facilities. The NWHRN will support long-term care patient placement during an evacuation with a team of trained individuals (Long-Term Care Response Team) who can identify available long-term care resources and coordinate with evacuating and receiving facilities to place residents.

F. Patient Transportation

1. Mass Casualty Patient Transportation

In an MCI, EMS will notify the DMCC as soon as possible. EMS on scene will coordinate directly with the DMCC to receive information on patient destination and communicate the appropriate transportation assets for each patient. If additional transportation is required EMS will coordinate directly with local Emergency Operations Centers (EOCs), existing mutual aid partners, or other existing resources (e.g., Washington State Fire Mobilization) to identify support.

2. Evacuation Patient Transportation

In a healthcare facility evacuation, the evacuating, or potentially evacuating facility will immediately begin to assess its potential transportation needs using the categories outlined below:

- Total requiring Critical Care Transport
- Total requiring isolation for infectious disease
- Total requiring bariatric transport (Non-ambulatory and >400lbs.)
- Total requiring Advanced Life Support (ALS) transport
- Total requiring ALS pediatric and neonatal transport
- Total requiring Basic Life Support (BLS) transport
- Total wheelchair van/bus patients – consider healthcare owned (evacuating or receiving facility) vehicle assets
- Total wheelchair but can pivot into a seat – consider healthcare owned (evacuating or receiving facility) vehicle assets
- Total for standard non-ambulance ground transport – consider healthcare owned (evacuating or receiving facility) vehicle assets
- Total discharge to home:
  - Total wheelchair van/bus patients
  - Total for standard ground transport or privately-owned vehicle

Evacuating facilities should also consider needed transportation assets for patients' family members and staff who may travel with patients to the receiving facility. Refer to Attachment C for definitions of the criteria for each of these transportation types.

The evacuating facility should request transportation support, which may include local EMS agencies. The evacuating facility should establish a patient pick-up location within or outside the facility and designate a transportation liaison to co-locate and communicate with on-scene EMS Medical Transportation liaison and the DMCC/Long-Term Care Response Team concerning patient needs, destination, and transportation assets. Evacuating facilities should coordinate with the on-scene EMS through unified command. If additional transportation assets are required, the evacuating facility and/or EMS on scene will coordinate directly with mutual aid agreements, the local EOC (or through the local healthcare coalition), or other existing resources, to identify support.

Receiving facilities should establish a patient receiving area at their facility, and if possible, communicate that designated area with incoming transportation vehicles.

G. Patient Tracking

Patient tracking is the process for documenting and following information about a patient including the patient's physical location and other limited information about the patient such as condition, disposition, and patient identifying information. Patient tracking is a vital element of healthcare situational awareness, operations, and family reunification. Accurate and timely tracking of patients in a mass casualty or healthcare facility evacuation is vital to avoid adverse consequences for the patients, their families, responding organizations and the community recovery as a whole.

The NWHRN administers a Regional Patient Tracking Concept of Operations that provides a framework for accurate patient tracking through an online system (WATrac) and a paper-based backup. The concept of operations has identified: core data elements vital for tracking; processes and protocols to maintain tracking; and critical partners that may need patient tracking information to support operations and family reunification.

In an MCI or facility evacuation patient care and transport is paramount, but tracking should begin as soon as possible. In an MCI, it is important that patient tracking processes initiate immediately after a patient first receives healthcare services. This may occur when patients are at the incident, transported, or self-report to a point of definitive care. During an evacuation, the patient tracking process should be initiated before a patient is evacuated from a facility. The patient's whereabouts and condition will be tracked throughout the incident until the patient or the patient's guardian[2] resumes responsibility for the patient.

The ability for EMS providers to document patient identifying information may be extremely limited. As such, the priority for EMS is to begin the patient tracking process by initiating a unique identifier for the patient in the field (a unique identifier is a number that may be tracked by means of bar-coded triage bands/tags) at the point of transport. The collection of patient identifying information will be prioritized once the patient arrives at a point of definitive care. In larger or more complex incidents, it may be necessary to centralize patient tracking information in a centralized database (WATrac) or through a manual process. In this case the NWHRN will coordinate centralized patient tracking with area healthcare facilities and partners as outlined in the Regional Patient Tracking Concept of Operations (See References).

Patient tracking is one aspect of larger victim accounting and family assistance processes, sometimes linked to a jurisdiction's operation of a Family Assistance Center (FAC) or Local Disaster Assistance Center. Patient tracking information supports the identification of individuals associated with an incident, along with information on the deceased, missing persons and uninjured persons.

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[2] Guardian could include state agency if patients are transferred out of state in a state--coordinated patient movement effort or any legally appointed guardian, next of kin, designated health care agent, or responsible healthcare provider.

H. Patient Preparations

1. Medical records and patient information

   The evacuating facility is responsible for providing, as best possible, receiving facilities with the available patient information and medical records upon transfer. This could include the Patient Evacuation Tracking Forms (See Attachment D), overview of the patient and care needs, a copy of the electronic medical records, any paper based records, insurance information, and other pertinent information. Both the evacuating and receiving facilities are responsible for tracking the patient's movements. If available, WATrac will be used in the methods outlined in the patient tracking section. There are additional tracking resources that can be used by the evacuating and receiving facilities in Attachment E.

   Upon receipt of a patient, the receiving facility begins following internal protocols to register the incoming patient but not discard any documentation or unique identifiers transferred from the evacuating facility or assigned by all other entities involved in the patient's movement.

2. Patient medications

   Patient medications should be sent with the evacuating patient, if possible, especially for specialty patients (such as pediatrics) when being transferred to facilities that do not usually treat these patient populations. It is at the discretion of the receiving facility whether to continue to use any transferred medications or order their own. Additional considerations may be necessary if controlled substances must be transferred with the patient. See Attachment F for the Controlled Substance Transfer Form.

3. Communication with families

   The evacuating facility is responsible for notifying both the patient's family or responsible party and the patient's attending or personal physician of the situation. The receiving facilities may assist in notifying the patient's family and personal physician.

   If the resources of the evacuating facility and/or receiving facilities are overwhelmed, a centralized call center (through LHJ and/or local emergency management) may be used to receive patient tracking information (either by fax, in paper copy, courier, or WATrac) and proactively provide status information to families or responsible party and the patient's attending or personal physician. Impacted facilities can request mobilization of a coordinated call center (to support family reunification and information) via their LHJ or local emergency management. Call center information will be disseminated in multiple way, which may include: broadcast via television, radio, social media, hospital operators and recorded messages.

I. Equipment/Supplies/Staff

During an MCI or facility evacuation, receiving facilities may need additional staff (clinical and non-clinical), supplies, and/or equipment to support patient needs. If possible and time allows, evacuating facilities should consider providing staff, supplies, and equipment to

accompany or follow patients to receiving facilities. If the evacuating facility is not able to supply needed resources, receiving facilitates should identify appropriate sources of additional staffing, supplies, and equipment. This may include contacting their normal vendors, contractors, and partner facilities. If there continues to be additional need, the receiving facilities can contact the NWHRN or local emergency management agency to officially request resource support. All requesting agencies will follow local resource requesting procedures and complete the WA State 213RR Resource Request form (Attachment G).

Staff provided to receiving facilities should present to the facility with identification badges and appropriate licensure information. Healthcare facilities will follow internal processes for receiving staff and verifying identity, licensure, and providing organization credentials and privileges. It is the responsibility of sending and receiving facilities to tracking staff throughout the response.

Transportation of staff, supplies, and equipment will be coordinated between the requesting and lending parties, including processes for demobilization, return of resources, and replacement of consumed resources if appropriate.

J. Alternate Care Systems

LHJs, in coordination with the NWHRN and local healthcare partners, maintain community plans that support alternate care systems within the community. These coordinated systems may help expand healthcare delivery through multiple modes including: triage, outpatient care, hospital care, evacuation support, and additional healthcare facilities. These systems can reduce the additional burden on the healthcare system in a large-scale patient movement incident. These plans are maintained by LHJs as separate documents and are not attached to this plan. Refer to the full plans for complete descriptions of the response procedures (see References section).

K. Large-Scale Patient Movement

Depending on the incident, patient movement operations may require the support of additional resources from neighboring regions, states, or federal partners. Below is an overview of inter-regional, state, and federal coordination for patient movement, see the referenced appropriate plans for more detail about each of these processes.

1. Neighboring regions

   Larger regional incidents, or multi-regional incidents may require the coordination between multiple regions to transport and place patients at appropriate receiving facilities. In this scenario, the NWHRN, LHJ, DMCCs, and EMS partners should notify their respective counterparts in neighboring regions and request required support. These notifications may be coordinated through supporting EOCs, if activated. Coordination in these events will follow the Western Washington Patient Movement Response Plan (in development). Additionally, activation and coordination of state-level entities, such as the State DMCC and the state-level medical surge and patient movement plans will

follow their respective procedures. Requests for mutual assistance of other regions within the state of Washington can be made through the Washington Mutual Aid System (WAMAS) as outlined in RCW 38.56.

2. Emergency Medical Assistance Compact (EMAC) and Pacific Northwest Emergency Management Arrangement (PNEMA) Support

When local and state resources to support patient movement are exceeded, support can be requested through EMAC or PNEMA from other states or countries. Strike teams for EMS, medical care providers, etc. can be requested from other states to support the care and movement of patients in the region. Requests for EMAC or PNEMA support are coordinated centrally through the Washington State EOC; the NWHRN and LHJs will follow established protocols to facilitate these requests.

3. Federal patient movement

When local and state level capabilities have been exceeded, federal patient movement support can be requested through the Washington State EOC. Federal resources can support patient movement processes in several ways:

- Ambulances via the Federal National Ambulance Contract – resources can be available to respond within 24 hours of a request.
- National Disaster Medical System (NDMS) – has three operational components that can support patient movement operations including:
  - Medical response personnel, teams, and supplies to support care in the affected region.
  - Outbound patient movement processes to evacuate patients from an affected area.
  - Support of definitive care at receiving facilities.
- Joint Patient Assessment and Tracking System (JPATS) and Strike Teams – support the tracking of patients moved through NDMS.
- Service Access Teams (SATs) –support the medical and social services of patients moved through NDMS. These teams require local/state support for logistics sustainment.

Communications

A. 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 communication to local partners and DOH. The NWHRN will:
- Provide situational awareness on healthcare operations to all healthcare, local and state partners on the patient movement incident.

- Assist healthcare organizations with communications during the patient movement incident.

B. Communications with Public

Evacuating facilities will coordinate organizational messaging. The LHJ will coordinate public information and risk communications messaging and education. The NWHRN, LHJs, and the DOH will coordinate to ensure consistency of messaging. The NWHRN and LHJs will participate in any Joint Information System (JIS) established for the patient movement incident. The NWHRN and LHJs will involve their Public Information Officer (PIO), or designee, to coordinate public messaging.

C. Communications with Families

It is a primary responsibility of an evacuating facility to notify patients' family members about their movement. During an MCI, multiple facility evacuation, or if an evacuating facility is unable to fulfill this responsibility, there may need to be a regional coordinated support of family information and notification. In these scenarios, LHJs or local emergency management may establish a call center to support the reunification of patients and their families. A full description of these processes and roles and responsibilities can be found in regional family reunification plans (see references).

Demobilization

The Regional Patient Movement Response Plan may be demobilized when all patients have been moved to appropriate definitive care, all patient have been entered in patient tracking and all patients have been confirmed received at the destination healthcare facility to support their needs. This demobilization may occur when:

- The DMCC/Long-Term Care Response Team has demobilized.
- All patients have arrived at receiving facilities.
- The patient tracking process has been connected to the regional family reunification processes.

Following demobilization of this plan, additional regional response operations, such as patient tracking, may continue to support family reunification, provide family support services, and support community and healthcare recovery.

The DMCC or Long-Term Care Response Team (through NWHRN) will lead in notifying all appropriate partners of their demobilization. The NWHRN will notify all healthcare and emergency management partners of demobilization of this plan. At that time:
- All activations are demobilized.
- Final situational awareness information is distributed to all partners.
- All partners are notified of the demobilization.
- A debrief and after-action process is established.

The following activities should be considered:
- Return of any borrowed assets (e.g. equipment, staff, resource).

- 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 operational activities that need to be revised or continued.

Responsibilities

A. Primary Agencies

1. Northwest Healthcare Response Network (NWHRN)
   - Activate the plan, as needed, and notify regional partners
   - Establish the Healthcare Emergency Coordination Center (HECC) to support a patient movement response and support ESF-8 operations
   - Gather, analyze, and distribute situational awareness information to and from healthcare organizations
   - Support/lead healthcare resource requests and coordinate with appropriate partners
   - Support/lead regional patient tracking and the connection to family reunification processes
   - Coordinate with healthcare organizations to support patient movement operations
   - Participate in the JIC/JIS to support healthcare operations, as appropriate
   - Support the coordination of patient distribution in long-term care evacuations through the Long-Term Care Response Team
   - Coordinate the Disaster Clinical Advisory Committee to provide guidance on patient movement strategies, as appropriate

2. Local Health Jurisdictions (Public Health)
   - Activate the plan, as needed, and notify regional partners
   - Establish the emergency coordination operations to support a patient movement response
   - Serve as the lead local agency for ESF-8: Public Health and Medical Services response
   - Coordinate with the NWHRN and local emergency management to support resource requests for patient movement
   - Support regional patient tracking and the connection to family reunification processes
   - Implement plans to support alternate care systems/facilities, as needed, to support patient movement
   - Exercise the authorities of the local health officer in support of response goals
   - Coordinate public health strategies with neighboring jurisdictions during a multi-county incident
   - Participate in the JIS to support healthcare operations, as appropriate
   - Serve as a conduit to the DOH for coordination of state-level patient movement

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3. Disaster Medical Control/Coordination Center (DMCC)/Long-Term Care Response Team
   - Activate the plan, as needed, and notify regional partners
   - Activate patient placement operations and notify regional facilities
   - Coordinate the placement of patients with evacuating and receiving facilities
   - Communicate with EMS entities transportation needs and destinations for patient movement
   - Track patient condition (initial condition only) for the purposes of patient distribution

4. Hospitals and Long-Term Care Facilities
   - Activate internal emergency plans and structures to support patient evacuation or managing patient surge
   - Provide care to patients during a patient movement incident
   - Coordinate with the DMCC/Long-Term Care Response Team and respond to request(s) for updated patient bed information
   - Coordinate with EMS and unified command (if established)
   - Coordinate with local partners including:
     o NWHRN for situational awareness and patient movement operations
     o NWHRN and/or local emergency management for resource needs
   - Track patients leaving or arriving at the facility using regional protocols and systems
   - Coordinate with regional family reunifications process
   - Provide assistance to other healthcare organizations during a response pursuant with signed mutual aid agreements
   - Tracking assets loaned or received by facility

5. Emergency Medical Services (EMS)
   - Activate internal processes to support patient movement
   - Coordinate with on-scene response entities (unified command if established) and/or evacuating healthcare facility(s)
   - Notify the DMCC/Long-Term Care Response Team of activations due to MCIs or healthcare facility evacuations
   - Coordinate with DMCC/Long-Term Care Response Team regarding patient distribution
   - Initiate patient tracking in the field. Request the activation of regional patient tracking, as appropriate
   - Transport patients to receiving facilities
   - Coordinate with local emergency management for resource support needs

6. Local Emergency Management
   - Activate the EOC, as appropriate

- Support resource requests from healthcare organizations, healthcare coalitions, DMCC, Long-Term Care Response Team and/or EMS to support patient movement, elevating to state and federal entities, as appropriate
- Coordinate with the NWHRN and LHJ to support healthcare operations
- Support coordination with local family reunification processes
- Serve as a conduit with Washington State EOC for resources, as appropriate
- Provide regular situation briefings to local elected and appointed officials
- Support operations of a JIC/JIS for public information

7. Other Healthcare Organizations

Other healthcare organizations can include: outpatient facilities (clinics, urgent care, ambulatory surgery, dialysis, etc.), blood centers, and other support agencies.

- Establish emergency operations structures, as appropriate
- Support regional healthcare organizations in patient movement operations, as appropriate
- Provide healthcare situational awareness information to the NWHRN
- Provide assistance to other healthcare organizations during a response following signed mutual aid agreements
- Provide assistance as alternate care systems to the level of their capabilities

8. Neighboring Regional Partners
- Respond to requests for support from DMCCs/Long-Term Care Response Team, healthcare coalitions, EMS, LHJs, and/or local emergency management
- Provide healthcare situational awareness information, as requested
- Coordinate patient movement and patient tracking operations according to multi-regional patient movement plans (in development)

9. Other Primary Agencies (may include):
- Medical Examiners/Coroners/Prosecutors
- Medical Vendors/Suppliers

B. Support Agencies

1. State Government Agencies
- Activate Washington State EOC and DOH emergency coordination operations, as appropriate
- Coordinate multi-jurisdictional patient movement response
- Activate state-level plans for medical surge and patient movement, as appropriate
- Activate the Washington State DMCC(s) to support multi-regional patient placement, as appropriate

- Coordinate the Washington State Disaster Medical Advisory Committee to provide strategic guidance on patient movement strategies, as appropriate
- Coordinate with federal and neighboring state partners if the response exceeds resources
- Provide support for patient movement operations, as requested
- Coordinate to support transportation resource needs for patient movement
- Provide support for medical and non-medical resource needs of local healthcare providers
- Provide direction on legal and statutory regulations and modifications

2. Federal Government Agencies
   - Coordinate with DOH and Washington State EOC when a response exceeds local and state resources
   - Coordinate federal-level resource requests
   - Provide and coordinate federal resources to support the movement of patients within or outside of the region

Administration, Finance, and Maintenance

A. Mutual Aid Agreements
Depending on the scale of the patient movement incident, additional resources, including staff, equipment, and supplies, may be required to support patient movement to receiving facilities and support their definitive care. To provide a structure for coordination and sharing, area hospitals have signed a regional mutual aid agreement (Mutual Aid Plan for Healthcare Resource Sharing) to support evacuation and share resources across facilities in an emergency, including staff and durable and disposable resources (See References). It is assumed all healthcare organizations will exhaust internal resources and normal channels for resupply before activating the mutual aid agreement. Resource requests will be submitted to the NWHRN or local emergency management partners. Additionally, the DOH maintains a state-wide mutual aid agreement for hospitals to facilitate sharing of resources during an emergency response (See Attachment H).

Authorities and References

A. Review Process and Plan Update
1. This plan will be updated, as needed, based on the evolution of planning activities and partnerships, or in coordination with the Regional Improvement Plan after exercises or real-world events.
2. The plan will be provided to the 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 with appropriate committees and 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. Training and Exercise

Upon completion and acceptance of this plan by healthcare coalition's partners and leadership, training should be conducted for all relevant partners on the procedures, protocols, and tools to execute the plan.

This plan will be exercised once per fiscal year (July 1 – June 30) by all healthcare coalitions as part of the annual HHS Assistant Secretary for Preparedness and Response (ASPR) Hospital Preparedness Planning (HPP) Coalition Surge Test. The Coalition Surge Test is a yearly requirement for all healthcare coalitions that receive federal funds for preparedness planning. The Coalition Surge Test requires coalitions to test the simulated evacuation of 20% of the healthcare coalition region's staffed acute care bed capacity.

D. References

Regional Healthcare System Emergency Response Plan
Regional Patient Tracking Concept of Operations
Mutual Aid Plan for Healthcare Resource Sharing
King County Alternate Care Systems Plan
Pierce County Alternate Care Facility Plan (placeholder)
Kitsap County Alternate Care Facility Plan (placeholder)
King County Mass Fatality and Family Assistance Plan
Region V Joint Family Assistance Center 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.

Long-Term Care Response Team – The NWHRN coordinates a team of long-term care staff to serve as the Long-Term Care Response Team to support the placement of long-term

care patients during a healthcare facility evacuation within King, Kitsap and/or Pierce Counties.

B. Acronyms

ALS – Advanced Life Support
ASPR – Assistant Secretary for Preparedness and Response
BLS – Basic Life Support
CMS – Center for Medicare & Medicaid Services
DMCC – Disaster Medical Control/Coordination Center
DOD – Department of Defense
DOH – Department of Health
DSHS – Department of Social and Human Services
EMAC – Emergency Management Assistance Compact
EMS – Emergency Medical Services
EOC – Emergency Operations Center
ESF-8 – Emergency Support Function-#8
FAC – Family Assistance Center
HECC – Healthcare Emergency Coordination Center
HHS – Department of Health and Human Services
HPP – Hospital Preparedness Program
JIC/JIC – Joint Information Center/System
JPATS – Joint Patient Assessment and Tracking System
LHJ – Local Health Jurisdiction
MAP – Mutual Aid Plan
MCI – Mass Casualty Incident
NDMS – National Disaster Medical System
NICU – Neonatal Intensive Care Unit
NIMS – National Incident Management System
NWHRN – Northwest Healthcare Response Network
PIO – Public Information Officer
PNEMA - Pacific Northwest Emergency Management Arrangement
SATs – Service Assistance Teams
WAMAS - Washington Mutual Aid System
WATrac – Washington's Bed Tracking and Patient Tracking System

Attachments

A. Attachment A: Emergency Contact Information

B. Attachment B: Long-Term Care Response Team Protocols (in development)

C. Attachment C: Categorization of Patients for Evacuation: Charge Nurse Criteria

D. Attachment D: Patient Evacuation Tracking Form

E. Attachment E: Patient/Medical Record & Equipment Tracking Sheet

F. Attachment F: Controlled Substance Transfer Form

G. Attachment G: State 213RR – Resource Request Form

H. Attachment H: Mutual Aid Agreement for Emergency Response

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