



Healthcare System Emergency Response Plan

Infectious Disease Surge Annex

Version 5, June 2021

Record of Changes

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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
3.	Plan updated based on Acute Infectious Disease Advisory Group suggestions	July 2017	Aaron Resnick
4.	Plan updated with the following edits: inclusive of new Coalition service area; DOH lead agency for coordinating notification to LHJs; mutual aid section	November 2018	Aaron Resnick
5.	Annex revised and reviewed by partner agencies	June 2021	Marissa Cummings, MPH

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Definitions and Acronyms

Definitions:

- **Northwest Healthcare Response Network (NWHRN)** –The Western Washington 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 HECC to facilitate situational awareness, resource matching, communications, and coordination among regional healthcare providers and partner agencies.
- **Disaster Clinical Advisory Committees (DCAC)** – Is an integral component of an ethical, responsive, transparent, and clinically responsible health emergency decision-making structure. These multi-disciplinary committees meet regularly and as necessary in an emergency to provide expert clinical advice on issues such as regional medical surge and crisis standards of care. The DCACs may also advise local health officers and other policymakers during health emergencies.
- **Washington Medical Coordination Center (WMCC)** – Is a patient transfer and patient level loading entity based out of Harborview Medical Center in Seattle, Washington. The WMCC supports triaging and level loading of patients across Washington State. The WMCC was developed to support the COVID-19 pandemic and as of June 2021, is still in operation and supporting patient level loading across Washington State.

Acronyms:

- ASPR: Department of Health and Human Services office of the Assistant Secretary for Preparedness and Response
- CDC: Centers for Disease Control and Prevention
- CSC: Crisis Standards of Care
- DMCC: Disaster Medical Coordination Center
- DOH: Department of Health (Washington State)
- EEI: Essential Elements of Information
- ESF-8: Emergency Support Function #8: Public Health and Medical Services
- EMS: Emergency Medical Services
- EOC: Emergency Operations Center
- HECC: Healthcare Emergency Coordination Center (NWHRN)
- ICS: Incident Command Structure
- LHJ: Local Health Jurisdiction
- LHO: Local Health Officer
- MERS-CoV: Middle East Respiratory Syndrome

- MCM: Medical Countermeasures
- MOU: Memorandum of Understanding
- NPI: Non-Pharmaceutical Interventions
- NWHRN: Northwest Healthcare Response Network
- PPE: Personal Protective Equipment
- SARS: Severe Acute Respiratory Syndrome
- SME: Subject Matter Expert
- STD: Sexually Transmitted Disease
- WMCC: Washington Medical Coordination Center

Introduction: Overview and Background

In a globalized society, emerging and established infectious diseases are easily transported and transmitted around the world. The Western Washington and 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. These infectious diseases may include Ebola, Marburg, pandemic and avian influenza, Middle East Respiratory Syndrome Coronavirus (MERS-CoV), Severe Acute Respiratory Syndrome (SARS), COVID-19 or other known and unknown emerging and special pathogen infectious diseases. Other examples could be outbreaks of established diseases (e.g., measles) that may require a resource-intensive response, multi-county coordination, and/or statewide response efforts. As recently experienced in the COVID-19 pandemic, an infectious disease outbreak can quickly overwhelm healthcare resources through a surge in patients seeking medical care. Because of this, it is important to consider infectious disease surge planning when supporting preparedness efforts and understand how an infectious disease surge event could impact Western Washington.

Definition: For the purposes of this Infectious Disease Surge Annex, an infectious disease surge is defined as a response to any infectious disease event that goes above and beyond routine infectious disease investigation, coordination, and response, and requires significant multi-agency coordination. An infectious disease surge may be due to a novel, emerging and/or special pathogen infectious disease that may cause high morbidity and/or mortality or may be a disease of high consequence (e.g., highly transmissible, such as measles). These example scenarios would likely require extensive coordination with partner organizations, including NWHRN.

An infectious disease surge is not defined by absolute number of patients, but rather the potential impact to healthcare in terms of preparation and response and the degree to which multi-agency coordination is required. This includes but is not limited to extensive infection prevention and control measures, potential changes to healthcare operations, need for increased staffing or training and personal protective equipment (PPE) procurement.

The Infectious Disease Surge Annex identifies roles, responsibilities, and interdependencies of regional response agencies involved in an infectious disease surge response, including the coordination of healthcare organizations, Local Health Jurisdictions (LHJs), Tribal Governments, Emergency Medical Services (EMS) and other local and state partners. This Annex has been developed through the collaboration and expertise of local, state, tribal public health partners and other partners in healthcare, infection prevention and disease, and emergency management, and will serve as a template for infectious disease outbreak response efforts within the NWHRN service area.

Purpose

The purpose of this Annex is to serve as a concept of operations for a coordinated regional response in the NWHRN service area related to the potential healthcare related consequences of an infectious disease surge. This Annex describes the coordination of decision making, operations,

communication, and demobilization/recovery for an infectious disease surge response. Specifically, the purpose of this Annex is to:

1. Identify indicators of an infectious disease surge event and associated response actions identified for NWHRN and other partners to respond to.
2. Establish a coordination system for gathering situational awareness, identifying partner impacts and coordinate support as needed.
3. Describe roles and responsibilities for healthcare, the NWHRN, LHJs, local response agencies, emergency management, community, non-governmental, and local, state, federal and tribal partners prior to and during a regional response for an infectious disease surge.
4. Describe procedures for communications and coordination among state and local public health, healthcare agencies and other local partners during a response to document and identify resource gaps and needs.
5. Provide information on resources and guidance compiled by local, regional, and state subject matter experts (SMEs).
6. Inform partners of protocols for patient level-loading in the event of a patient surge to reduce the likelihood of overwhelming any one facility's capacity.
7. Provide information on relevant just-in-time training to support an infectious disease surge.
8. Identify an evaluation and exercise plan for the specialty function.

Scope

The Infectious Disease Surge Annex is an appendix to the NWHRN Regional Healthcare System Emergency Response Plan (See Appendix A). This Annex is applicable for any novel or special pathogen infectious disease event that may strain healthcare resources. This Annex outlines coordination and operations for incidents wherein the complexity or duration requires regional coordination of information, resources and/or response activities. This Annex is not applicable for the routine management of infectious diseases such as tuberculosis, foodborne illness, or sexually transmitted diseases (STDs) within the community, unless the situation requires extensive regional coordination and resource sharing.

The information in this Annex 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 response partners, including state, tribal and local public health. It includes a general concept of operations for responding to an infectious disease surge event, as well as the clinical components, including: staffing, surveillance, community-based testing, mortuary services, etc. This Annex 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 establishes common goals, strategies, and terminology consistent with other regional and local plans.

This Annex applies to:

- Any novel, emerging, and/or special pathogen infectious disease event that goes above and beyond routine infectious disease investigation, coordination, and response; and likely requires significant multi-agency engagement.

- A surge in infectious disease cases that may require medical attention, thus potentially overwhelming hospital capacity and operations.
- Healthcare organizations, NWHRN, LHJs, tribal partners, Washington State Department of Health (DOH) and all partner agencies with whom there are established memoranda of agreement, procedures, or protocols for infectious disease events.
- A novel, emerging and/or special pathogen infectious disease event within or impacting the Northwest Healthcare Response Network’s service area.

Planning Assumptions

All planning assumptions outlined in the NWHRN Healthcare Emergency Response Plan apply to this Annex. The specific planning assumptions to this Infectious Disease Surge Annex are:

1. This Annex is meant to provide an overview of healthcare system response to an infectious disease surge event and should not replace any partner’s existing infectious disease plans already established, but rather emphasize coordination and integration of existing and relevant regional plans to support coordination efforts.
2. 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 scope of the infectious disease surge.
3. During, or in anticipation to an infectious disease surge event, there may need to be changes to response operations to protect response personnel and ensure the continuity of essential response functions, such as transitions from in-person response operations to virtual response operations (as seen during COVID-19).
4. The objectives of public health and healthcare facilities may differ in an infectious disease surge event: public health is primarily concerned with community disease control, while healthcare facilities are focused on the clinical care of individual patients.
5. LHJs maintain their own infectious disease plans for multiple situations, including isolation and quarantine procedures. This Annex does not replace standard public health infectious disease procedures and processes already established.
6. Responses to an infectious disease surge event may require coordination with other regional, state, and federal partners that may not traditionally work with public health, healthcare or coalitions during steady-state operations.
7. Local and state health and government officials have the authority to change or implement procedures to protect the public’s health, including mandatory isolation and quarantine.
8. Healthcare organizations and systems throughout the region will commit their own resources to address internal challenges prior to releasing resources to other healthcare organizations.
9. In a major infectious disease surge, there may be state or local orders that impact healthcare operations (for example: restrictions on non-urgent medical procedures, licensing waivers, hospital and long-term care visitation policies, etc.)
10. Those responding to the infectious disease event may use and share essential elements of information (EEI) to determine facility operational status during an infectious disease surge event, allowing for compilation of data to understand facilities capability as it pertains to capacity, PPE, census, etc.

11. Regional coordination of patient level-loading may be necessary to avoid any single facility from becoming overwhelmed.
12. Healthcare organizations will rely on existing contracts with medical suppliers and pharmaceutical vendors to the maximum extent possible before reaching out to their LHJ or Local Emergency Management partners.

Concept of Operations

A. Activation of the Annex

- This Annex may be activated during any infectious disease event that warrants coordination between healthcare organizations when the day-to-day resources and plans are insufficient to address the current or anticipated infectious disease response needs and may occur concurrently with the activation of other plans.
- This Annex is meant to facilitate a rapid response activation. Therefore, request for activation of this Annex may originate from any local healthcare organization, local and/or state Disaster Medical Coordination Center (DMCC), LHJs, local/state emergency management, as well as the NWHRN Duty Officer and leadership. Where appropriate and time permitting, parties should consider consulting with one another prior to activation. If time permits, parties may also consider consulting with other LHJs, local emergency management, or any other regional entities or emergency response partners that may be impacted by the infectious disease surge event.
- Annex activation triggers may include (but are not limited to):
 - One or more suspected or laboratory confirmed novel and/or special pathogen infectious disease cases identified in the region.
 - Regional coordination required to assist with infectious disease-related monitoring, laboratory testing, patient care, patient movement, etc.
 - Multiple counties affected by an infectious disease surge that requires a coordinated response.
 - Regional coordination required for information coordination, risk communication, public information, and/or media response.

B. Notification and Warning

- The NWHRN Healthcare Emergency Coordination Center will activate prior to or immediately following the activation of this Annex, though partner emergency coordination centers may activate prior to the activation of this Annex. The HECC will operate in coordination with any other activated local/regional/state coordination centers.
- The NWHRN and many local health jurisdictions maintain 24/7 contact numbers for epidemiology/communicable disease and/or emergency preparedness specialists. LHJs are the first line of contact for healthcare organizations in the event of an infectious disease surge event. If you are unsure of the appropriate contact information, please contact the NWHRN Duty Officer at 425-988-2897.
 - In the event of an infectious disease surge event of an unannounced patient(s) that presents to a healthcare organization, healthcare providers should contact

their LHJ epidemiology/communicable disease representative(s), who will then contact the DOH duty officer(s) and NWHRN duty officer as needed.

- In the event of a previously identified person of infectious disease risk (e.g., a person being monitored locally or transferred into the region following travel to a country experiencing an emerging and/or special pathogen infectious disease outbreak), the LHJ epidemiology/communicable disease representative and/or Local Health Officer (LHO) should notify receiving healthcare providers and the NWHRN Duty Officer.
- If this Annex is activated to support operations for one county only, NWHRN may support communicating with surrounding LHJs per the activated LHJs request to determine a potential need for larger activation or coordination.
- In the event of a mass infectious disease event (e.g., outbreak in a congregate setting), the Disaster Medical Coordination Center (DMCC) may be activated. The DMCC will notify the impacted LHJ's duty officer and/or the NWHRN duty officer. Additionally, the LHJ, DMCC or NWHRN should notify the appropriate patient movement partners and stakeholders, such as the State DMCC and/or the Washington Medical Coordination Center (WMCC) for awareness and potential patient transfer/level-loading needs.
- Following notification, the NWHRN and the LHJs will identify the appropriate partners to further notify. Partners may include:
 - Neighboring LHJs
 - DOH
 - Local healthcare organizations/providers
 - Local EMS
 - WMCC
 - DMCC
 - Centers for Disease Control and Prevention (CDC)/Assistant Secretary for Preparedness and Response (ASPR)
 - Local emergency management
 - Other health partners as necessary

C. Command, Control, and Coordination

- The NWHRN will activate the Healthcare Emergency Coordination Center (HECC) to support the coordination for an infectious disease surge response. Please refer to the NWHRN Regional Healthcare System Emergency Response Plan (Appendix A) for more information.
- It is recognized that there are overlapping roles and responsibilities for an infectious disease surge response between LHJs, healthcare organizations, and the NWHRN. It is recommended that all parties use an Incident Command System (ICS) structure to coordinate internal and multiagency responses to an infectious disease event.
- LHJ may activate their ESF-8 response to assist in coordination for an infectious disease surge response.
- The LHJ may also work through defined public health channels to coordinate with the DOH.

- DOH will be the lead agency for coordinating notification to LHJs if a possible infectious disease patient(s) lives, works, or traveled in/through another LHJ region.
- Coordination among regional partners for an infectious disease surge response should follow the tiered communications approach outlined in Appendix B: Regional Infectious Disease Decision-Making and Communications Protocol. Appendix B outlines key decision points concerning 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.

D. Roles and Responsibilities

Roles and responsibilities for stakeholders are outlined to include NWHRN, healthcare, LHJs, local emergency management, state, tribal and federal partners and will be consistent with roles and responsibilities identified in the NWHRN Regional Healthcare System Emergency Response Plan (Appendix A).

A. Primary Agencies

- Northwest Healthcare Response Network (NWHRN):
 - Support coordination of local and regional public health and healthcare in response to an infectious disease surge in the NWHRN service area.
 - Gather and distribute situational awareness information to and from healthcare organizations, local, state, tribal and federal public health/emergency management, and other partner organizations.
 - Support coordination of medical and non-medical resource needs for healthcare organizations via mutual aid requests.
 - Convene clinically focused and subject matter experts to prepare for, respond to, and support an infectious disease surge event.
- Local Health Jurisdictions (Public Health):
 - Obtain and provide information to healthcare about travelers who may be monitored following travel from/to a region experiencing an ongoing infectious disease outbreak.
 - Lead policy decision making for healthcare and public health response during an infectious disease surge.
 - Assess the public health threat, evaluate potential consequences, and determine what measures are needed to protect the public.
 - Monitor cases and contacts of cases in an infectious disease event.
 - Coordinate public information, media communications and communications with healthcare providers concerning an infectious disease surge response.
 - Advise healthcare organizations on laboratory testing processes, environmental cleaning and decontamination, patient/staff/visitor screening and other infection prevention measures specific to the surge in question.

- If the patient(s) is being monitored as a potential special pathogen risk and requires medical attention, the LHJ should coordinate the transfer of patient(s) to an appropriate healthcare facility as dictated by type of infectious disease by communicating with appropriate partners, including NWHRN.
- Healthcare Organizations:
 - Achieve and maintain a level of preparedness to be able to appropriately screen, manage and/or transfer a surge of infectious disease patients.
 - Provide medical care for patients during an infectious disease response.
 - Communicate with LHJs regarding disease identification of a reportable disease, including suspected novel cases.
 - Communicate with LHJs among other partners regarding patient placement, movement, and care.
 - Consider communicating with the Washington Medical Coordination Center should the facility notice any geographic trends in disease, such as patients primarily coming from a single long-term care facility, school, workplace, etc.
 - Consider contacting the NWHRN for medical and non-medical resource needs.
 - Provide timely situational awareness information regarding the infectious disease response when requested by partners.
- Disaster Medical Coordination Center (DMCC)
 - In an announced or unannounced mass infectious disease event (e.g. multiple patients from a single facility), the DMCC may collaborate with the NWHRN among other partners in the coordination of patient distribution for level-loading purposes.
 - Notify local hospitals and LHJs in the event that a suspected infectious disease response will require regional coordination of healthcare. NWHRN will be notified by a DMCC or LHJs.
- Washington Medical Coordination Center (WMCC)
 - The WMCC supports patient transfer and patient level loading in order to decompress and hence not overwhelm any one healthcare facility.
 - The WMCC is not meant to take precedence over standard transfer procedures and should not be utilized unless all standard transfer procedures have been exhausted.
 - The WMCC will monitor healthcare capacity and strain statewide to identify potential regions or facilities that may require additional support in the event of patient surge.
 - The WMCC was developed to support to COVID-19 pandemic and as of June 2021, is still in operation and supporting patient level loading across Washington State.
- Local Emergency Management
 - Fulfill resource requests from healthcare organizations if unable to fulfill through their standard protocols.

- Support community logistical and contractual needs (e.g., field hospital to decompress surrounding hospitals).
- Work with local partners to develop response structures and teams to strategize and address infectious disease-related impacts (such as school closures or PPE needs).
- Coordinate and communicate with NWHRN regarding healthcare partner needs and non-medical resource requests.
- Tribal Health, Emergency Management and Clinics:
 - Share situational awareness information.
 - Consider notifying NWHRN for medical or non-medical resource needs.
 - Coordinate response actions with regional health jurisdictions and the NWHRN.
- Outpatient Clinics:
 - Engage with the NWHRN, local and state public health to determine and understand impact of infectious disease event within facility's geographic area.
 - Identify ways to support other healthcare facilities, such as increasing outpatient urgent/emergent appointments to help manage a surge.
- Emergency Medical Services:
 - Coordinate with healthcare facilities and/or local health jurisdictions to align infection prevention protocols and guidance, such as donning/doffing and decontamination.
 - Develop and/or enhance 9-1-1 dispatch screening related infectious disease identification and concerns.
 - Work with response agencies and healthcare partners to identify protocols and processes to reduce turnaround times and staff exposures during patient surges.
 - Collaborate with regional response and healthcare partners throughout the infectious disease surge event, including aligning public messaging and, if capable, supporting medical countermeasures such as testing and vaccination.

B. Support Agencies

- State Department of Health (DOH)
 - Coordinate and lead multi-jurisdictional response to an infectious disease surge.
 - Coordinate with federal partners if the response exceeds local and state resources.
 - Coordinate notification to LHJs if the possible infectious disease patient(s) lives, works, or traveled in/through another LHJs region.
 - 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, community-based testing, vaccine allocation and distribution, depending on the infectious disease event.
- 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.

Mission Areas

A. Essential Elements of Information, Indicators and Triggers

- NWHRN and partner organizations may request and use essential elements of information (EEI) to determine healthcare facility status, anticipate potential resource needs, and assess healthcare system stress within the NWHRN service area prior to and/or during an infectious disease surge event. The EEI may come from state-wide systems such as WATrac and WA HEALTH to help determine current healthcare operating status and potential future needs.
- EEI may also be gathered via targeted survey methods distributed by NWHRN or other response agencies.
- Healthcare facility partners are strongly encouraged to complete requests for EEI to the best of their ability in order for response partners to fully understand current and projected operating pictures, challenges, threats, etc.
- For more information on EEI, please refer to Appendix C, the NWHRN Situational Awareness Annex.
- Some indicators and triggers for scaling up or down in infectious disease surge response may include:
 - Disease epidemiologic trends (increasing or decreasing trends).
 - Syndromic Surveillance (such as COVID-19-like-illness, influenza-like-illness, emergency department visits and admissions).
 - Significant infectious disease outbreaks and/or concerns regarding hospital capacity thresholds.
 - Additional co-occurring concerns that may impact conventional healthcare operations such as: trauma cases, flu season, institutional outbreaks, or outbreaks among those experiencing homelessness.

B. Space and Non-Pharmaceutical Interventions

- Conduct initial patient screening via phone at point-of-scheduling, or upon initial patient entrance into facility to determine potential infectious disease risks.
- When considering space and Non-Pharmaceutical Interventions (NPI), facilities should consider their ability to expand number of inpatient beds, operational hours, and screening.

- All hospitals should utilize as much space as possible for supporting additional inpatient beds in the event of an infectious disease surge.
- If necessary, facilities should utilize engineering methods to increase negative pressure spaces.
- Review procedures to streamline patient throughput and rapidly discharge patients to free up beds.
- Consider restructuring waiting areas to allow patients to sit 6 – 10 feet from others (dependent on infectious disease social distancing metrics).
- Consider other distancing measures such as outside waiting areas or allowing patients to wait outside the facility or in their vehicles.
- Consider restricting the number of visitors to beginning-of-life and/or end-of-life visitation only to reduce the amount of potentially exposed staff, visitors, and patients.
- Consider indicators and thresholds for suspending certain operations (such as elective procedures) in order to increase capacity and preserve PPE and protect staff.
- Facilities should consider developing memorandums of understanding (MOUs), and accepting offers of loaned space, staff and supplies from facilities who have decreased their operations (e.g., ambulatory surgery centers).

C. Staff

- Facilities should have an established protocol for staff experiencing symptoms or potential exposure to a pathogen of concern. These protocols should align with public health recommendations and should be updated frequently based on disease epidemiology. These protocols should include but are not limited to:
 - Screening upon arrival.
 - Staying home when ill.
 - Notifying supervisor of any relevant symptoms, especially if staff have been in contact with infectious patients.
 - Isolation and quarantine processes in place.
 - Return to work guidelines.
- Ensure facilities have procedures to request and utilize emergency healthcare volunteers from resources such as the Washington State Emergency Registry of Volunteers.
- Limit the number of staff physically interacting with suspected or confirmed infectious disease patients.
- Develop and maintain staff surge processes to support patient surge.
- Identify opportunities for telecommuting or telemedicine to reduce potential exposure and preserve PPE.
- Cross-train staff in additional surge-related competencies, such as healthcare worker health screening.
- Educate staff on facility obligations for PPE management and procedures for resource requesting from other entities.
- Identify staff who work at multiple facilities in the event there is an outbreak at a partner facility and the staff may have been exposed and at risk for being infectious.

- Plan for staff reductions due to external circumstances, such as school closures, personal vulnerabilities, family member vulnerabilities, etc.
- Facilities should provide, or plan to provide, on-going and/or just-in-time staff training for guidance, screening, and situational awareness prior to and/or during an infectious disease event.
- Educate staff early regarding the role of LHJs, Drop Teams, and other partners/resources that may provide guidance or support during an infectious disease event.
- During an infectious disease event, implement staff screening or attestation protocols for any potential similar symptoms of the infectious disease in question.
- Staff should be educated, trained, and have competency assessed for all cleaning and disinfection procedures in the facility.
- Ensure staff have adequate training for PPE utilization (donning and doffing) and infection control measures.

D. Supplies

- **i. Personal Protective Equipment**
 - Resources such as PPE may be in short supply prior to or during an infectious disease surge event; therefore, enhanced monitoring of PPE availability, burn rate, etc. may be necessary.
 - Partners should consider PPE shortage mitigation measures prior to or early in a potential infectious disease surge event.
 - Coordinate with vendors to determine if normal ordering procedures have been disrupted. Exhaust all normal protocols with vendors and contractors prior to contacting external partners to request PPE.
 - Consider using tools such as CDC [PPE Burn Rate Calculator](#) to estimate how much PPE personnel are expected to need.
 - Consider reviewing the DOH Interim Supplemental Guidance for Prioritization of N95 and Other Respirators in Inpatient Hospitals During Times of Supply Shortage guidance (Appendix D).
 - The NWHRN will support mutual aid requests for PPE as much as possible during an infectious disease surge but may be limited in its ability to fulfill mutual aid requests based on the supply chain constraints.
- **ii. Laboratory**
 - Timely diagnosis of an infectious disease patient is critical to a coordinated and efficient response, and therefore should occur at initial symptom complaint of a patient seeking care. However, it is understood that testing for a novel disease may be limited. In these situations, DOH and LHJs, in coordination with federal partners should develop, coordinate, and disseminate testing strategies.
 - Relevant healthcare organizations, LHJs, and DOH should coordinate with appropriate laboratories to determine which specimens to draw, appropriate PPE to safely draw those specimens, protocols to transport and test specimens, and method(s) to communicate results of laboratory testing based on whether the disease is classified a notifiable condition.

- Depending on the suspected pathogen, the Washington State Public Health 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 regarding specimen collection and timing of testing needs, as well as establish the appropriate point of contact at DOH and their LHJ to communicate findings.
 - The LHJ and DOH should be immediately notified following a laboratory result to indicate next steps (i.e., quarantine, contact tracing, etc.).
- **iii. Waste Management**
 - Healthcare organizations should work through normal vendors and channels to ensure all waste produced in the screening and care of infectious disease patients is handled and disposed of as required by the category of waste protocols identified by the pathogen identified.
 - 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 infectious disease patients as well as coordinating with the appropriate utilities as needed.
 - For guidance on the handling of Category A solid waste see Appendix E: Interim Planning Guidance for Handling Category A Solid Waste

E. Patient Tracking

- In the event of a surge in infectious disease patients, the DMCC(s) will coordinate the distribution of patients and may request the support of the WMCC among other partners.
- LHJs and/or DOH will provide clinical guidance on infectious disease patient management and infection control measures when necessary.
- DCAC/DMAC may also provide guidance or support in clinical decision making.
- In the event of an evacuation to healthcare (i.e., a congregate facility outbreak requiring several patients needing hospital admissions), patients will be tracked to their final hospital destination via WATrac or a paper-based method per NWHRN Patient Tracking Appendix (See Appendix F).
- Additionally, in the event of an evacuation, or difficult to place patients, the WMCC can be utilized.
 - The WMCC is not meant to take precedence over standard process or protocols, such as those among health system transfer centers.
 - The WMCC can be contacted 24/7 at 206-520-7222 or 877-520-7222.
 - See Appendix G for more information about the WMCC.

F. Transportation

- Local EMS agencies will have internal guidelines and protocols for responding to possible 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.
- EMS, in coordination with 911 dispatch centers, should consider enhanced infectious disease telephone screening when an infectious disease event is identified.

- Transportation method/mode considerations should account for the number of patients, acuity level, and confirmed or suspected 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 long-distance transport. For non-Ebola patients, healthcare organizations and public health agencies should use standard transport protocols and mechanisms and for arranging transport to appropriate facilities.
- If standard ground transport protocols do not support certain suspected infectious disease cases, facilities and local EMS should consider reaching out to American Medical Response (AMR) to determine if they can support the transfer. This contact should happen early and with advanced notice to AMR about the suspected infectious disease patient.
- In the event of an infectious disease surge requiring transportation of multiple infectious disease patients, the DMCC and/or WMCC will be activated (if not already), and transport control will follow existing protocols as identified in the NWHRN Patient Movement Annex (Appendix H).

Special Considerations

A. Equity, Access, Cultural/Religious Considerations

- It is important to consider language barriers, functional needs and cultural and religious traditions when caring for an infectious disease patient. Standard protocols when interacting with an infectious disease patient may require isolation and strict visitor and other restrictions. It is important in these situations to be sensitive to cultural differences, expectations, and practices that may be in tension with infectious disease practices and to approach these tensions with compassion and understanding.

B. Behavioral Health

- During and following an infectious disease event, protocols may need to be established to support a surge in behavioral health needs for staff, patients, and the community. Infectious disease events can impact behavioral health due to isolation and quarantine, fear of contracting or spreading the disease, and loss of patients and/or family members among other negative impacts. Healthcare organizations, LHJs, DOH and the NWHRN should work together to facilitate information sharing and standardization of guidance and resources provided to address behavioral health concerns. Behavioral health response may need to continue long after an infectious disease surge response has been demobilized.

C. Special Pathogens

- Depending on the infectious disease event, a surge may result in many cases and also may include a surge in response efforts. This may occur with special pathogens such as a novel or high consequence infectious disease (such as Ebola), where there may be a small group or even a single patient, but the response needed will cover multiple agencies and jurisdictions. Given an infectious disease surge involving high consequence or special pathogens, DOH has identified a tiered hospital system comprising of frontline facilities, assessment hospitals and treatment centers to support these patients.
 - Frontline facilities are identified as all acute care hospitals. Frontline facilities should be able to identify a suspected infectious disease patient, isolate the patient away

from other patients and staff, and inform their LHJ and DOH (if needed). Frontline facilities should be able to support the care of the suspected patient for up to 24 hours until the patient can be transferred to an assessment or treatment center.

- Assessment hospitals should be able to identify a suspected patient, isolate the patient, inform their LHJ and DOH (if needed), as well as potentially collect samples for the patient and observe and provide necessary treatment for up to 48 hours.

Assessment hospitals in Washington are:

- Providence Regional Medical Center Everett
- Providence St. Mary Medical Center (Walla Walla)
- Treatment centers should be able to identify a suspected patient, isolate the patient, inform their LHJ and DOH, collect samples and provide care and treatment for the patient during their entire length of stay. Treatment centers in Washington are:
 - Harborview Medical Center
 - Seattle Children's Hospital
 - Providence Sacred Heart Medical Center & Children's Hospital (Spokane) – the federally designated Treatment Center for the Pacific Northwest region

D. Medical Countermeasures

- The NWHRN will support planning, allocation, and distribution of medical countermeasure (MCM) needs for healthcare organizations during an infectious disease surge event. These MCMs may include:
 - Vaccine planning, allocation, and distribution.
 - Anti-viral drug allocation.
 - PPE and equipment needs.
- Should a facility require support for obtaining certain MCMs, the NWHRN will support mutual aid requests to link healthcare facilities to share resources.

E. Fatality Management

- A death due to a diagnosed 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, whereas 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 decedent. LHJs and the DOH will coordinate any changes in guidance or reporting associated with deaths due to an infectious disease. If healthcare organizations need assistance in coordinating the care of the decedent, 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 infectious disease patients. For an example of guidelines for the handling of human remains, see the CDC Ebola human remains guidelines in Appendix I.

Demobilization and Recovery

A. Demobilization Indicators

- The NWHRN, in consultation with partners (healthcare, LHJs and DOH) will work together to determine a threshold which may allow for partial or full demobilization of the Infectious

Disease Surge Annex and transfer any outstanding coordination back to normal operational channels. Triggers and indicators for demobilization may include:

- 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 specific threat.
- Completion of the monitoring period for all exposed persons without an increase or threat of increase in additional exposures.
- 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 stabilizing pattern.
- School/childcare attendance return to baseline levels.
- Call center volume (911 and other call centers) return to baseline levels.
- EMS call reports (type and volume) return to baseline threshold.
- Community and social media concerns decrease.
- Media requests for information decrease.

B. Demobilization Communication

- The NWHRN, in consultation with partners (healthcare, LHJs and DOH) will communicate the demobilization of the Infectious Disease Surge Annex to all partners who received the initial Annex activation notice. The Infectious Disease Surge Annex demobilization will likely be communication by e-mail and/or other NWHRN Communication Methods (WATrac, Alert Media).
- Depending on the scope of the infectious disease event, the NWHRN will lead and/or participate in a debrief and after-action process. Should the NWHRN lead an after-action process, the final report will be communicated and distributed to partners.

C. Recovery

- The following recovery activities should be considered following demobilization:
 - Return of any borrowed assets, such as equipment.
 - Debrief participating local, regional and/or state partners with after-action reports, as well as debrief about potential improvement plans and a coordinated approach to incorporating improvement plans/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 long-term.
 - Communication of any operational activities that need to be revised or continued.

Training and Exercise

- Training for roles and responsibilities for all relevant partner agencies will occur following the finalized Infectious Disease Surge Annex.
- Exercises including some or all of the Infectious Disease Surge Annex, including tabletop and functional exercises will occur with all relevant partners and include post-exercise evaluations that will provide improvement plans addressing required core capabilities.

- The NWHRN will assess the training and exercise needs of all coalition partners annually using a capabilities assessment to inform goals and objectives for the following year.

Authorities and Maintenance

- **Review Process and Annex Update**
 - Sections of this Annex 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 incidents.
 - The Annex will be provided to the LHJs, healthcare organizations, and regional partners for review and input.
 - Following review, a final copy will be provided to regional partners. Healthcare organizations are expected to share the updated Annex internally within appropriate colleagues.
- **Maintenance**
 - The Annex will be reviewed every three years or as needed following the process outlined above.

Appendices

Appendix A: [NWHRN Regional Healthcare System Emergency Response Plan](#)

Appendix B: [NWHRN Regional Infectious Disease Decision-Making and Communications Protocol](#)

Appendix C: [NWHRN Situational Awareness Annex](#)

Appendix D: [DOH Interim Supplemental Guidance for Prioritization of N95 and Other Respirators in Inpatient Hospitals During Times of Supply Shortage](#)

Appendix E: [ASPR Interim Planning Guidance for Handling Category A Solid Waste](#)

Appendix F: [NWHRN Patient Tracking Annex](#)

Appendix G: [Washington Medical Coordination Center Operational Framework](#)

Appendix H: [NWHRN Patient Movement Annex](#)

Appendix I: [CDC Ebola Human Remains Guidelines](#)