NORTHWEST HEALTHCARE
Response Network.

Healthcare System Emergency Response Plan

Patient Movement Annex

Version 2, May 2019

Record of Changes

Version No.	Description of Change	Date Entered	Posted By
1.	Regional Patient Movement Response Plan Created	February 2018	Rebecca Lis (NWHRN)
2.	Document updated with new language and to incorporate new coalition area	May 2019	Herakles Li (NWHRN)

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Introduction

Patient movement is a vital component of a coordinated healthcare response. 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), clinics, urgent care centers, healthcare coalitions, health departments, emergency management, and other supporting partners. The Northwest Healthcare Response Network (NWHRN) coordinates patient tracking and movement for the Western Washington region for any emergency incident or event.

Purpose

The purpose of this Patient Movement Annex is to:

1. Describe the coordination and procedures of a patient movement process within the coalition service area for all patient movement events and incidents, such as MCIs, healthcare facility (hospital and long-term care) evacuations, and inbound patient movement event.
2. Describe the process to support placement, tracking, and movement of patients in a patient movement response.
3. Define roles and responsibilities for healthcare facilities, the 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 Patient Movement Annex is an annex to the larger Healthcare Systems Emergency Response Plan and is applicable when patients are moved due to an MCI, healthcare facility evacuation, or inbound patient movement incident that requires regional coordination within the coalition service area. For the purposes of this document the term "coalition service area" is defined as the geographic region of western Washington which is served by the NWHRN, and currently includes 25 Sovereign Tribal Nations and 15 counties. This annex is not applicable for the daily/routine movement of patients by EMS or healthcare facilities nor does this annex supersede existing facility, county, or regional plans and procedures for patient movement.

The information in this annex applies to the roles and responsibilities of healthcare organizations (including hospitals and long-term care facilities) 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 annex 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 annex establishes common goals, strategies, and terminology with other regional and local plans.

Planning Assumptions

Planning assumptions for this annex include the following:

1. All healthcare systems, hospitals, and long-term care facilities are expected to maintain plans with the following components:
    a. Full-facility evacuations
    b. Receiving a surge/influx of patients
    c. Communicating with regional partners, particularly about their current bed availability
    d. Processes to support resource needs and requesting resources
2. Events or incidents that trigger patient movement 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 or inbound patient movement events can take hours or days to place and move all patients to receiving facilities.
3. Resources to support patient movement and surge may be in short supply, or delayed, in the county, region, or state (e.g., transportation).
4. The definition of MCI varies in scale between regions and is dictated by local resources and available support for MCI response.
5. Healthcare organizations and partners involved in the response will activate their emergency response structure.
6. 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.
7. 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.).
8. 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.
9. Response to large scale disasters may require coordination with other regional, state, and federal partners.
10. Routine methods of communications and transportation may be strained and disrupted.
11. To best accommodate care needs, patients may be moved across regional boundaries (i.e. county lines, tribal lands, coalition service area etc.). Disaster Medical Control/Coordination Centers (DMCCs) and the NWHRN will notify neighboring regions and healthcare organizations during a patient movement scenario in case patients are transported beyond regional boundaries.
12. 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 annex may be activated prior to or during any event or incident where there is a current or potential need to move patients throughout a region including an MCI, hospital evacuation, long-term care facility evacuation, or inbound patient movement event. This annex activation may occur concurrently with activation of other plans.
- This annex can be activated by the NWHRN or at the request of a DMCC, an LHJ, or an evacuating or potentially evacuating facility. Additional partners, such as EMS, emergency management, and receiving facilities, may request the activation of this annex through the DMCCs, the NWHRN, or the LHJ.
  - MCI: DMCCs[1] will be notified of the incident by EMS or dispatch.
  - Hospital evacuation: DMCCs should be notified by the currently, or potentially, evacuating facility. DMCCs (optionally with the support of NWHRN) will notify regional hospitals of a potential patient movement incident.
  - Long-Term Care evacuation: The NWHRN and relevant LHJs should be notified by the currently or potentially evacuating long-term care facility. Following notification, the NWHRN will activate the Long-Term Care Response Team[1] which will notify potential receiving facilities within the region, or neighboring regions if appropriate. The NWHRN will also notify LHJs, emergency management, and other relevant partners if they have not been notified already. See the Long-Term Care Response Appendix for detailed information and team protocols (See References).
  - Inbound Patient Movement: DMCCs, NWHRN, and LHJs will be notified of the event by the state or federal partners. DMCCs will work with the NWHRN to notify other regional partners once activated.
- If the annex is activated by only one of the above entities (DMCC, NWHRN, or LHJ) the NWHRN will ensure the other partners are notified immediately following activation. (See Attachment A for Emergency Contact Information)
- The Department of Health (DOH) must be notified for hospital evacuations due to its licensing role in healthcare facilities. In a long-term care facility evacuation, the State Department of Social and Health Services (DSHS) and/or DOH must be notified. Notification to these entities will be completed by the evacuating facility or the NWHRN, if requested.
- Following activation, the NWHRN and/or LHJ will notify local EMS and identify other appropriate partners to further notify. Partners may include:
  - Fire, EMS and law enforcement Public Safety Answering Points (PSAPs)
  - Neighboring Healthcare Coalitions, LHJs, or DMCCs
  - DOH/DSHS
  - Other local healthcare organizations
  - Local emergency management

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

o Other partners as appropriate

B. Patient Movement Concepts

1. Mass Casualty Patient Movement

MCI thresholds and triggers vary from county to county but the concepts for triage, and patient movement remain the same. The basic concept of patient movement in an MCI is to triage patients as accurately as possible and transport 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.), evacuating facilities should coordinate with receiving facilities on the location of necessary care when 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 patients. It is suggested that teams should be pre-designated by hospitals either before the incident or in the moment and include at least two clinicians (e.g., nurses, physician assistants, physicians, etc.) with knowledge of the level of care being provided.

Please refer to the Long-Term Care Response Appendix for long-term care facility specific evacuation information (See References).

3. Specialty Patient Movement

There are several groups of specialty patients 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-identifying facilities capable of receiving specialty patients. If this information is identified, it should be coordinated with their local DMCC prior to an evacuation. 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 and staff to a receiving facility to better support care for those patients

- Sending advance teams to receiving facilities to prepare space and staff for specialty patients

- Placing patients using pre-identified partner facilities that could accommodate appropriate care needs

- Moving patients beyond regional boundaries to accommodate patient care needs

- Establishing telehealth capabilities to support care at non-traditional receiving facilities

4. Inbound Patient Movement

While a healthcare facility evacuation or MCI typically deals with patient movement within our coalition service area, an inbound patient movement event deals with the movement of patients from a disaster struck area arriving to our coalition service area for care. These incidents may be part of the National Disaster Medical System (NDMS) response. The Federal Department of Health and Human Services (HHS) serves as the federal coordinating patient movement entity. This annex deals with both NDMS activation and non-NDMS activated inbound patient movement events.

Assumptions for an inbound patient movement event include:

1. Patients being transported have received an initial assessment and are in stable condition when being moved out of the disaster-struck region to a healthcare facility in our coalition service area where they will receive definitive care.

2. The sending facility may directly or through HHS channels provide at least some notice for partners on the expected timeframe and number of patients. Depending on the

distance and number of patients, it may take hours or days to identify placement and move all patients to receiving facilities.

3. Western Washington regional infrastructure (transportation, communication, etc.) is operating as normal.

4. Patients will arrive and be distributed from one or more staging areas (e.g., an airport) through the Puget Sound Federal Coordinating Center (PSFCC) for an NDMS activation.

Please see the Inbound Patient Movement Appendix for full details (See References).

C. Command, Control, and Coordination

Any patient movement scenario that requires regional coordination will involve multiple organizations. Tasks 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. The following sections on patient placement, transportation, and tracking outline the key components and processes required to execute this general concept of coordination.

- Key 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 will primarily be communicating with Incident Command at the scene or evacuating facility. Additionally, they will communicate with receiving facilities for placement of patients.
- The Long-Term Care Response Team will operate as part of the NWHRN Healthcare Emergency Coordination Center (HECC) Operations section.
- 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 function may be part of secondary movement or coordination and may not be coordinated by the DMCCs/Long-Term Care Response Team directly.

Figure 1: The following figure is intended as an illustrative example of how Mass Casualty or Single Facility Evacuation communication and patient movement would occur.
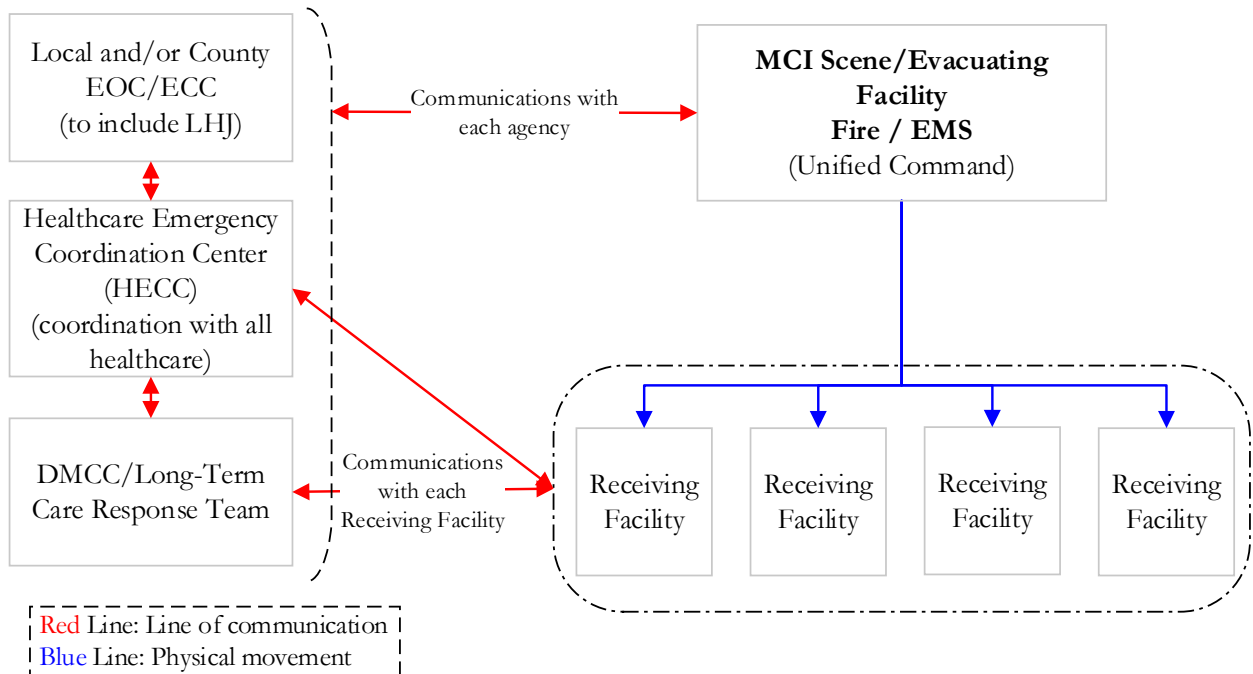
Figure 2: The following figure is intended as an illustrative example of how Multiple Facility Evacuation communication and patient movement would occur.
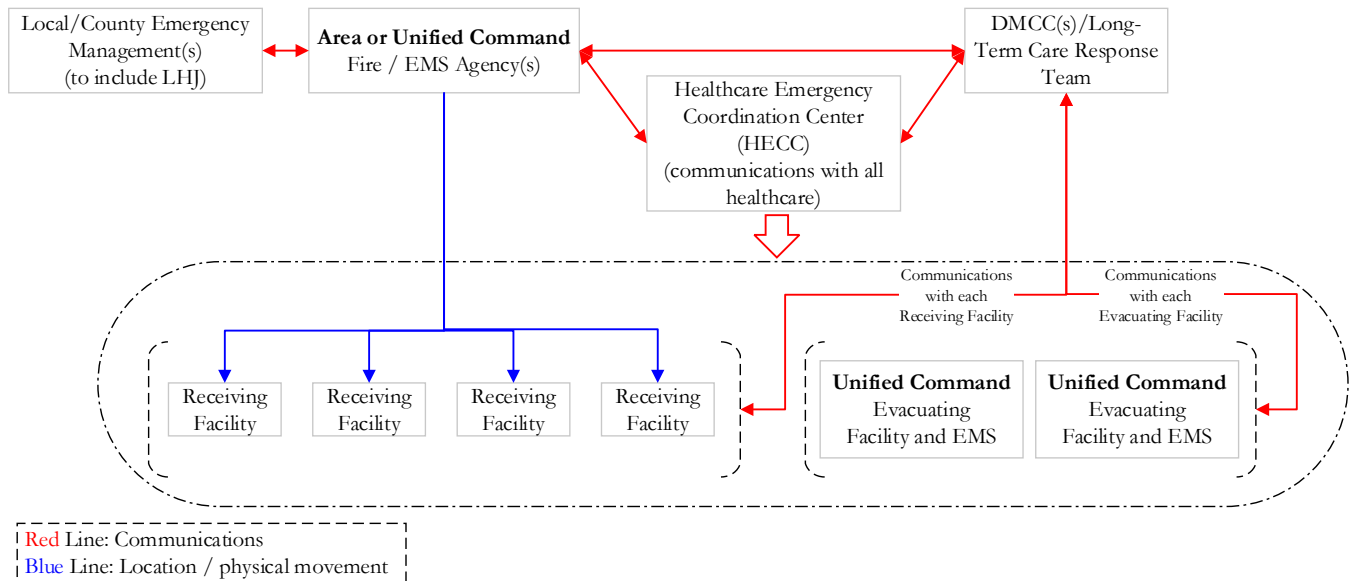
In a multiple facility evacuation scenario, there will need to be coordination among regional partners to support prioritization of facility evacuation timing, if possible. Depending on the incident, there might be impacts to transportation infrastructure, EMS/transportation resources or receiving facilities that may preclude the movement of all evacuated patients at once. In this scenario, the DMCCs/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 to:

- Activate facility evacuation plan, activate internal notification processes for staff and leadership, establish appropriate ICS positions, and support coordination with outside partners and resources. Coordinate directly with Area or Unified Command, when established.
- Assess 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.
- Notify the NWHRN or local emergency management if there is resource support that can prevent or slow an evacuation.
- Notify the DMCC (hospital evacuation) or NWHRN (to activate the Long-Term Care Response Team).
- Implement all census-reduction procedures to minimize the number of patients who need to be moved to another healthcare facility.
- Identify transport needs for all patients within the evacuating facility. See the patient transportation section of this plan for additional details.
- Identify staff, resources, equipment and medications that can go with evacuating patients.
- Identify, contact, and move 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 and relevant patient transportation resources at the facility.
- Ready 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.
- Ready any resource, medications, or supplies that will be transported with the patient. See equipment/supplies/staff section for more details.
- Notify appropriate regulating authority (DOH and/or DSHS) if the facility will be evacuating.
- Notify patient's family or responsible party of evacuation. See patient information and documentation section for more details.

2. Receiving Facility

When notified of a patient movement incident or event, potential receiving facilities should prepare to:

- Communicate their bed availability via WATrac as the primary means and other methods only if WATrac is not available or if the receiving facility does not use WATrac.
- Activate internal processes to create additional beds and space (e.g., early discharge, census reduction, internal surge plans, staff call backs, etc.).
- Activate internal command structures to support possible patient surge.
- Determine and communicate receiving area to incoming transport vehicles. If time and resources allow, this communication could be coordinated with support of the NWHRN.
- Ready staff and receiving area(s) for patient arrival.
- Ready internal processes to receive healthcare staff from evacuating facility or other regional facilities.
- Communicate actual or potential resource needs to support the additional patients with the NWHRN and/or local emergency management.
- Participate in patient tracking processes for all patients received via WATrac, or appropriate paper-based back-up process. Specifically take 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 large incident, 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), the status of transportation infrastructure, and the availability of receiving facilities.

In an MCI, hospital evacuation situation, or inbound patient movement event, patient placement is coordinated by the DMCCs. The DMCCs 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 DMCCs. The role of the DMCCs is to:

- Receive notification from evacuating facility and/or EMS on scene to activate the DMCC during an MCI or hospital evacuation and the lead agency for an inbound patient movement event.

- 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 pertinent information.
- Request hospital bed availability information from area hospitals prior to and/or during an incident.
- Determine appropriate patient destination and advise EMS agencies (and patient transportation entities) and healthcare organizations on these destination(s) prior to, during, and/or following an incident (MCI or evacuation).
- Communicate with receiving facilities on the patients they will receive.
- Seek assistance, as necessary, from public safety agencies, PSAPs, the NWHRN, LHJs, neighboring local DMCCs, and/or State DMCCs.

If a local DMCC is overwhelmed and/or requires assistance in its operations, it can request support from its back-up facility or a neighboring county/district's DMCC. In addition to the local-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 a state-wide DMCC if it is overwhelmed or unable to complete its functions.

The local DMCC(s) within the coalition service area are as follows:

- <u>North District:</u> Island, San Juan, Skagit, Snohomish, & Whatcom County
  - Providence Everett Medical Center (Everett)
- <u>Central District:</u> King & Pierce County
  - Harborview Medical Center (Seattle) – King County DMCC
  - Good Samaritan Hospital (Puyallup) – Pierce County DMCC
- <u>Northwest:</u> Clallam, Jefferson, & Kitsap County
  - Harrison Medical Center CHI Franciscan (Bremerton) – Kitsap County DMCC Only
- <u>West:</u> Grays Harbor, Lewis, Mason, Pacific, and Thurston County
  - Providence St. Peter Hospital (Olympia)

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 DMCCs as soon as possible. EMS on scene will coordinate directly with the DMCCs 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 PSAPs, existing mutual aid partners, Emergency Operations Centers (EOCs), 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 discharge to home:
  - Total wheelchair van/bus patients
  - Total for standard ground transport or privately-owned vehicle
- 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 (not including pediatric or neonatal)
- 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

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 B 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 DMCCs/Long-Term Care Response Team concerning patient needs, destination, and transportation assets. If additional transportation assets are required, the evacuating facility will work with EMS on scene to coordinate directly with mutual aid agreements via their PSAP, 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.

3. Inbound Patient Movement Transportation

    During an inbound patient movement event, patient transportation will be handled primarily by local EMS agencies and private carriers as appropriate. They will work with receiving facilities, PSAPs, Emergency Management, and DMCCs to prepare transport for arriving patients and secure necessary resources for the operation.

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

G. Patient Tracking

Patient tracking is the process for documenting and maintaining 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 community recovery.

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

During patient movement response, 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. An inbound patient movement event would share similar tracking expectations as a facility evacuation. 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 during an MCI. The priority for EMS is to begin the patient tracking process by initiating a unique patient identifier 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. This principle likely also applies to rapid hospital evacuations. In

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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.

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 Patient Tracking Appendix (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 all individuals associated with an incident, along with information on deceased, missing and uninjured persons.

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 patient information could include the Patient Evacuation Tracking Forms (See Attachment C), 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.

   The receiving facility will follow internal protocols to register the incoming patient but does 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 when being transferred to facilities that do not usually treat these patient populations. It is at the discretion of the receiving facility 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 E 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 ways, which may include: broadcast via television, radio, social media, hospital operators, and recorded messages.

I. Equipment/Supplies/Staff

During the response, 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. Please refer to Attachment E for a tracking template on patient medical records and equipment. If the evacuating facility is not able to supply needed resources, receiving facilitates should identify appropriate sources of additional staffing, supplies, and equipment. These sources 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 F).

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 evacuating and receiving facilities to track 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

The NWHRN will support LHJs and local healthcare partners with regard to developing and maintaining 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 annex. 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 coalitions

Larger incidents that expand beyond the NWHRN coalition service area, may require coordination between multiple coalitions 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. 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 emergency management via the Washington Mutual Aid System (WAMAS) as outlined in RCW 38.56.

2. Emergency Management 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

Patient movement may be demobilized when: all patients have. This demobilization may occur when:

- All patients have been moved to appropriate definitive care
- The DMCC(s)/Long-Term Care Response Team has demobilized.
- All patients have been entered in patient tracking and all patients have been confirmed to have arrived at their receiving facility
- The patient tracking process has been connected to the regional family reunification processes.

Following demobilization of this annex, 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 DMCCs 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 annex. 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 reports, discuss improvement plans, and create a coordinated approach to incorporating recommendations into future planning.
- Communications 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 Healthcare System Response Plan, the Patient Movement Annex, and other supporting annexes and appendices, as needed, and notify regional partners
   - Establish the HECC to support a patient movement response and support ESF-8 operations
   - Gather, analyze, and distribute situational awareness information to and from healthcare organizations, LHJs, and local emergency management.
   - 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 their response plan 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
- Serve as a conduit to the DOH for coordination of state-level patient movement

3. Disaster Medical Control/Coordination Center (DMCC)/Long-Term Care Response Team
- Activate their response plan 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 regarding 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 manage patient surge
- Provide care to patients during a patient movement incident
- Coordinate with the DMCCs/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 to signed mutual aid agreements
- Track 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 DMCCs/Long-Term Care Response Team of activations due to MCIs or healthcare facility evacuations
- Coordinate with DMCCs/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
   - Support resource requests from healthcare organizations, healthcare coalitions, DMCCs, 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. Sovereign Tribal Nations
   - Coordinate with the NWHRN, county agencies, and healthcare organizations
   - Provide and receive healthcare situational awareness information

10. 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

Authorities and References

A. Review and Update Process
1. This annex will be updated, as needed, based on the evolution of planning activities and partnerships, and after exercises or real-world events.
2. The annex 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 annex internally with appropriate committees and leadership.
4. The NWHRN Board of Directors will be briefed when updates to this annex are completed.

B. **Maintenance**

This annex will be reviewed every two years, or as needed, following the process outlined above.

C. **Training and Exercise**

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

This annex 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**

This plan annex is supportive of local, state, and tribal procedures. This plan is not meant to supersede partner mass fatality or family reunification planning. For a complete list of references please refer to the full Healthcare System Emergency Response 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 the coalition service area.

B. **Acronyms**

ALS – Advanced Life Support
ASPR – Assistant Secretary for Preparedness and Response
BLS – Basic Life Support
CMS – Centers for Medicare & Medicaid Services
DMCC – Disaster Medical Control/Coordination Center

DOD – Department of Defense

DOH – Washington State Department of Health

DSHS – Washington State Department of Social and Health Services

EMAC – Emergency Management Assistance Compact

EMS – Emergency Medical Services

EOC – Emergency Operations Center

ESF-8 – Emergency Support Function-#8

FAC – Family Assistance Center

FCC – Federal Coordinating Center

HECC – Healthcare Emergency Coordination Center

HHS – U.S. Department of Health and Human Services

HPP – Hospital Preparedness Program

JIC/JIS – 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

PSFCC – Puget Sound Federal Coordinating Center

SATs – Service Assistance Teams

WAMAS - Washington Mutual Aid System

WATrac – Washington's Bed Tracking and Patient Tracking System

Attachments

A. Emergency Contact Information

B. Categorization of Patients for Evacuation: Charge Nurse Criteria

C. Patient Evacuation Tracking Forms (ICU/Critical Care, Acute Care, LTC)

D. Patient/Medical Record & Equipment Tracking Sheet

E. Controlled Substance Transfer Form

F. State 213RR – Resource Request Form