Southeastern Healthcare
Preparedness Region

ESF-8 Response & Recovery Plan

SOUTHEASTERN HEALTHCARE
PREPAREDNESS REGION

ESF-8
STATE MEDICAL RESPONSE SYSTEM

The Southeastern Healthcare Preparedness SHPR Region's Regional ESF-8 Response and Recovery Plan may be distributed by both hard copy and electronic means. The SHPR Healthcare Preparedness Manager is responsible for plan distribution to regional ESF-8 partners.

RECORD OF CHANGES AND ANNUAL REVIEW

Change Number	Date of Change	Date Posted	Initials
1	**6/3/2019**	**6/10/19**	**HG**
2	**06/29/2020**	**06/29/2020**	**HG**
3	**6/21/2021**	**6/21/2021**	**HG**

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I. INTRODUCTION

PURPOSE

Every county in the state has ordinances that address emergency management. Authority and responsibility rests at the local level. The purpose of the Southeastern Healthcare Preparedness Region (SHPR) Response and Recovery Plan is to support the following four functions of the regional emergency response effort:

- Maximize the protection of lives and health care properties while minimizing preventable morbidity and mortality.
- Document guidelines and procedures for responding to a natural, chemical, biological, radiological, nuclear, or explosive emergency that threatens the medical and public health of the region.
- Contribute to ESF-8 (public health and medical services) at the local, regional and state level and other medical partners in preparation for and in response to a medical emergency.
- Enable the region to continue to operate and provide services as normally and effectively as possible in the event of a medical emergency.

SCOPE

The plan is applicable to medical response and recovery for all disaster and pre-planned special events with direct, indirect, or threatened consequences that may require medical resources beyond those routinely available to the affected jurisdictions or through standing agreements. This plan provides guidelines, establishes protocols, develops concepts, identifies tasks, lists responsibilities, and provides resource management information necessary to provide a regional response in support of an incident that exceeds the ESF-8 capabilities of local jurisdictions.

This plan is not intended to establish jurisdiction over any existing federal, state, regional, or local plans and policies. The plan serves as a resource for coordination and allocation of ESF-8 resources available within the region. Other emergency response agencies, such as fire and law enforcement, are key stakeholders to the response.

SITUATION

The SHPR area is exposed to hazards that have the potential to cause damage, mass casualties, and mass fatalities. The plan addresses medical response to and recovery from natural and human-made hazards that could adversely affect the region. When necessary, regional disaster medical services may supplement assistance to local governments in mitigation of, planning for, response to, and recovery from a major emergency or disaster. These activities include, but are not limited to the following:

- Assessment of medical needs
- Provision of medical care personnel
- Provision of medical equipment and supplies
- Coordination assistance for transportation of medical supplies
- Coordination assistance for transportation of personnel
- Coordination assistance for transportation of patients, including evacuation
- Provision of emergency responder health and safety

CAPABILITIES

Access to regional capabilities should be coordinated through appropriate procedures (e.g., local emergency management, mutual aid, local management entities, or the Regional Healthcare Preparedness Manager. Functional annexes to this plan provide more details on these critical resources.

PLANNING ASSUMPTIONS

- The region will experience emergency situations and disasters that may cause death, injury, and damage, or may necessitate evacuation and sheltering.
- Additional regional, state, and federal capabilities may be needed to supplement and assist the local jurisdictions.
- During a disaster, large numbers of injured, ill, and affected persons are likely to converge on medical and healthcare facilities in or near affected areas.
- There will be more functional and special needs challenges than anticipated. The needs and magnitude of homebound and special needs population is difficult to assess and may stress medical response.
- Disruption of sanitation services, loss of power, and massing of people in shelters will increase risk of disease and injury.
- A disaster could cause widespread damage to critical medical infrastructure and key resources.
- Normal communications systems may be destroyed, degraded, or rendered inoperable.
- Emergency medical response and recovery capabilities may be enhanced by employment of supplemental resources obtained through regional mutual aid agreements and from the private sector.
- An outbreak of a communicable disease may be widespread and become epidemic or pandemic.
- Healthcare facilities may be unable to accommodate the volume of affected persons. Additional temporary treatment facilities may be created in alternative facilities.
- Healthcare facilities may be affected by diseases, chemical, or biological agents and may be closed until they are cleared for use.

- Healthcare facilities may experience personnel shortages.
- A communicable disease outbreak or terrorist event may disrupt essential services.
- Additional transportation may be needed to evacuate patients to the appropriate hospital or medical facility and may be obtained through local or state mutual aid agreements and/or from the private sector.
- Transportation may be needed to transport fatalities to funeral homes and/or designated sites.
- Assistance may be required to maintain the continuity of medical and public health services.

II. CONCEPT OF OPERATIONS

GENERAL

The size, nature, and complexity of a disaster will determine activation of the response and recovery assets and services as well as the scope of operations needed to support the response. Primary authority and responsibility for the response to and recovery from a disaster rests with local government.

Local governments should use their plans to coordinate services and resources of the local medical system. Locally available medical and public health resources should be used to meet the immediate needs of a jurisdiction. Local requests for assistance should be transmitted to the county emergency operations center (EOC) for assessment and mission assignment by emergency management staff.

SHPR, has the responsibility of implementing its regional Medical Response System, in accordance with established plans, policies, and guidelines. During a disaster, this Regional ESF-8 Response and Recovery Plan will be activated to assist with the coordination and deployment of non-local medical assets and services to augment local needs.

The Healthcare Preparedness Manager or designee serves as a regional ESF-8 liaison for the assessment of medical needs and the coordination of non-local medical assets and services as identified by mission assignments from North Carolina State Emergency Management (NCEM), North Carolina Office of Emergency Medical Services. The Healthcare Preparedness Manager or designee may also assist in the coordination of restoration of medical services in the area affected by the disaster.

SITUATIONAL AWARENESS

Upon receiving notification of a multiple casualty incident or medical/public health emergency in the SHPR region, the Healthcare Preparedness Manager or designee will be available to report progress and ongoing needs of healthcare entities in their regions as requested by the North Carolina Office of Emergency Medical Services.

Situational awareness with regional ESF-8 partners and related emergency response agencies will be accomplished routinely through onsite visits, oral and written communication, or other methods as deemed appropriate by SHPR and their partners.

The State Medical Asset Resource Tracking Tool (SMARTT) has been replaced with Continuum and will be used to provide information on bed availability throughout the region. NCTERMS will be employed to electronically create personnel rosters, notify personnel of deployments, and track deployed personnel by mission.

MEDICAL RESOURCE MANAGEMENT

General

Once a local assessment has been completed and a medical support mission has been directed to the State Medical Response System (SMRS), local and state medical assets from non-affected areas may be mobilized to respond as requested through the mission assignment process. Those assets may include activation of any portion of the SMRS. The Healthcare Preparedness Manager or designee, working with the North Carolina Office of Emergency Medical Services may be asked to assist with the coordination of the response. The composition and capabilities of the SMRS are described in the SMRS Annex to this plan.

Local Activation

Activation of local medical resources and the flow of subsequent medical support requests will correspond to the incident. When medical capabilities of the jurisdiction are adequate to resolve an incident and the magnitude of an incident does not warrant the activation of the county emergency operations center, a local health or medical agency/facility in need of support may request assistance directly from the Healthcare Preparedness Manager or designee.

However, when an incident occurs that begins to stress the medical capabilities of a jurisdiction, decisions to initiate requests for medical resource support will usually be made by local authorities in coordination with their county emergency management agency. The diagram below, *Local Request of HCC Assets and Teams*, provides an outline of these processes.

The process for obtaining medical assets and services is outlined below:

- A multiple casualty incident, medical/public health emergency, or other medical need occurs at the local level and requires medical support.
- Local officials anticipate a need for support and activate existing mutual aid agreements with surrounding entities and jurisdictional resources (e.g., trauma center, surrounding hospital, additional EMS response).
- Local EMS systems, hospitals, and other health/medical facilities request local support through the local emergency management agency or emergency operations center while simultaneously alerting the Healthcare Preparedness Manager or designee as the need/anticipated need for medical support increases.

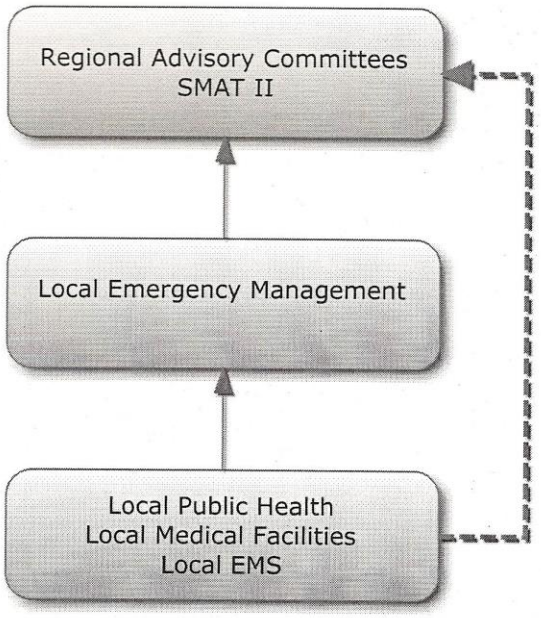
OR

- Local EMS systems, hospitals, and other health/medical facilities request support directly from the Healthcare Preparedness Manager. (When the response does not warrant activation of the local emergency management agency and the needed asset belongs to the HCC.)
- Local emergency management alerts the Healthcare Preparedness Manager of the pending request, and HCC assets are mobilized to support the request. Healthcare Preparedness Manager or their designee notifies North Carolina Office of Emergency Medical Services of support rendered.

OR

- The Healthcare Preparedness Manager alerts appropriate HCC response elements of the pending request and mobilizes to support. Healthcare Preparedness Manager or their designee notifies the North Carolina Office of Emergency Medical Services of support rendered.

Local Request of HCC Assets and Teams



Intra-Jurisdictional Activation

SHPR can assemble a support cell of personnel through employees, partners, and/or relevant support agencies to assist ESF-8 lead agency with the assessment and coordination of medical assets and capabilities as requested. This support cell may be located in a convenient location as requested by SHPR with the primary purpose of supporting the ESF-8 lead in the Emergency Services Branch of the State Emergency Operations Center (SEOC) for state-level incidents, or the ESF-8 desk at the North

Carolina Emergency Management Regional Coordination Center (RCC) for local or regional-level incidents. The support cell will assist ESF-8 partners fill gaps in the coordination of medical assets and beds, gather medical information and situation reports, and provide HCC-owned supplies and equipment as necessary.

State Activation

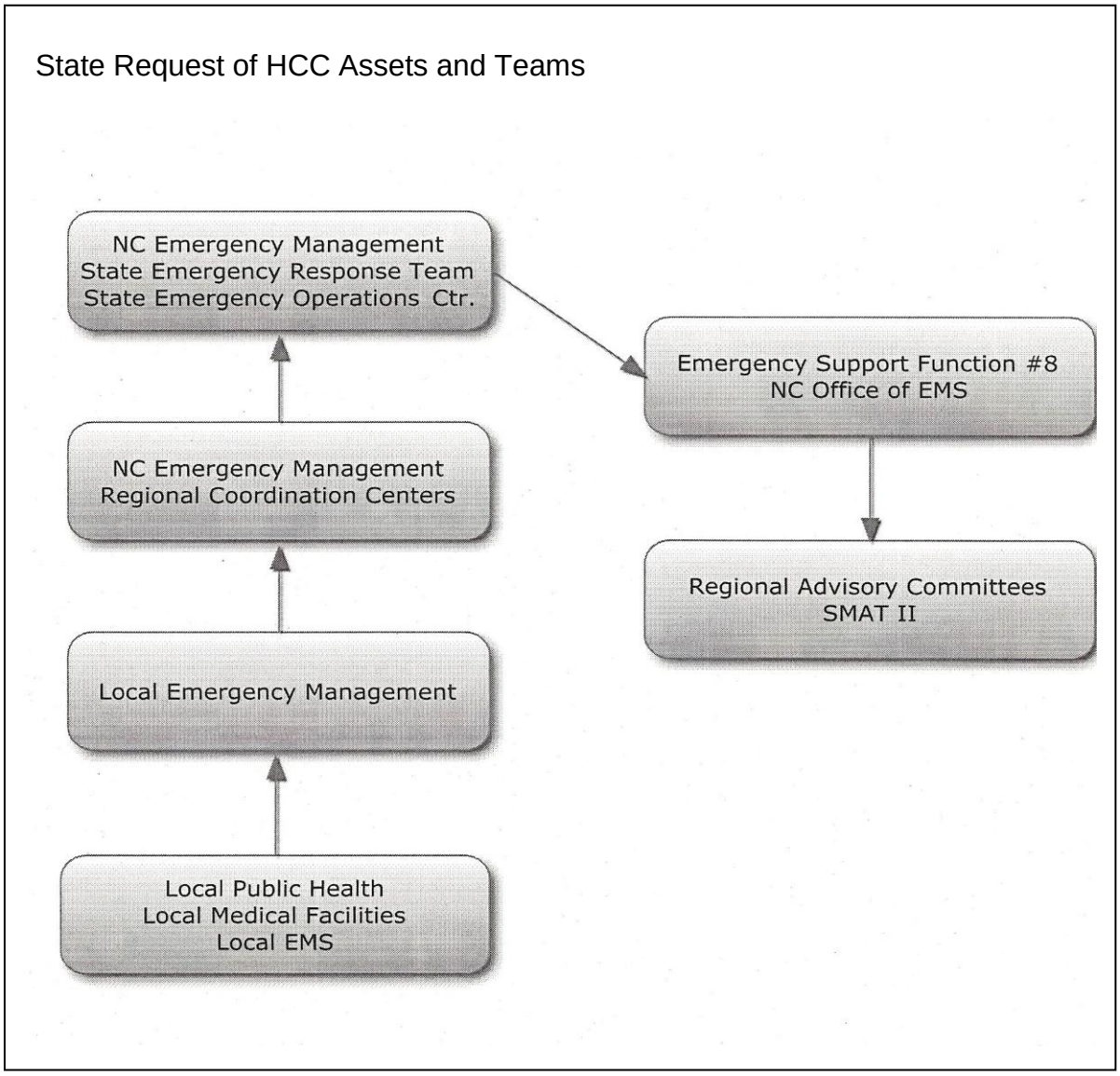
Resource requests are typically directed to the appropriate RCC for approval and mission assignment. If the RCC does not have the assets available to assign the mission, requests can be directed to the SEOC for further action. Refer to *State Request of HCC Assets and Teams* below.

During times when the RCC is not activated, the county ESF-8 coordinator or local emergency management coordinator may request assistance from the Healthcare Preparedness Manager or designee.

The process for obtaining medical assets and services is outlined below:

- A multiple casualty incident, medical/public health emergency, or other medical need occurs at the local or regional level that overwhelms local or regional medical capabilities.
- Local officials anticipate a need for greater support and activate existing mutual aid agreements with surrounding entities and regional resources (e.g., trauma center, surrounding hospital, additional EMS response).
- Local EMS systems, hospitals, and other health/medical facilities request regional support through the RCC/SEOC while simultaneously alerting the Healthcare Preparedness Manager or designee as the need/anticipated need for medical support increases.
- The Healthcare Preparedness Manager alerts appropriate response organizations of the pending request. NOTE: The formal request to North Carolina Emergency Management/North Carolina Office of Emergency Medical Services must originate from the county emergency management coordinator, as a result of statutory requirements of North Carolina General Statute 166A (North Carolina Emergency Management Act) related to funding/mobilization procedures at the state level.
- The RCC/SEOC forwards the support request to the State Emergency Response Team (SERT) ESF-8 lead for review and approval.
- SERT ESF-8 lead, in coordination with the support cell, reviews the request for validity and advises the RCC or local emergency management coordinator and the Healthcare Preparedness Manager or designee regarding regional/state medical response approval.

- The Healthcare Preparedness Manager or designee will notify appropriate regional stakeholders and internal SMRS personnel of the approved activation.



HCC Notification

Upon the receipt of a request for medical support, SHPR will provide ESF-8 support to jurisdictions, facilities, and agencies in response to an incident as requested. Support for these requests will be provided initially through established mutual aid agreements. The Healthcare Preparedness Manager or designee will function in accordance with this plan and their established standard operating procedures for alerting, coordinating support requests, and activating and mobilizing internal HCC assets for the delivery of assistance.

Federal Activation

In the event that state resources are insufficient and a state of emergency has been declared by the governor of North Carolina, the SERT Leader, in coordination with the

Federal Emergency Management Agency Emergency Response Team (FEMA-ERT) may request support for federal medical response.

PUBIC HEALTH RESOURCE MANAGEMENT

Local health departments and districts have the responsibility of protecting the health of the populations within their jurisdictions. Disasters that introduce disease (e.g. food-borne, vector-borne) or contamination (e.g. chemical, biological, radiological) into the population or the environment are of primary concern to public health organizations. The scope of public health response and recovery include:

- Monitoring health status before, during, and after public health emergencies
- Diagnosing and investigating urgent health conditions and health hazards in the community
- Disseminating protective health information
- Mobilizing community partnerships to prepare for and respond to public health crises
- Developing policies and plans that support individual and community preparedness
- Enforcing laws and regulations that protect health and ensure safety

Although there may be differences between each local health department, these operations are generally implemented and maintained in accordance with each department's/district's emergency response plans under the authority of their health director or designee. Integration of response between public health and medical jurisdictions is accomplished through planning at the local, regional, and state level.

During a disaster, the local health director or designee has the responsibility of activating public health plans and mobilizing local public health response teams. These teams are responsible for the following:

- Assess public health needs.
- Review and prioritize requests for assistance relating to communicable disease outbreaks and medical countermeasures.
- Determine personnel and resource needs.
- Verify the nature and extent of public health problems.
- Establish appropriate monitoring and surveillance procedures.
- Activate and deploy supplies, equipment, and support personnel to staging areas.
- Initiate public information programs.
- Assess long-term health impacts during recovery.

As the disaster begins to stress local public health capabilities, the health director or designee will request additional resources from the state division of public health. Upon activation of the county emergency operations centers, local health departments will provide emergency operations center representatives. All requests for public health resources will follow resource request procedures established by emergency management.

Acquisition of public health resources

Requests should flow from the healthcare/medical facility/agency to the county emergency operations center for mission assignment to the local health department.

Replenishment of public health resources

Requests should flow from the local health department to the county emergency operations center to the RCC or SERT for mission assignment to the state division of public health.

In the event that state public health resources are expended and a state of emergency has been declared by the governor of North Carolina, the SERT Leader, in coordination with the Federal Emergency Management Agency Emergency Response Team (FEMA-ERT) may request support for federal public health response.

SHPR INVENTORY MANAGEMENT PROCESS

Access to cashed equipment and supplies

- Use iCams system to search within our or other coalition inventories.
- Search by item, asset tag, expiration, lot, model, etc.
- Items will be listed under a physical location and can be located there within the facility/vehicle.

Inventory Management Process

Receiving:

- As inventory is received, it is checked against the purchase order and then input into iCams.
- If items cannot be immediately entered into iCams, it should be placed in the designated holding area, so that staff are aware that the items has not been entered into iCams, and therefore should not be used.
- If a received item is not on the iCams master list, a written request to the designated iCams regional administrator for creation. Information needed to be supplied: item description, make, model, cost and identify which of the following are needed for the item: serial number, lot number, hazardous material, control substance status (all where applicable). Once notice is given that the item has been added as a master, then the item should be entered into iCams, identifying the location stored.

Storing Inventory:

- Consumables and equipment should be assigned a location in the iCams inventory management system, and the placed in that physical location.

- Inventory is stored in trailers, vehicles, tri-wall boxes, totes, rolling carts, pod boxes, and crash carts.
- Consumables should be stored in a manner that promotes the oldest item being consumed first.
- Some inventory is stored loose on shelves/racks and some are stored stacked on pallets.
- The location of all items can be located in iCams by searching location, item, or model.
- All equipment and supplies should be stored appropriately inside a protected warehouse and or trailer.

Expiring inventory:

- It should be common practice to maintain accurate information in the iCams system. This will allow the system to properly notify the user of approaching expiration dates.
- Weekly notifications will be automatically generated by iCams and sent to the Logistics Coordinator. This report indicates any expiration dates that will occur within the next six months. The Logistics Coordinator shall review this information and remove from inventory, any item expiring within three months. Those items that can be exchanged at the Novant Health, New Hanover Regional Medical Center's distribution center for like-kind and quantity for a product with a "new, more distant" expiration date.
- The exchanged items should be entered into iCams per the practice outlined above.
- Expiring items that cannot be exchanged should be reported in writing to the person assigned to order items through Lawson, online ordering platforms or via retail. Replacements should be ordered in a timely manner as to avoid having expired inventory on-hand. Once replacements are received, items should be entered into iCams per the practice outlined above.

Expired inventory:

- Expired items should immediately be removed from service and disposed of in a manner compliant with Novant Health policy.
- These items are moved to in iCams to: SHPR > Items Disposed / Expired / Lost / Destroyed.

ORGANIZATION AND ASSIGNMENT OF RESPONSIBILITIES

Agency/Department/ Position	Responsibilities
STATE	
North Carolina Office of Emergency Medical Services	• Administer the NC Medical Reserve Corps (MRC) program. • Provide leadership in coordinating and integrating the overall state efforts that provide medical assistance to a disaster-affected area. • Coordinate and direct the activation and deployment of medical personnel, supplies, equipment, and pharmaceuticals (non SNS) (with public health as needed). • Assist in the development of local capabilities for the onsite coordination of all emergency medical services needed for triage, treatment, transportation, tracking, and evacuation of the affected population with medical needs. • Establish and maintain the cooperation of the various state medical and related professional organizations in coordinating the allocation of EMS system resources from unaffected areas to areas of need. • Assist in coordinating the evacuation of people in medical facilities in the disaster area. • Coordinate the medical sheltering response by implementing the State Medical Support Sheltering Plan.
North Carolina Division of Public Health – Public Health Preparedness & Response (PHP&R)	• Provide leadership in directing and coordinating state efforts to provide public health assistance to the affected area. • Provide the epidemiological investigation of a known or suspected threat caused by chemical, biological, or nuclear agents. • Provide laboratory testing in support of clinical laboratories on specimens from persons that may have been exposed to a chemical, biological, or nuclear agent. • Activate the Strategic National Stockpile (SNS). • Provide guidelines for quarantine and isolation in order to prevent further transmission of disease. • Provide guidelines for prophylaxis and treatment of exposed and affected persons. • Direct and coordinate the activation and deployment of personnel, supplies, and equipment in response to requests for state assistance. • Establish monitoring systems for the protection of public

	health. • Provide guidance and assistance to local public health departments, health care entities, and the general public. • Investigate disease outbreaks.
North Carolina Division of Emergency Management	• Activate and manage the state's Response Section within the SERT. The section will 1) serve as the direct contact with FEMA for all response operations; 2) ensure that individuals and families have access to state and federal programs in the aftermath of a disaster; 3) develop and maintain partnerships with state, federal and voluntary organizations that deliver resources to disaster victims; and 4) help citizens, state and local officials, and business leaders reduce the impacts of an event that overwhelms local and regional capabilities. • Assign area coordinators to assess the situation, coordinate activities of state agencies on scene, and relay recommendations or requests for resources to the SERT. • Lead State efforts to support evacuation and mass patient transport requirements. • Manage and operate daily State emergency operations center.
REGIONAL	
Southeastern Healthcare Preparedness Region	• Coordinate and manage the response of regional SMRS assets and supplies. • Maintain situational awareness with regional partners. • Coordinate and manage the SHPR SMAT II and MRC programs. • Assist in the coordination of regional ESF-8 resources during a disaster as requested. • When requested, serve as liaison between local and state ESF-8 agencies. • Act as the regional liaison for issues related to the operation of regional medical communications. • Work with North Carolina Office of Emergency Medical Services and other partners to maintain adequate supply of critical medical resources.

	• Maintain, update, and distribute the Regional ESF-8 Response and Recovery Plan.
SMAT II	• Assist local agencies with rapid decontamination and medical care of victims. • Provide credentialed healthcare personnel that can supplement a healthcare facility's workforce in natural or human-made events. • Establish and operate a fifty bed self-sustained field medical unit. • Establish and operate a medical support shelter. • Provide medical care at local special events and large gatherings. • Support medical component of urban search and rescue team. • Support medical surge operations at local hospitals within the region. • Support alternate care sites and alternate care facilities established by local hospitals. • Assist local public health agencies with health education, preventative health screenings, and vaccination clinics. • Assist affected hospitals. • Establish a mass immunization/drug distribution center. • Support pharmacy operations with mobile pharmacy unit.
Trauma Centers	• Provide community and regional medical care and support in response to a disaster. • Serve as the lead hospital for the HCC as defined by the North Carolina Hospital Preparedness Program (HPP). • Develop and maintain a disaster preparedness plan and program. • Participate in the statewide Hospital Mutual Aid Agreement.
LOCAL	
Hospitals	• Provide community and regional medical care and support in response to a disaster. • Develop and maintain a disaster preparedness plan and program. • Participate in the statewide Hospital Mutual Aid Agreement.

	• Develop and maintain standard operating guidelines for mental health operations during emergency/ disaster situations. • Plan for coordination of triage operations with EMS systems and other response agencies. • Coordinate transport of patients and bed capacity with other hospitals in the region. • Identify alternate care facilities, plan for staffing of facilities, and maintain resource capabilities for these facilities. • Provide support to SMAT II.
EMS Systems	• Provide out-of-hospital acute medical care to patients with injuries and illnesses within their respective counties. • Transport to definitive care facilities patients with illnesses and injuries. • Participate in mutual aid in support of other counties within the region or state. • Develop and maintain standard operating guidelines for emergency medical service activities during emergency and disaster situations. • Plan for coordination of ambulance/rescue activities throughout the region during disasters and mass casualty incidents. • Identify equipment and manpower limitations. • Develop mutual aid agreements for needed resources during emergency and disaster events. • Coordinate with regional hospitals concerning receipt of mass casualties during emergency and disaster events. • Coordinate with the county health director and social services director to determine emergency transportation needs for special needs populations. • Support regional or state ambulance strike team initiatives.
SMAT III	• Provide mass medical decontamination. • Provide mass triage assistance. • Provide responder health and safety / rehabilitation in support of large incidents.
Public Health	• Respond to disease outbreaks by characterizing the outbreak, implementing containment actions, providing treatment and protection methods including PPE and pharmaceutical interventions, providing guidance on these measures, and implementing recovery plans for individual

	and community health. • Protect and improve the health of their respective county. • Assist with coordination of clinical healthcare in such areas as children's health, maternity care, communicable diseases, immunizations, women's health, and family planning. • Develop and support a public health response to natural or human-made disasters.
Medical Reserve Corps	• Provide volunteer medical and public health support to local and regional ESF-8 agencies and facilities during local emergencies and other times of community need.
Emergency Management	• Serve as the lead agency within the local emergency operations center. • Serve as the requesting agency for resources and support. • Initiate local state of emergency declarations. • Activate and manage local emergency operations centers. • Coordinate emergency sheltering operations with human service agencies for general and functional/special needs populations. • Coordinate implementation of a county plan for medical evacuation and local medical support shelters. • Support SMAT III when applicable.

INFORMATION COLLECTION AND DISSEMINATION

Information collection and dissemination incorporates information/intelligence sharing, physical communications (systems and processes), and public information.

Information / Intelligence Sharing

Information pertinent to ESF-8 operations includes weather forecasts (National Weather Service, National Hurricane Center), health surveillance (Centers for Disease Control and Prevention, public health, hospitals), and other threat-related information (Department of Homeland Security, law enforcement). The availability of clear and prompt information related to these three broad areas will allow ESF-8 agencies to monitor changes in patterns and identify potential conditions and trigger points necessary for ESF-8 plan activation. Accurate status reporting of ESF-8 resources is critical, both during normal and disaster-focused operations.

(Refer to the SHPR Information Sharing Plan for more details)

NC Continuum is a web-based tool capable of monitoring hospital, EMS system and health center resources and bed availability on a regular basis. The Multi-Hazard Threat Database support resource (MHTD), and WebEOC allow agencies at all levels of

response to maintain operational awareness of response and support requirements in near real time. Access to these systems is available through the following:

- NC Continuum: http://www.continuum.emspic.org/login
- MHTD: http://www.ncagr.gov/oep/MHTD/index.htm

Communications

Radio, wire line (telephone) and internet communication are vital to the rapid response and success of any emergency operation. In the event of a catastrophic incident or wide spread emergency, the ability to communicate the situation and ESF-8 response requirements across the region and throughout the state is even more essential. Widespread damage to infrastructure including broadcast, television and commercial communications systems, telephone and internet systems will make it difficult to maintain situational awareness. Each jurisdiction and healthcare agency must ensure that interoperable, robust, redundant, and reliable communications capabilities exist for their use. The communications systems must include mechanisms for alerting, coordinating and maintaining communication prior to, during, and after any emergency incident.

All communications systems must be in accordance with the North Carolina Statewide Communications Interoperability Plan (SCIP) and conform to the Viper Medical Network model. Equipment standards and capabilities must be sufficient to protect the citizens as well as provide continuity of medical operations. The systems must be capable of providing simultaneous, real-time, or near-real-time communication between county communications centers, emergency operations centers, and other appropriate local and state agencies.

The North Carolina VIPER network (Voice Interoperability Plan for Emergency Responders) is the state primary public safety interoperable radio system. Within the 800 MHz VIPER network, the VIPER Medical Network (VMN) provides the fundamental medical communications system for the state. The statewide 800 MHz voice communications system allows responders from all public safety disciplines to work together across a common standards based radio system. The network has a common infrastructure to provide adequate transmission to handheld radio devices throughout the state. All hospitals and community health centers in North Carolina have VMN control radios and participate in the VMN.

Additional information is available at the following sites:

- State of North Carolina Statewide Communications Interoperability Plan: https://www.ncdps.gov/documents/viper-interoperability-communications-plan
- State of North Carolina VMN Reference Information: https://www2.ncdhhs.gov/dhsr/EMS/pdf/dtmfref.pdf

Public Information

Public information operations, including media and press releases, will be handled in accordance with established policies and procedures through local (county emergency operations centers and hospitals) and state public affairs offices. Both hospital and county emergency management public affairs are responsible for communicating

information to audiences during a disaster and should work together utilizing the Joint Information System (JIS). Public information procedures, practices, and policies will be in accordance with local/state guidelines and incorporated into the emergency plans of all ESF-8 agencies. Individuals with the responsibility for disseminating public information should be identified prior to an event.

Medical and Public Health Communications

Communications between medical and public health response organizations are essential to maintaining these services during a disaster. Communication and dissemination of medical and public health resource information during a disaster is expected to occur through multiple and redundant communication pathways including the following:

- Locally between health departments and health/medical facilities.
- Regionally between health departments and regional/local health/medical facilities and HCCs.
- Statewide between the North Carolina Division of Public Health (Public Health Preparedness & Response) and the North Carolina Division of Health Service Regulation (Office of Emergency Medical Services)
- Regionally and statewide between the North Carolina Division of Health Service Regulation (Office of Emergency Medical Services), HCCs, and other health/medical partners

These communication pathways are expected to be used in accordance with emergency management standards and policies established between the affected medical and public health response organizations.

ADMINISTRATION, FINANCE AND LOGISTICS

Expenses incurred while conducting emergency response operations may be reimbursable in accordance with North Carolina policy or statutes. All ESF-8 agencies, organizations, and facilities within the region should

- Be responsible for administrative, logistical, and financial support to their personnel during implementation of this plan. This support should be in accordance with established state and local policies and mutual aid agreements.
- Document and track all costs associated with the disaster.
- Fund costs up front during the initial stages of response and submit requests for reimbursement in accordance with established state and local policies and mutual aid agreements. All costs associated with operations or coordination with military agencies (federal or state) will be tracked separately.
- Report unfunded requirements to the SERT as they are identified.
- Maintain records of personnel and equipment used and supplies consumed during emergency operations. Compensation and cost recovery for resources, including manpower, will be in accordance with current mutual aid agreements.

Agencies and/or facilities will have various routes to pursue possible reimbursement for services and supplies. Three specific avenues for local jurisdictions to follow include the Robert T. Stafford Disaster Relief and Emergency Assistance Act, the North Carolina Emergency Management Mutual Aid Agreement, and the North Carolina Hospital Association Mutual Aid Agreement. The process to follow when applying for reimbursement depends upon the type of emergency and the type of formal disaster declaration. All efforts should be coordinated through the local emergency management offices for the various jurisdictions.

Less defined by local, state or federal emergency or disaster declarations, supporting healthcare agencies are responsible for all personnel cost and expenses including salary, travel, benefits, and other related expenses except for food and lodging while on site, which shall be managed as defined by existing memorandum of understanding or state mutual aid agreements. Certain federal regulations exist even in a state of emergency, such as Emergency Medical Treatment and Active Labor Act (EMTALA) and Health Insurance Portability and Accountability Act (HIPAA).

III. DIRECTION, CONTROL, AND COORDINATION

Key officials, both elected and assigned, are responsible for deciding response and/or recovery priorities at the local and state level. State officials have the authority to issue mission assignments that involve the commitment of state personnel and/or material resources and the expenditures of state funds to resolve emergency and/or disaster requirements. The activation of the SMRS for a state-sponsored mission requires approval from the ESF-8 lead agency.

Within the region, SHPR coordinates with local agencies/hospitals to facilitate their support of the impacted community as requested. Local agencies will follow their established lines of direction and control. During emergency operations, local, regional, and state emergency responders will remain under the established management and supervisory control of their parent organizations to the extent possible.

SHPR supports local governments and ESF-8 agencies within the region in their efforts to sustain or re-establish continuity of operations in a disaster situation. While SHPR may offer jurisdictions additional support available to maintain critical ESF-8 functions, the burden of planning for continuity of operations rests with the local jurisdictions, agencies, and facilities. All emergency response plans in this region should address additional resources required to maintain continuity of operations, including personnel.

SHPR will work with local and state governments, agencies, volunteer groups, and industry during a disaster to coordinate actions, provide information, and resolve issues. Additionally, the HCC staff conducts periodic conferences and training on ESF-8 disaster response, recovery, and post-disaster mitigation issues.

IV. PLAN DEVELOPMENT AND MAINTENANCE

State, regional, local, public, and private organizations share responsibility for safeguarding the public's health and safety. This plan has been developed and coordinated with all participating organizations within the SHPR region, and it provides for

integrated response and recovery activities. This allows each organization to have a clear understanding of its role during emergencies and disasters. The SHPR Regional ESF-8 Response and Recovery Plan will be exercised at least annually.

This plan will be reviewed annually and following significant all-hazards events. All readers are invited to submit recommended changes to this plan. Recommended changes should be made in the form of substitute language and forwarded to the SHPR office. Approved changes to the plan will be published and distributed as necessary.

V. ANNEXES

ANNEX A Behavioral Health

ANNEX B Communicable Diseases

ANNEX C Critical Medical Infrastructure and Key Resource (CI/KR)

ANNEX D Hurricanes

ANNEX E Mass Casualty

ANNEX F Mass Fatality

ANNEX G Mobile Disaster Hospital

ANNEX H Patient Evacuation and Movement

ANNEX I Severe Weather

ANNEX J Special Events

ANNEX K Special Medical Needs Sheltering

ANNEX L State Medical Response System (SMRS)

ANNEX M

ANNEX O

ANNEX P

ANNEX A: BEHAVIORAL HEALTH

The following organizations and agencies support efforts of the SHPR to prepare for and respond to Behavioral Health operations resulting from a disaster in the region.

Local Agencies:	**Behavioral Health Providers**
	Emergency Management
	EMS Systems
	Fire and Police Departments
	Hospitals
	Management Entities
Regional Agencies:	**Southeastern Healthcare Preparedness Region**
State Agencies:	**North Carolina Division of Emergency Management**
	North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services
	North Carolina Division of Public Health/Public Health Preparedness and Response
	North Carolina Office of Emergency Medical Services
Federal Agencies:	**Department of Health and Human Services**
	Department of Homeland Security
	Federal Emergency Management Agency
	Occupational Safety and Health Agency
	Office of the Assistant Secretary for Preparedness and Response

OVERVIEW

Purpose

This annex outlines procedures and guidelines for assisting residents with their emotional needs during all phases of a disaster. The annex describes how SHPR will support existing plans, procedures, and operations in regards to behavioral health. In general, behavioral health response begins at the local level and transitions to state and federal levels when the capacity to respond at the previous level has been exceeded.

Situation

SHPR is subject to many potential disasters that could endanger large numbers of people. Within the disaster context, there is increased risk for adverse behavioral health outcomes such as acute anxiety, post-traumatic stress syndrome, suicide, and substance

misuse. The role of the public behavioral health authority includes regulatory and service provision responsibility to

- Provide assistance to support recovery.
- Prevent or reduce the frequency of psychiatric conditions and substance misuse.
- Promote the behavioral health needs of all residents and responders.

Disaster behavioral health services can help mitigate the severity of adverse psychological effects caused by the disaster for individuals, families, communities, and emergency responders. The behavioral health system recognizes that preparedness, response, and recovery efforts must be designed and delivered to meet the needs of populations within SHPR.

In addition to the needs of the general population, some individuals are at greater risk of long-term adverse behavioral health effects post-disaster. Recovery is enhanced by the availability of assistance that normalizes emotional response after a disaster while reducing adverse outcomes such as substance misuse, anxiety, or depression.

Assumptions

- Disaster behavioral health may help meet the emotional needs of the community and lessen the psychological impact of the disaster for individuals, families, communities, and first responders through all phases of the disaster (e.g. preparedness, response, and recovery).
- People who experience symptoms after an event are unlikely to seek assistance from the behavioral health community.
- Outreach is the most effective way to identify and offer needed support to persons affected by a disaster.
- Technical assistance, public education, and training related to behavioral health needs may be the extent of support provided for smaller events.
- Continuity of care for behavioral healthcare populations may be affected if entire facilities and hospitals must be evacuated.
- Behavioral health assistance may be needed for an extended duration as issues may manifest themselves after the disaster.
- The number of people requiring behavioral health intervention may exceed those seeking medical assistance.

CONCEPT OF OPERATIONS

ESF-8 agencies within SHPR work with behavioral health services and local, regional, and state emergency operations centers to coordinate the public health, medical and limited social service resources during a disaster.

Disaster behavioral health is part of a larger, multi-layer, multi-disciplinary disaster response. Disaster behavioral health responders work in concert with healthcare providers, public health, emergency management, first responders, social services

agencies, peers, schools, faith-based organizations, and Voluntary Organizations Active in Disasters (VOAD).

During and after disaster, ESF-8 agencies and facilities within SHPR, as well as related state and local behavioral health agencies, must be prepared to serve broad populations of individuals not typically eligible for public behavioral health services. Behavioral healthcare during a disaster includes continuity of care.

The first response to a disaster occurs locally, and the capacity to respond to the psychological effects of disaster must be organized and implemented at the local level. Local planners understand the cultural, social, and psychological needs of people in their area. Local emergency operations plan behavioral healthcare annexes may address the availability of behavioral healthcare providers, the availability of operational behavioral healthcare hospitals and facilities, and the need to continue uninterrupted treatment with prescription medications.

Community-based mental health services, developmental disabilities services, and substance abuse services are managed through a network of local management entities that cover all counties within SHPR. These programs oversee and manage local behavioral health services such as the following:

- Mental health
- Child and family mental health services information
- Deaf and hard of hearing
- Substance abuse (DWI Services, Governor's Institute on Alcohol and Substance Abuse, Treatment Accountability for Safer Communities, Managing Access for Juvenile Offender Resources and Services, Jail Diversion)
- Developmental disabilities (Community Alternatives Program for Persons with Mental Retardation/Development Disabilities, traumatic brain injury)

The North Carolina Department of Health and Human Services and the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services contract with the local management entities to serve as the conduit for public behavioral health responsibilities and to coordinate the behavioral health response with their providers at the local level. Local management entities are structured as a one-county program or as a multi-county area authority.

Designated local management entities serve as crisis providers and may be called upon to support functions within specific counties or regionally in the event of a disaster. A listing of SHPR local management entities, by county, can be found at http://www.ncdhhs.gov/mhddsas/lmedirectory.htm.

Each local management entity will maintain a disaster plan in accordance with state CSM guidance that is service area wide in its focus and addresses disaster preparedness and response on a county-by-county basis. It will provide guidance about when to implement disaster behavioral health operations, procedures for the management of staff during and after a disaster, and guidance for determining the appropriate level of response for communities in need of behavioral health support.

If a disaster impacts a community, it is the responsibility of the impacted service providers or outside emergency responders to notify their respective local management entity's

disaster response coordinator so that appropriate action may be taken in conjunction with identified crisis providers. Local management entities serve as the main contact for relaying crisis needs as requested by county emergency management, local American Red Cross chapters, SHPR, and state and federal governmental departments.

SHPR will assist local agencies and facilities with coordination of volunteers, faith-based organizations, mutual aid agreements, local management entities, and regional and state behavioral health response in accordance with processes identified in the base plan. This includes activation and deployment of the SMAT II as required.

Local emergency management, local management entities, and SHPR will maintain visibility on the behavioral healthcare programs and facilities within SHPR that may require relocation or augmentation. These include the following:

- Inpatient services
- Outpatient services
- Psychiatric residential treatment facilities
- Residential treatment facilities
- School-based psychiatric services
- Long-term care facilities
- Substance abuse treatment facilities

North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services is responsible for maintaining capacity and readiness at the state level to assist communities in meeting their behavioral health needs following a disaster. If the local community needs additional responders, North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services has developed and maintains a group of responders trained in disaster behavioral health response that can be requested in accordance with the state emergency operations plan.

The North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services Disaster Preparedness Response and Recovery Plan identifies processes, procedures, and priorities and outlines responsibilities for behavioral health operations in response to a disaster. Services may be provided in a shelter, disaster assistance center, medication dispensing site (such as in a pandemic influenza event), and various locations throughout the community.

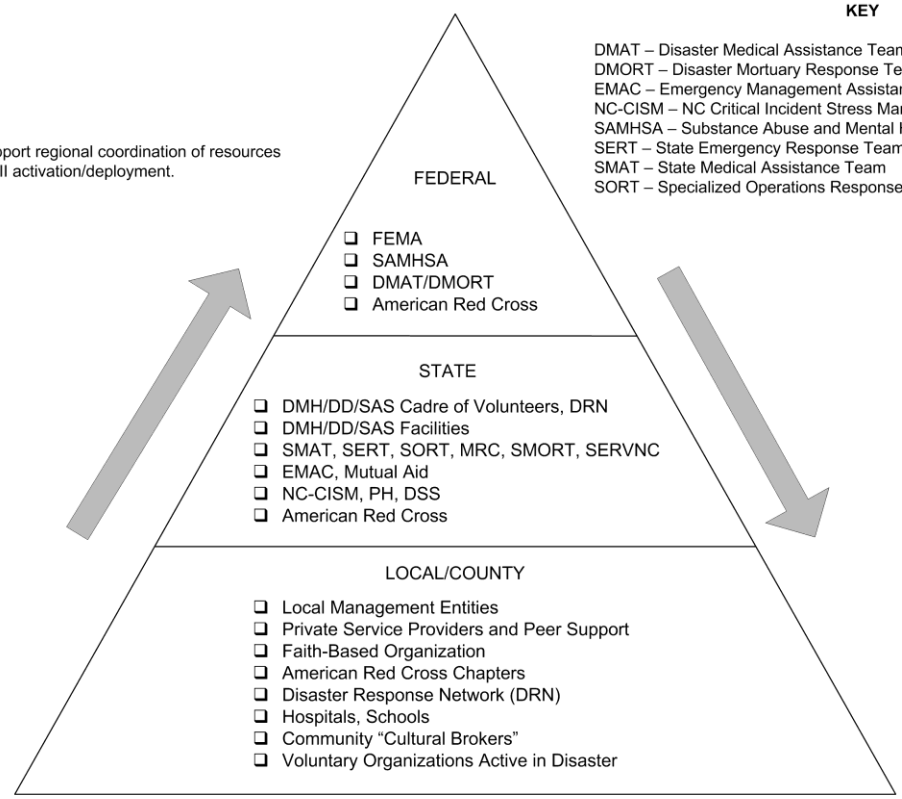
A disaster behavioral health responder may conduct rapid needs assessments, provide immediate psychological first aid and outreach, or even participate in death notification. The disaster behavioral health responder must respond with a recognized response agency.

The pyramid below illustrates the disaster behavioral health response agencies/partners at the local, regional, state, and federal levels.

KEY

DMAT – Disaster Medical Assistance Team
DMORT – Disaster Mortuary Response Team
EMAC – Emergency Management Assistance Compact
NC-CISM – NC Critical Incident Stress Management
SAMHSA – Substance Abuse and Mental Health Services Administration
SERT – State Emergency Response Team
SMAT – State Medical Assistance Team
SORT – Specialized Operations Response Team

NOTE: RACs support regional coordination of resources to include SMAT II activation/deployment.



ORGANIZATION AND ASSIGNMENT OF RESPONSIBILITIES

Agency/Department/Position	Responsibilities
STATE	
North Carolina Office of Emergency Medical Services	• Provide leadership in coordinating and integrating the overall state efforts that provide medical assistance to a disaster-affected area. • Coordinate and direct the activation and deployment of state resources of medical personnel, supplies, equipment, and pharmaceuticals. • Assist in the development of local capabilities for the onsite coordination of all emergency medical services needed for triage, treatment, transportation, tracking, and evacuation of the affected population with medical needs.
North Carolina Division of Public Health – Public Health Preparedness & Response (PHP&R)	• Provide leadership in directing and coordinating state efforts to provide public health assistance to the affected area. • Serve as the primary public agency for health and medical care. • Collaborate with the North Carolina Division of Emergency Management and North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services to establish expectations and infrastructure for effective behavioral health response to a disaster. • Direct and coordinate the activation and deployment of personnel, supplies, and equipment in response to requests for state assistance. • Provide guidance and assistance to local public health departments, healthcare entities, and the general public.
North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS)	• Serve as the primary public agency for disaster behavioral health. • Collaborate with the North Carolina Division of Emergency Management, North Carolina Office of Emergency Medical Services, and North Carolina Health and Human Services to establish expectations and infrastructure for effective behavioral health

	response to a disaster. • Coordinate support with the federal government. • Coordinate with local management entities to support local communities. • Participate in disaster recovery partnership activities. • Participate in the Immediate Services and Regular Services phases of the FEMA Crisis Counseling Program. • Deploy staff to provide outreach services.
North Carolina Division of Emergency Management	• Collaborate with the North Carolina Department of Health and Human Services and North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services to establish expectations and infrastructure for effective behavioral health response to a disaster. • Activate and manage the state's Response Section within the SERT. The section will 1) serve as the direct contact with FEMA for all response operations; 2) ensure that individuals and families have access to state and federal programs in the aftermath of a disaster; 3) develop and maintain partnerships with state, federal and voluntary organizations that deliver resources to disaster victims; and 4) help citizens, state and local officials, and business leaders reduce the impacts of an event that overwhelms local and regional capabilities.
REGIONAL	
Southeastern Healthcare Preparedness Region/SMAT II	• Assist in the coordination and implementation of local emergency operations plan behavioral health annexes as needed. • Report to North Carolina Office of Emergency Medical Services on the progress and ongoing needs of behavioral health requirements in SHPR. • Serve as official liaison between local ESF-8 behavioral health entities and the state, coordinating SHPR resources during disaster/mass casualty events. • Coordinate SHPR disaster activities during any SMAT deployment or other event where the Office of Emergency Medical Services activates SMRS assets and/or resources. • Assist local and state governments, local management

	entities, and North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services in effective development of priorities as they pertain to behavioral health. • Facilitate regional behavioral health disaster response collaboration between SHPR's hospitals, EMS systems, local management entities, local health departments, local and regional emergency management, community health centers, rural health centers, long-term care facilities, assisted living facilities, college and university health centers, dialysis centers, and all related emergency response agencies. • Maintain a contact list for SHPR's local management entities. • Be prepared to conduct a full or partial SMAT II activation in support of a community affected by a disaster and augment or provide needed personnel, medical products.
LOCAL	
Local Management Entities	• Manage the community-based mental health, developmental disabilities, and substance abuse services related to disaster response within SHPR. These services include mental health, child and family mental health, deaf and hard of hearing, substance abuse, and developmental disabilities. • Respond to the requirements of the local incident commander or county emergency operations center. • Identify a disaster behavioral health preparedness and response coordinator to serve as a liaison with local emergency management, local providers, hospitals, SHPR, and other local or regional agencies. • Maintain a disaster plan in accordance with state guidance that is service area wide in its focus and addresses disaster preparedness and response on a county-by-county basis. • Develop mutual aid agreements with other local management entities and disaster response agencies within SHPR to enhance their behavioral health capabilities. • Develop a local behavioral health response infrastructure with community response partners such as American Red Cross, Salvation Army, North Carolina Critical Incident Stress Management, North

	Carolina Department of Social Services, public health, peer support, cultural brokers, faith-based organizations, and other Voluntary Organizations Active in Disaster. • Deploy responders to shelters, emergency operations centers, disaster assistance centers, or designated site. • Ensure early intervention such as psychological first aid, counseling of responders, and identification of people in need of longer term crisis counseling or mental health services. • Coordinate assessment of needs for persons with disabilities. • Work with community disaster response partners in providing disaster behavioral health services. • Communicate with North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services regarding resource needs. • Assign staff to needs assessment teams, early intervention teams, community relations teams, and disaster/incident hotlines. • Coordinate outreach activities consistent with the FEMA Crisis Counseling Program.
Hospitals	• Incorporate disaster behavioral health into emergency operations plans, policies, and procedures. • Provide behavioral health support to other regional facilities, agencies, or responders during a disaster under mutual aid.
EMS Systems	• Develop plans and procedures that address disaster behavioral health.
Emergency Management	• Work with local, regional, and state emergency management, emergency medical services, local management entities, SHPR, and human services agencies to identify and develop behavioral health support emergency operations plan annexes and related issues and priorities. • Maintain a contact list of all appropriate supporting local management entities.

ANNEX B: COMMUNICABLE DISEASE (TO BE UPDATED WITH HID ANNEX)

The following organizations and agencies support SHPR efforts to prepare for and respond to a Communicable Disease outbreak occurring within the region.

Local Agencies:	**Emergency Management** **EMS Systems** **Fire and Police Departments** **Hospitals** **Public Health Agencies**
Regional Agencies:	**Southeastern Healthcare Preparedness Region**
State Agencies:	**North Carolina Division of Emergency Management** **North Carolina Division of Public Health/Public Health Preparedness and Response** **North Carolina Office of Emergency Medical Services**
Federal Agencies:	**Centers for Disease Control and Prevention** **Department of Health and Human Services** **Department of Homeland Security** **Federal Emergency Management Agency** **Occupational Safety and Health Agency** **Office of the Assistant Secretary for Preparedness and Response**

OVERVIEW

Purpose

This annex outlines procedures and guidelines for reducing the morbidity, mortality, and social and economic disruption caused by an outbreak of a communicable disease. The annex describes how the SHPR region will support existing plans, procedures, and operations.

Situation

A communicable disease is any medical illness that is caused by microscopic organisms. Invading microorganisms include viruses, fungi, bacteria, and parasites. Sources for these organisms include the environment, animals, insects, and other mammals—including humans. Transmission usually occurs by inhalation, ingestion, direct contact, or bites by a contaminated vector. Many communicable diseases can cause outbreaks and

epidemics. For this reason, identification, evaluation, and mitigation of communicable diseases are essential to protecting public health. Communicable diseases can occur naturally, through human error (e.g. food borne outbreaks), or through deliberate acts of bioterrorism.

A communicable disease outbreak may range between a small outbreak (small number of individuals in a limited area, little morbidity and mortality, and a straightforward epidemiological investigation) and a large outbreak (large number of people over a wide geographical area, high mortality, and complicated epidemiology). Communicable disease outbreaks may differ from other types of emergencies because they can last for days, weeks, or months and require ongoing resources before resolution.

Planning Assumptions

- Location of treatment sites may be difficult to predict or control.
- Information may change rapidly as the outbreak is characterized. Multiple, redundant communications systems may be necessary to reach the public and healthcare providers.
- A communicable disease outbreak may not be identified until people are ill and/or dying.
- A communicable disease outbreak may not be characterized quickly.
- The North Carolina SERT may not be activated until the scope is fully characterized, which may be late in the course of the event.
- A communicable biological threat may occur in any season or any location, with or without advance notice.
- Biological threats may be introduced into the population via food, water, zoonotic routes (infected animals), entomological routes (infected insects), air, fomites (surfaces), or person-to-person contact.
- A communicable disease outbreak that begins elsewhere could spread quickly to North Carolina and the region.
- The majority of the population may be susceptible to a novel illness.
- Non-pharmaceutical preventive measures may be required to limit the spread of a communicable disease, including social distancing (avoiding close contact and public gatherings) and universal precautions (hand-washing, gloves, and respiratory protection around infected individuals).
- Pharmaceuticals (including vaccines) may not be available or able to limit the impact of the disease, and if available, the supply may be limited.
- Operational response may be severely degraded throughout an event.
- Tribal, state, and local jurisdictions may be overwhelmed and unable to provide or ensure provision of routine services.
- Support of ill patients may strain healthcare resources, including staff and essential medical equipment support.
- Hospitals may be overwhelmed during the response stage.

- The ability to dispense medication and administer vaccine is directly related to local capacity.
- Risk groups for severe to fatal infection from biological agents cannot be predicted with certainty.
- Measures such as limiting public gatherings, school closings, and altered staffing procedures could limit the outcome of the event.
- Quarantine and other movement restrictions may have minimal effect on the spread of the disease if it has a very short incubation period and asymptomatic individuals continue to transmit the virus.
- Designated triage, isolation, and quarantine areas will be needed for large numbers of patients presenting to hospitals for care.
- The state of North Carolina is responsible for activating the Strategic National Stockpile plan.

CONCEPT OF OPERATIONS

General

North Carolina has a strong, decentralized, public health system involving both state agencies and local health departments. Together they provide the foundation for responding to public health emergencies. North Carolina has a core set of statutes that comprise the essential tools for identifying and responding to public health emergencies such as pandemic influenza, other naturally occurring outbreaks, and terrorist incidents using chemical, biological, or nuclear agents.

Local governments, working with their public health department counterparts, have incorporated emergency medical plans into their jurisdictional emergency operation plans. Additionally, public health departments have developed comprehensive emergency medical plans that include provisions for coordination among all elements of the local medical system and agreements with secondary providers.

During an incident involving a communicable disease, locally available medical resources will be used to the extent possible to meet the immediate needs in the jurisdiction. As local public health and medical resources become depleted, elements of the SMRS may be requested to provide assistance. Requests for assistance will be in accordance with the resource request process outlined in the base plan.

A communicable disease outbreak may be first recognized by a variety of means:

- Clinicians may recognize increases in illnesses presenting to their practice or recognize an unusual disease.
- Local hospital emergency rooms may observe a number of similar cases.
- A public health epidemiologist may identify an illness pattern or a single case of significance in a hospital or through surveillance systems such as the North Carolina Disease Event Tracking and Epidemiologic Collection Tool (NC DETECT).
- A local health department may receive reports from several sources and determine that they are linked.

- A state subject matter expert for a particular disease may notice a cluster of related laboratory results.

Regardless of how the outbreak is first detected, local health departments and state subject matter experts will coordinate event documentation in NC Electronic Disease Surveillance System (NC EDSS) and report the progress of their investigation.

A critical stage of any communicable disease outbreak is its detection through active and passive surveillance systems. Once a communicable disease has been detected, the local health departments and state health department can begin their investigation as to cause, control, prevention, and recovery efforts. Specifically, effort will be directed to accomplish the following tasks:

- Investigate disease outbreaks and unusual situations and implement control measures to minimize further transmission of disease.
- Monitor disease-reporting by physicians and laboratories in order to detect trends and to assess the public health impact of diseases.
- Provide a channel of communication between public health agencies, private physicians, and hospital and occupational infection control personnel.
- Explain public health interventions and disseminate health education messages to the community and the media.

The SHPR Healthcare Preparedness Manager will assist local emergency management and public health in the coordination of additional medical assets to augment local needs. The Healthcare Preparedness Manager serves as a conduit for both information and resource coordination during a communicable disease outbreak.

The public health authority is held by the local public health director in each county/district and is responsible for any type of response.

For major local public health incidents, the local health director or designee may establish a local public health command center, which will serve as the direction and control point for all tactical decisions. If additional resources are needed (e.g., a mobile public health command post), it will be deployed at the request of the local health department through the chain of communication at the time of the request as described in the base plan. This reflects the possibility that a local emergency operations center may not yet be established.

The State of North Carolina Emergency Operations Plan outlines response to a widespread public health threat. The North Carolina Division of Public Health is represented in the SERT Operations Section. If the state emergency operations center is activated, the public health command center will communicate through the North Carolina Division of Public Health representative at the SERT. Additionally, public health representatives may be asked to serve as technical advisors directly to the state emergency operations center director.

Depending on the severity or potential severity of the outbreak, the state health director may advise the director of emergency management to activate the SERT. For routine, contained, communicable disease outbreaks, the investigation team is responsible for generating an epidemiology summary report of the outbreak investigation. In a high-profile, large, or potentially large communicable disease outbreak (e.g., pandemic

influenza or severe acute respiratory syndrome [SARS]), the state health director will activate the public health command center to coordinate the public health response.

The public health command center supports the state health director and state epidemiologist by serving as the control and coordination point for response to multijurisdictional public health events in North Carolina. The public health command center coordinates the activities of the North Carolina Division of Public Health and liaisons with local health agencies, North Carolina Department of Health and Human Services, and the public health representatives at the SERT.

Isolation and Quarantine

Quarantine is the restriction of a person who is well but has been exposed to a communicable agent and might become communicable. Isolation is the confinement of a person who is ill with a communicable agent and can transmit the disease.

The state health director and the local health directors have the authority to direct quarantine and isolation. The local health department is responsible for the monitoring of individuals in quarantine. In rare incidences, the resources of the SMAT II and/or SMAT III may be requested to give medical care and establish alternate care sites in support of quarantine and isolation measures.

Mass Prophylaxis/Strategic National Stockpile (SNS)

The North Carolina Strategic National Stockpile Plan requires coordination of the public health system and SMRS to ensure the overall SNS response is operationally integrated. Deployment of SNS is from the receipt, staging, and storing (RSS) site to local/county receiving sites (LRC). From the LRCs, assets from the SNS then flow to points of dispensing (POD) designated by local health departments, including non-hospital treatment sites, special needs facilities, and hospitals for the prophylaxis and/or care of healthcare workers and patients.

SHPR can provide the following support:

- Medical evaluation and referral of symptomatic patients who report to points of distribution
- Assistance with vaccinations or dispensing prophylactic medications to healthcare workers at their place of employment
- Staff augmentation at PODs
- Provision of logistical support for PODs (e.g. tents and cots)

Biological Terrorism

Biological terrorism presents additional challenges to the public and healthcare systems. In addition to responding to the threat of a communicable agent, ESF-8 agencies will work closely with law enforcement. Law enforcement agencies have the responsibility to investigate the criminal threat.

SHPR will work in cooperation with local health departments, local/regional HAZMAT response teams, and state agencies. The North Carolina Division of Public Health

established the following programs to enhance the public health system for response to bioterrorism and other public health emergencies:

- State Public Health Laboratory Bioterrorism and Emerging Pathogens Unit and its regional bioterrorism laboratory capabilities (Buncombe, Mecklenburg, and Pitt counties)
- North Carolina Health Alert Network for secure communication of time-sensitive information
- North Carolina Disease Event Tracking and Epidemiologic Collection (NCDECT) Tool, which collects health surveillance information from hospital emergency departments, the Carolinas Poison Center, and other medical facilities

ORGANIZATION AND ASSIGNMENT OF RESPONSIBILITIES

Agency/Department/ Position	Responsibilities
STATE	
North Carolina Office of Emergency Medical Services	• Provide leadership in coordinating and integrating the overall state efforts that provide medical assistance to an area affected by communicable disease or biological agents. • Coordinate and direct the activation and deployment of state resources of medical personnel, supplies, equipment, and pharmaceuticals (with public health as needed). • Assist in the development of local capabilities for the onsite coordination of all emergency medical services needed for triage, treatment, transportation, tracking, and evacuation of the affected population with medical needs.
North Carolina Division of Public Health – Public Health Preparedness & Response (PHP&R)	• Provide leadership in directing and coordinating state efforts to provide public health assistance to the affected area. • Provide the epidemiological investigation of a known or suspected threat caused by communicable disease or biological agents. • Provide laboratory testing in support of clinical laboratories on specimens from persons who may have been exposed to communicable disease or biological agents. • Provide the procurement and allocation of immunizing agents and prophylactic antibiotics. • Provide the distribution of the Strategic National Stockpile.

	• Provide the appropriate conditions for quarantine and isolation in order to prevent further transmission of disease. • Provide guidelines for prophylaxis and treatment of exposed and affected persons. • Direct and coordinate the activation and deployment of personnel, supplies, and equipment in response to requests for state assistance. • Establish monitoring systems for the protection of public health. • Provide guidance and assistance to local public health departments, healthcare entities, and the general public. • Test water supplies in coordination with the SERT Infrastructure Branch. • Administer the North Carolina Medical Reserve Corps (MRC) program.
North Carolina Division of Emergency Management	• Activate and manage the state's Response Section within the SERT. The section will 1) serve as the direct contact with FEMA for all response operations; 2) ensure that individuals and families have access to state and federal programs in the aftermath of a disaster; 3) develop and maintain partnerships with state, federal and voluntary organizations that deliver resources to disaster victims; and 4) help citizens, state and local officials, and business leaders reduce the impacts of an event that overwhelms local and regional capabilities.
REGIONAL	
Southeastern Healthcare Preparedness Region	• Facilitate the development, implementation, and operation of a comprehensive medical system based on accepted principles of care to decrease morbidity and mortality resulting from communicable disease or biological agents. • Coordinate SHPR disaster activities during any SMAT deployment or other event in which the North Carolina Office of Emergency Medical Services activates the SMRS assets and/or resources in support of a communicable disease or biological incident. • Facilitate consistent and executable communicable disease or biological incident response plans for hospitals, EMS systems, local health departments, local emergency management, community health centers, rural health centers, long-term care facilities, assisted living facilities, college and university health centers, dialysis centers, and all related emergency response agencies

	located in the HCC. • Be prepared to support state-directed Strategic National Stockpile/mass prophylaxis operations. • Assist affected hospitals during communicable disease and/or biological incidents.
LOCAL	
Hospitals	• Provide community and regional medical care and support in response to a public health disaster. • Implement standard operating guidelines for mental health operations during emergency/disaster situations. • Assist in the coordination of triage operations with EMS systems and other response agencies. • Implement alternate care facilities plan when necessary. • Manage staffing and scarce resources policies.
EMS Systems	• Follow appropriate weapons of mass destruction (WMD) or communicable disease protocols as adopted by EMS system. • Be prepared to respond under mutual aid in support of other counties within the region or state. • Follow adopted standard operating guidelines for emergency medical service activities during communicable disease and/or biological incidents. • Provide medical surge assistance.
Public Health	• Develop and implement a public health response to natural or human-made disasters. • Develop protocols for notification from and reporting to local first responders, healthcare providers, and North Carolina Division of Public Health during urgent and emergent public health preparedness events or potential events. • Coordinate with the HCC when an incident occurs. • Monitor and review available county-level public health surveillance data. • Implement local Epidemiologic Investigation Teams (Epi Teams) plans. • Educate local first responders and healthcare professionals on the appropriate protocols for reporting incidents including suspicious substance incidents. • Communicate and coordinate activities with public health

	epidemiologists. • Implement and enforce public health control measures associated with an incident. • Coordinate the investigation and surveillance of public health threats in the county in coordination with North Carolina Division of Public Health and preparedness partners.
Emergency Management	• Serve as lead agency during an incident and primary point of contact for resource support and coordination.

ANNEX C: CRITICAL MEDICAL INFRASTRUCTURE AND KEY RESOURCE RESTORATION (COOP PLAN)

The following organizations and agencies support efforts to coordinate rapid and efficient assessment and restoration of critical medical infrastructure and key resources within the region.

Local Agencies:	**Emergency Management** **EMS Systems** **Fire, Police, and Sheriff's Departments** **Hospitals**
Regional Agencies:	**Southeastern Healthcare Preparedness Region**
State Agencies:	**Department of Public Safety** **Department of Environment and Natural Resources** **Department of Health and Human Services** **Department of Public Information** **Department of Transportation** **Disaster Response Network** **Division of Emergency Management** **Office of Emergency Medical Services**
Federal Agencies:	**Centers for Disease Control and Prevention** **Department of Defense** **Department of Health and Human Services Occupational Safety and Health Agency** **Department of Homeland Security** **Federal Emergency Management Agency** **Office of the Assistant Secretary for Preparedness and Response**

OVERVIEW

Purpose

The success of regional ESF-8 operations is dependent upon the continuing function and/or restoration of critical medical infrastructure and key resources within the community that have been damaged or rendered inoperable by a disaster. This annex

describes the procedures and guidelines that allow the region to coordinate rapid and efficient assessment and restoration of critical medical infrastructure and key resources.

Situation

Medical critical infrastructure (hospitals, nursing homes, long-term care facilities, health care providers, and pharmacies) and key resources (ventilators, x-ray machines, and oxygen) may be affected by natural and human-made incidents. Infrastructure lifelines (transportation, communication, and utilities) may be damaged and impact local health and medical services. The disruption of services (laundry, sanitation, and medical waste), loss of power, and massing of people in shelters may increase the potential for disease and injury. A disaster may impact availability and accessibility of staff, pharmaceuticals, supplies, and equipment; access to healthcare facilities; and/or access to commercial or private laboratories.

During the early phases of some incidents, medical facilities and key ESF-8 resources may downsize to essential personnel. Staff availability will be a key priority to maintain patient care.

Disaster recovery planning is an ongoing, dynamic process that continues throughout the event. All medical ESF-8 facilities and agencies will comply with their local plans, policies, and procedures. Pre-positioning of equipment and establishment of protocols with supporting agencies and vendors will allow a rapid and effective response to emergencies and disasters, minimizing the impact on government operations, businesses, and the general public.

Medical supply availability may be limited as a result of vendor capability to provide support during an incident. Hospitals, long-term care facilities and other inpatient and outpatient facilities and pharmacies will rely on existing emergency service contracts with appropriate vendors for medical equipment, pharmaceuticals, linens, and day-to-day supplies.

Emergency medical, health, and related services will be restored to normal operations during the recovery period as soon as possible and within the limitations and capabilities allowed by local/state government following the emergency or disaster.

Every county within SHPR has plans and assessments that list the potential natural, technological, and human-made threats to residents, property, the economy, and the environment. Additional information may be found in the North Carolina Mitigation Plan.

Planning Assumptions

- Natural, technological, and human-made disasters can overwhelm local health and medical facilities and services, requiring emergency coordination of casualties.
- Health and medical facilities may be severely damaged, destroyed, or rendered unusable.
- The North Carolina Division of Emergency Management, the Department of Homeland Security, the Centers for Disease Control and Prevention, and the Federal Emergency Management Agency Region 4 are available to assist with local communities with critical medical infrastructure and key resource repair and restoration.

- Local county governments, working with the SERT, will assume responsibility for assessment and recovery of critical infrastructure such as utilities, roads and highways, communications networks, and security.
- Qualified and specialized personnel are necessary to complete on-the-spot repairs during the disaster and to conduct post-disaster damage assessments.
- Detailed damage assessments trigger deployment of regional, state, and federal resources.
- All hospitals within the SHPR will maintain sufficient emergency back-up power capabilities.
- Availability of medical care personnel may be limited as a result of injury, personal concerns/needs, or limited access to work locations.
- Medical facilities still operational after the emergency or disaster will be overwhelmed by the “worried well, walking wounded” and seriously injured victims in the aftermath of the occurrence.
- Hospitals, long-term care facilities, and other inpatient and outpatient facilities and pharmacies are expected to know their critical resources and update inventories annually.

CONCEPT OF OPERATIONS

Overall, processes and procedures for requesting resources and communications will be in accordance with the base plan. Medical CI/KR within the SHPR region includes the following:

- Critical infrastructure:
    - Hospitals
    - EMS systems
    - Laboratories
    - Ambulance services
    - Pharmacies
    - Home care health systems
    - Nursing homes and long-term care facilities
- Key resources:
    - Specialized medical personnel
    - Medical supply chains
    - Radiological services
    - Ventilators
    - Oxygen supplies
    - Dialysis

SHPR will work with medical facilities and agencies to identify potential issues and mitigation strategies in advance of an incident. These strategies will be evaluated in conjunction with regularly scheduled drills and exercises. Elements associated with

medical CI/KR disaster recovery planning consist of deciding in advance what, how, when, and who are needed to provide a solution that will sustain critical functions. The planning process includes steps that identify and document components critical to a recovery solution:

- Identifying and prioritizing critical medical (ESF-8) systems, resources, and functions
- Performing impact analysis
- Developing a notification plan
- Developing a damage assessment plan
- Designating a disaster recovery site
- Developing a plan to recover critical medical (ESF-8) functions
- Identifying and documenting security controls
- Designating responsibilities

In order for ESF-8 to be operationally effective, local emergency management must ensure the restoration of utilities and communications, transportation routes, fuel availability, and security prior to viable efforts to restore medical CI/KR.

During an incident, SHPR will support coordination of critical information through the following:

- Coordinate mutual aid to provide facilities, staff, resources, essential equipment, or bed space for patients.
- Track of the operational status of ESF-8 agencies and facilities.
- Identify ESF-8 issues from the impacted area to the SERT and North Carolina Office of Emergency Medical Services.
- Address medical CI/KR restoration priorities with local and state emergency management agencies, to include estimated time of recovery.
- Coordinate the partial or full activation and use of SMAT II.

Critical medical infrastructure and key resource restoration may necessitate transportation of large quantities of medical supplies and materials to the disaster area. Provisions should be made in advance for the secure storage of these materials and controlled access. Climate controlled storage facilities and/or refrigeration may be required, and high-capacity electrical generators may be needed to offset the lack of electrical power.

ORGANIZATION AND ASSIGNMENT OF RESPONSIBILITIES

The following responsibilities address medical CI/KR and restoration. Refer to the base plan for general requirements.

Agency/Department/Position	Responsibilities
STATE	

North Carolina Office of Emergency Medical Services	• Provide leadership in coordinating and integrating the overall state efforts that provide medical assistance to a disaster-affected area through recovery. • Coordinate and direct the activation and deployment of state resources of medical personnel, supplies, equipment, and pharmaceuticals (with public health as needed). • Assist in the augmentation of local capabilities for the onsite coordination of all emergency medical services needed for triage, treatment, transportation, tracking, and evacuation of the affected population with medical needs. • Be prepared to provide Healthcare Facility Rapid Assessment Teams to pre-deploy to staging areas for immediate deployment to healthcare facilities designated as high risk via use of the Multi-Hazard Threat Database (MHTD).
North Carolina Division of Public Health – Public Health Preparedness & Response (PHP&R)	• Provide leadership in directing and coordinating state efforts to provide public health assistance to the affected area. • Provide the epidemiological investigation of a known or suspected threat caused by chemical, biological, or nuclear agents. • Provide laboratory testing in support of clinical laboratories on specimens from persons that may have been exposed to a chemical, biological, or nuclear agent. • Provide the procurement and allocation of immunizing agents and prophylactic antibiotics, to include the Strategic National Stockpile (SNS). • Direct and coordinate the activation and deployment of personnel, supplies, and equipment in response to requests for state assistance. • Establish monitoring systems for the protection of public health during recovery. • Provide guidance and assistance to local public health departments, health care entities, and the general public during recovery.
North Carolina Division of Emergency Management	• Activate and manage the state's Recovery Section within the SERT. The section will 1) serve as the direct contact with FEMA for all recovery operations, including medical infrastructure and key resources; 2) ensure that individuals and families have access to

	state and federal medical programs in the aftermath of a disaster; 3) develop and maintain partnerships with state, federal and voluntary organizations that deliver medical resources to disaster victims; and 4) help citizens, state and local officials, and business leaders reduce the impacts of natural hazards on the medical community.
REGIONAL	
Southeastern Healthcare Preparedness Region	• Assist with coordination and implementation of recovery/continuity of operations plans as needed. • Report to North Carolina Office of Emergency Medical Services on the progress and ongoing needs of healthcare entities in the HCC. • Track the status of medical CI/KR within the impacted area and the region. • Assist local and state governments in effective development of short term recovery priorities as they pertain to medical CI/KR. • Support long-term recovery goals and objectives in the region. • Support a full or partial SMAT II activation in support of medical CI/KR affected by a disaster.
LOCAL	
Hospitals	• Determine ability to support other regional facilities and agencies during a disaster under mutual aid.
EMS Systems	• Support regional facilities and agencies during a disaster under mutual aid.
Emergency Management	• Work with local, regional, and state emergency management, emergency medical, and human services agencies to address medical CI/KR issues and priorities.

ANNEX D: HURRICANES

The following organizations and agencies support efforts of the SHPR region to prepare for and respond to hurricanes in the region

Local Agencies:	**Emergency Management**
	Management Entities
	Fire and Police Departments
	EMS Systems
	Hospitals
Regional Agencies:	**Southeastern Healthcare Preparedness Region**
State Agencies:	**North Carolina Office of Emergency Medical Services**
	North Carolina Division of Public Health
	North Carolina Department of Public Safety
	North Carolina Division of Emergency Management
Federal Agencies:	**Department of Homeland Security**
	Federal Emergency Management Agency
	Department of Health and Human Services
	Department of Defense
	Office of the Assistant Secretary for Preparedness & Response

OVERVIEW

Purpose

This annex addresses issues related to the health and medical response to hurricanes and mitigation actions that can reduce or manage the impact on communities. The annex addresses pre-storm warning and preparations, response during and immediately after a storm, and general recovery actions for the region.

Situation

The hurricane season has some predictability as to when and where storms will strike the North Carolina coast. With sufficient warning, certain actions may be taken by governments, facilities, and agencies within SHPR in order to reduce the mortality and morbidity related to such storms.

Hurricanes have the potential to exhaust a jurisdiction's resources for both pre-landfall preparation and post-landfall recovery. Hurricanes may present life-threatening situations for a jurisdiction to manage that may exceed their capabilities and resources:

- Loss of critical infrastructure to provide electricity, water, wastewater, security, fire suppression, and emergency medical care
- Public health issues, including food and water safety, sanitation, vector control, immunizations, and controlling infectious diseases
- Pre-landfall evacuation of citizens from homes, long-term care facilities, hospitals, and schools
- First responder shelters
- Shelter and mass care for populations that did not evacuate or whose homes are uninhabitable as a result of the storm
- Long term recovery resources and agency support

These situations can arise regardless of the size and type of storm.

Planning Assumptions

- Hurricanes may produce significant injuries, damage facilities, interrupt power water, impact delivery of critical resources, prevent personnel from reaching work, and/or limit patient access to medical care.
- Public health and medical infrastructure in affected locations may be significantly compromised.
- Although hurricanes are not considered a no-notice event, warning times may vary.
- The majority of damage may result from downed trees, blocked roadways and driveways, and flooding.
- Public health and medical issues, including mold/mildew health hazards, may result from extended power outages impacting potable water supply, refrigeration for food and medicine, cooling/heating systems, septic systems.
- Special needs populations, such as the elderly and very young, may be immediately and seriously affected.
- Hurricanes may cause damage to hospitals, nursing and assisted living homes, residences, schools, utilities and government facilities, which may impact shelter operations.
- Special needs populations may have additional requirements for facilities and medical support staff.

CONCEPT OF OPERATIONS

Effective prevention and preparedness operations, early warning and evacuation, and well-trained and equipped response forces will minimize preventable morbidity and mortality caused by a hurricane. Effective pre-landfall prevention and mitigation initiatives can also reduce the amount of damage to ESF-8 resources and facilities. Successful re-

entry operations are critical to the rapid restoration of infrastructure and services in the impacted area.

Coordination between affected organizations across the state and the region is essential. For planning purposes, hurricane support operations are divided into two large categories, pre landfall and post landfall.

Pre Landfall

Pre-landfall coordination sets the parameters for success during a storm. Pre-landfall coordination activities include:

- Develop procedures and processes for monitoring weather conditions and maintaining open communication with the National Weather Service and the National Hurricane Center.
- Coordinate with state, regional, and local organizations responsible for emergency management activities as well as health and medical response in the event of a major hurricane to ensure the HCC plans are integrated into and consistent with local, regional, and state hurricane response plans.
- Develop and maintain lists of key resources and responders critical to evacuation and sheltering of citizens, especially medical and functional needs populations that may need special transportation and sheltering.
- Coordinate with local and state emergency management to assess needs and support medical and functional needs populations.
- Coordinate with local hospitals and long-term care facilities to determine the level of support they may require as a result of the storm. Include coordination with home health and hospice agencies in the region.
- Coordinate with law enforcement agencies to identify procedures for securing transportation routes to identified facilities.

When the National Hurricane Center advises that a hurricane or tropical storm has potential to threaten the coast of North Carolina, the Healthcare Preparedness Manager will contact all HCC hospitals, EMS agencies, public health, and appropriate healthcare facilities to discuss potential requirements and/or shortfalls for the activation of their respective emergency operations plans.

Each jurisdiction, hospital, and healthcare facility will evacuate its patients in accordance with their respective emergency operations plans, assuring that evacuation is completed on schedule. Requests for transportation support and/or bed space will be coordinate in accordance with mutual aid. Issues will be directed to the Healthcare Preparedness Manager for assistance.

In general, ESF-8 agencies will plan to dedicate resources in support of local first responders. These resources will be properly equipped and staged to provide the most effective support.

The HCC will assist in coordination of ESF-8 resource support requirements with the North Carolina Division of Emergency Management's Regional Coordination Centers, regional representatives of North Carolina Office of Emergency Medical Services, and the State Emergency Response Team. Working with the respective facilities and agencies

both in and outside the region, the HCC will help to ensure patient movement/transport and care requirements are met.

Post-Landfall

Post landfall coordination requirements are focused on response, re-entry, and recovery. Coordination activities include the following:

- Coordinate with city/county /state emergency management, local hospitals and long-term care facilities to determine their ESF-8 resource needs as a result of the storm.
- Maintain contact with state agencies involved in the response and work closely with RCCs to address issues.

SHPR will work with city/county/state emergency management to determine the resources necessary to provide support of medical and functional needs populations that may have remained within the impacted area. Additionally, SHPR will assist jurisdictions, agencies, and facilities in identifying resources necessary for their recovery operations post landfall. This includes transportation of patients to and from state medical support shelters or supporting hospitals (see Patient Evacuation and Movement Annex), patient care, surge operations (see Mass Casualty Annex), emergency medical services, and restoration of critical ESF-8 infrastructure (see Critical Medical Infrastructure and Key Resource Restoration Annex).

ORGANIZATION AND ASSIGNMENT OF RESPONSIBILITIES

Agency/Department/Position	Responsibilities
STATE	
North Carolina Office of Emergency Medical Services	• Provide support in accordance with the State of North Carolina Emergency Operations Plan. • Direct deployment of SMRS resources as required. • Coordinate and direct the activation and deployment of state resources of medical personnel, supplies, equipment, and pharmaceuticals (with public health as needed) to a disaster-affected area. • Assist in the development of local capabilities for the onsite coordination of all emergency medical services needed for triage, treatment, transportation, tracking, and evacuation of the affected population during a natural disaster. • Establish and maintain the cooperation of the various state medical and related professional organizations in coordinating the shifting of

	emergency medical services resources from unaffected areas to areas of need. • Coordinate the evacuation of special medical needs from the disaster area as necessary. • Coordinate the catastrophic medical sheltering response by implementing the state medical support shelters.
North Carolina Division of Public Health – Public Health Preparedness & Response (PHP&R)	• Provide support in accordance with the State of North Carolina Emergency Operations Plan. • Provide leadership in directing and coordinating state efforts to provide public health assistance to the affected area. • Establish monitoring systems for the protection of public health. • Provide guidance and assistance to local public health departments, healthcare entities, and the general public. • Investigate disease outbreaks.
North Carolina Division of Emergency Management	• Manage and operate daily state emergency operations center. • Approve requests for activation of SMRS resources. • Activate the CRES-SOG. • Activate Regional Coordination Centers. • Provide support in accordance with the State of North Carolina Emergency Operations Plan. • Activate and manage the state's Response Section within the SERT. The section will 1) serve as the direct contact with FEMA for all response operations; 2) ensure that individuals and families have access to state and federal programs in the aftermath of a disaster; 3) develop and maintain partnerships with state, federal and voluntary organizations that deliver resources to disaster victims; and 4) help citizens, state and local officials, and business leaders reduce the impacts of an event that overwhelms local and regional capabilities. • Lead state efforts to support evacuation and mass patient transport requirements.
REGIONAL	
Southeastern Healthcare	• Assist in the coordination of all regional ESF-8

Preparedness Region	resources during a natural disaster. • Assist in the coordination of HCC disaster response activities during any SMAT deployment or other event where the OEMS activates the SMRS assets and/or resources. • Serve as a liaison between local ESF-8 agencies and the state.
LOCAL	
Hospitals	• Provide medical support to the community.
EMS Systems	• Plan for coordination of ambulance/rescue activities throughout the region. • Coordinate with regional hospitals concerning receipt of patients. • Coordinate with the county health director and social services director to determine emergency transportation needs for special needs populations.
Public Health	• Provide for inspections of mass care facilities to assure proper sanitation practices are followed.
Emergency Management	• Develop and coordinate emergency preparedness, response and recovery operations within the community.

ANNEX E: MASS CASUALTY

The following organizations and agencies support efforts of the SHPR region to prepare for and provide support to a mass casualty incident in the region.

Local Agencies:	**Emergency Management**
	EMS Systems
	Fire and Police Departments
	Hospitals
	Management Entities
	Public Health Agencies
Regional Agencies:	**Southeastern Healthcare Preparedness Region**
State Agencies:	**Department of Public Safety**
	Division of Emergency Management
	Division of Public Health
	Office of Emergency Medical Services
Federal Agencies:	**Centers for Disease Control and Prevention**
	Department of Defense
	Department of Health and Human Services
	Department of Homeland Security
	Federal Emergency Management Agency
	Office of the Assistant Secretary for Preparedness and Response

OVERVIEW

Purpose

This annex provides guidelines for the SHPR region to coordinate and assist in the management of a mass casualty incident (MCI). It describes how the region will collaboratively develop and support existing facility plans, procedures, and operations and addresses surge capacity procedures during incidents that stress healthcare facilities beyond their capacity.

Situation

A Mass Casualty Incident (MCI) is any incident in which the number of persons needing medical services exceeds the existing capacity of the resources within the community. The general public more commonly recognizes events such as building collapses, train and bus collisions, earthquakes, and other large-scale emergencies as mass casualty

incidents. MCIs can occur in any community at any time as a result of natural or human-made events and may be of short or prolonged duration.

Within the SHPR region, the most likely MCIs include the following:

- Structural fires
- Severe weather
- Structural collapse
- HAZMAT
- CBRNE events
- Transportation incidents (e.g. rail, air, highway, and marine)

During a MCI, the majority of individuals who are mobile and have sustained minor injuries will self-refer to the nearest hospitals/healthcare facilities, resulting in a surge event before the more critically injured arrive. This surge of patients will stress the local and regional healthcare system rapidly, potentially without notice.

Planning Assumptions

- No-notice events may require an immediate response, but a pandemic or similar event may have a gradual onset and allow some pre-staging of resources.
- Local governments and medical and public health partners have mass casualty response plans for integration into their jurisdictional emergency operation plans.
- Significant aid from state and federal governments to counties may not be available for 48-72 hours.
- Hospitals closest to the incident site may be overwhelmed with ambulatory and less severely injured self-reporting, resulting in a surge event before the more critically injured arrive.
- Existing standards of care may be adjusted to provide a level of care appropriate for the circumstances given the resources available (sufficiency of care).
- A reduction or cessation of other ESF-8 and public health programs may be necessary in order to provide supplemental personnel for specific job actions required after a MCI.
- After a MCI, healthcare workers, emergency response workers, medical examiners, funeral directors, and morticians will face a sudden and increased demand for services.
- The number of hospital beds and the level of mortuary services available to manage the consequences of an MCI may be inadequate.
- Survivors, fatalities, responders and equipment will have to be screened for contamination after a HAZMAT or CBRNE event.
- A large-scale MCI may overwhelm local EMS systems and medical responders as well as the healthcare system if injuries resulting from the event require follow up hospitalization.

- Additional medical response/cleanup resources may be needed to supplement existing local capabilities and to provide backup or relief resources. Dependent on the nature of the event, these external resources may not be available.
- All hospitals within SHPR have current decontamination plans with trained personnel.
- The appropriate response teams within the region have access to information providing CBRNE material types, common agents, and their effects.
- Normal communication channels may be disrupted.
- CBRNE incidents may dictate that the incident site is a crime scene.
- EMS and other first responders will be suitably trained and briefed to minimize the threat of secondary explosive devices directed against responders or against evacuating citizens.

CONCEPT OF OPERATIONS

The effectiveness of the medical response to a MCI is based on mutual sharing of resources among EMS systems, hospital facilities, and healthcare providers.

Response to a MCI integrates several agencies using a variety of facilities and resources (medical and non-medical). As in any response operation, the local jurisdiction is responsible for incident management. Additionally, health and medical stakeholders should work to develop a comprehensive mass casualty plan for their respective entities that includes provisions for coordination among all elements of the local medical system and agreements with secondary providers.

Once an MCI is identified that will overwhelm the capabilities of the jurisdiction, appropriate agencies will initiate the process to request additional resources. Specifically, effort will be directed to accomplish the following:

- Triage
- Transport
- Treatment
- Surge Capability/Capacity
- Logistics support
- Medical staffing
- Communication channels among hospitals, EMS systems, public health agencies, and private physicians

Locally available medical resources will be used to the extent possible to meet the immediate needs of the incident. Requests for assistance will be in accordance with the resource request processes outlined in their respective emergency operations plans or mutual aid agreements, or as outlined in the base plan.

During an emergency response to a MCI, each hospital uses its internal processes and procedures to perform the following tasks:

- Patient tracking (reception, identification, admittance, transfer and/or diversion)

- Patient treatment (triage, stabilization, treatment, isolation, and quarantine)
- Bed expansion/surge capacity
    - Neighborhood help centers (casualty collection points), medical offsite triage, treatment, and transportation sites may be established in the community to provide triage and minor outpatient treatment before transport to a hospital, thus decreasing the surge impact at these facilities. Alternate care sites may need to be established.
    - Medical treatment facilities may expand their inpatient, outpatient, and ambulatory capacities by canceling or rescheduling elective surgical procedures, discharging non-critical patients, and diverting non-critical patients to other facilities. Additional specialized transportation assets may be required to support the discharge/diversion/transfer of patients.
    - Victims may be transported to outlying areas that have not been affected by the MCI, which will require communication of critical information and use of the Continuum system.
- Coordination of adjoining Regional deployable medical assets and/or personnel to support local response through the county emergency operations centers and SHPR Healthcare Preparedness Manager
- Regional sharing of medical resources from area healthcare facility partners, ambulatory care facilities, community healthcare centers, other healthcare providers, and Medical Reserves Corps volunteers
- State sharing of medical personnel resources located in other HCCs

CBRNE and HAZMAT incidents create fear and anxiety in communities, increasing the number of “worried well” reporting to hospitals for evaluation. Hospitals should use existing in-house resources (social workers, chaplains, psychiatric case managers, patient representatives) to meet mental health needs. If additional resources are required, request for support will be made in accordance with existing procedures as outlined in the Behavioral Health Annex.

Prior to activation of the county emergency operations center, responding and supporting organizations, including SHPR, will handle resource needs internally. At this stage resource support requests may be made agency to agency. Once the county emergency operations center is activated, resource requests will be made in accordance with the processes outlined in the base plan. These requests will be processed and monitored through WebEOC if available in the county.

The SHPR Healthcare Preparedness Manager will assist local emergency management, EMS systems, hospitals, and public health in coordinating non-local medical assets to augment local needs. The Healthcare Preparedness Manager serves as a conduit for both information and resource coordination during a MCI, obtaining and coordinating resources for healthcare organizations, providing input to EMS systems for appropriate patient distribution, and matching resources to patients’ needs. As requested, the Healthcare Preparedness Manager will assist in the coordination of regional and state assets to respond to the MCI, to include coordination of those medical resources that may also come through the Emergency Management Assistance Compact (EMAC).

To facilitate this process, the HCC working with county emergency management coordinators, EMS system directors, local hospitals and other appropriate stakeholders will assist in the coordination of a scalable response to meet the needs of a MCI. This response should incorporate the following:

- Mutual aid agreements and memorandum of understanding with each of the participating healthcare entities
- Designated healthcare system activation (trigger) points
- Patient treatment
- Patient tracking
- Surge capacity

Hospitals can contact local emergency management to request support and inform SHPR of the request.

Federal assets to support a mass casualty event may be available and can include assets from the National Disaster Medical System as well as the SNS.

ORGANIZATION AND ASSIGNMENT OF RESPONSIBILITIES

Agency/Department/Position	Responsibilities
STATE	
North Carolina Office of Emergency Medical Services	• Provide leadership in coordinating and integrating the overall state efforts that provide medical assistance to a disaster-affected area. • Coordinate and direct the activation and deployment of state resources of medical personnel, supplies, equipment, and pharmaceuticals (with public health as needed). • Assist in the development of local capabilities for the onsite coordination of all emergency medical services needed for triage, treatment, transportation, tracking, and evacuation of the affected population with medical needs. • Be prepared to provide Healthcare Rapid Assessment Teams to pre-deploy to staging areas for immediate deployment to healthcare facilities designated as high risk via use of the Multi-Hazard Threat Database (MHTD). • Be prepared to provide Long-Term Disaster Assessment Teams to assess healthcare entities in affected areas through Division of Facility Services/North Carolina Office of Emergency Medical Services.

North Carolina Division of Public Health – Public Health Preparedness & Response (PHP&R)	• Provide leadership in directing and coordinating state efforts to provide public health assistance, evacuation, and patient transportation to the affected area. • Direct and coordinate the activation and deployment of personnel, supplies, and equipment in response to requests for state assistance. • Provide the epidemiological investigation of a known or suspected threat caused by chemical, biological, or nuclear agents. • Provide laboratory testing in support of clinical laboratories on specimens from persons that may have been exposed to a chemical, biological, or nuclear agent. • Procure and allocate immunizing agents and prophylactic antibiotics, including the SNS. • Establish monitoring systems for the protection of public health during response and recovery. • Provide guidance and assistance to local public health departments, healthcare entities, and the general public during response and recovery. • Test water supplies during recovery in coordination with the SERT Infrastructure Branch.
North Carolina Division of Emergency Management	• Activate and manage the state's Response Section within the SERT. The section will 1) serve as the direct contact with FEMA for all response operations; 2) ensure that individuals and families have access to state and federal programs in the aftermath of a disaster; 3) develop and maintain partnerships with state, federal and voluntary organizations that deliver resources to disaster victims; and 4) help citizens, state and local officials, and business leaders reduce the impacts of an event that overwhelms local and regional capabilities. • Lead state efforts to support evacuation and mass patient transport requirements.
REGIONAL	
Southeastern Healthcare Preparedness Region	• Report to the North Carolina Office of Emergency Medical Services on the progress and ongoing needs of healthcare entities in the HCC. • Notify all SHPR member agencies and supporting organizations upon activation of the plan. • Communicate with member agencies and support

	organizations to compile and exchange information concerning the extent of the MCI and the status of response operations. • Provide such information through the SHPR to the county and state emergency operations centers. • Serve as a liaison between health and medical agencies and the state, coordinating regional ESF-8 resources during a MCI. • Coordinate regional medical activities during any SMAT deployment or other event where the OEMS activates the SMRS assets and/or resources. • Facilitate the identification of issues/shortfalls, development of mitigation strategies, and resource coordination to support a MCI. • Assist local and state governments in effective development of short term recovery priorities as they pertain to a MCI. • Update and submit alternate care site information to the North Carolina Office of Emergency Medical Services. • Be prepared to conduct a full or partial activation of the SMAT II in support of a MCI. • Be prepared to augment or provide needed SMAT II personnel, equipment, and services upon request.
LOCAL	
Hospitals	• Provide staff to support mass casualty operations (e.g., neighborhood help centers) until other staffing assets are available. • Communicate to SHPR information concerning the extent of the disaster and the status of response operations and resources. • Maintain procedures for safe and appropriate disposal of medical waste in a mass casualty event. • Be prepared to support other regional facilities and agencies during a disaster under mutual aid agreements.
EMS Systems	• Protect EMS personnel and other first responders from secondary devices and environmental and structural hazards. • Remove victims from direct hazard impact and stage them into the EMS system for triage and appropriate

	distribution to definitive care. • Focus casualty treatment in the field to stabilize life threatening medical conditions. • Shift healthcare priorities to those critically injured patients who are most likely to survive. • Provide appropriate transportation and distribution of patients in coordination with the SHPR Healthcare Preparedness Manager. • Maintain procedures for safe and appropriate disposal of medical waste in a MCI. • Manage fatalities on scene. • Be prepared to support other regional facilities and agencies during a disaster under mutual aid agreements.
SMAT III	• Be prepared to support other regional facilities and agencies during a disaster under mutual aid agreements.
Medical Reserve Corps	• Provide credentialed and trained medical volunteers to support a mass casualty incident response within the SHPR region. • Collect, compile, and maintain all essential information, generate reports and records concerning mass casualty disaster response.
Behavioral Health/Local Management Entities	• Provide mental health staff to support mass casualty operations, (e.g., crisis counseling response teams, mental health assessment and referral services) for mass casualty victims. • Provide short term crisis intervention and support services. • Coordinate with SHPR and the North Carolina Department of Mental Health to gain assistance from other mental health centers and facilities as needed. • Coordinate mental health services to communities and organizations through SHPR and the jurisdictional county ESF-8 representative. • Keep the public informed of available mental health mass assistance programs, in coordination with mass casualty support agencies and organizations. • Collect, compile, and maintain all essential information; generate reports and records concerning mass casualty disaster response.

American Red Cross	• Support county relief efforts through ESF-6 (Mass Care). • Support local response by opening emergency shelters and providing food, first aid, blood and blood products as necessitated by the event. • Assist with collection and reporting of information about the status of victims and assist with family reunification in coordination with SHPR and local emergency management. • Provide first aid and other related medical support at temporary treatment centers. • Provide behavioral health and spiritual care teams to support mass casualty operations, if requested. • Collect, compile, and maintain all essential information and generate reports concerning American Red Cross mass casualty disaster response.
Emergency Management	• Activate the county emergency operations center. • Mobilize, deploy, and coordinate resources to the impacted area to assist in lifesaving and life protection efforts and coordinate additional support resources. • Notify the public of the threat as appropriate and advise the population at risk of the necessary protective actions. • Activate the Emergency Alert System as required. • Coordinate shelter activities as required. • Coordinate the recovery activities of county departments and agencies.

APPENDICES

The appendices to the Mass Casualty Annex of the SHPR Regional ESF-8 Response and Recovery Plan add incident-specific guidance on surge and CBRNE or HAZMAT related emergencies.

- Appendix 1 - Surge
- Appendix 2 - Hazardous Materials and Chemical, Biological, Radiological, Nuclear and Explosive Events

APPENDIX 1 - SURGE

Background

Mass casualty events may severely challenge the ability of healthcare systems to adequately care for large numbers of patients (surge capacity) and/or victims with unusual or highly specialized medical needs (surge capability).

Medical surge is the capability to rapidly expand the capacity of the existing healthcare system (long-term care facilities, community health agencies, acute care facilities, alternate care facilities and public health departments) in order to provide triage and subsequent medical care. This includes providing definitive care to individuals at the appropriate clinical level of care within sufficient time to achieve recovery and minimize medical complications. Medical surge capability applies to any event resulting in a number or type of patients that overwhelm day-to-day acute-care medical capacity.

Planners should assume that medical resources are normally at or near capacity at any given time. Medical surge may result in increased need of personnel (clinical and non-clinical), support functions (laboratories and radiological), physical space (beds, alternate care facilities), and logistical support (clinical and non-clinical equipment and supplies).

Operations

Trigger points assist in the identification of regional resource availability and the potential need for non-regional assistance. To effectively respond to and meet the needs of a MCI, these trigger points will alert the hospitals and HCC that the healthcare facilities are approaching or at maximum capacity. Trigger points provide guidance on when to consider additional capacity tools (surge), such as expanded hospital spaces, acute care centers, ambulatory care centers, alternate care facilities, field treatment centers. Trigger points should also provide guidance when determining when to activate regional resources, such as SMATs and field hospitals.

APPENDIX 2 – HAZMAT AND CBRNE

Background

A HAZMAT or CBRNE incident may result in mass casualties. CBRNE related injuries will vary according to type, concentration and exposure.

Although an incident involving the accidental release of a toxic industrial chemical is far more likely, criminal or terrorist use of CBRNE weapons is possible. Processes and procedures for conducting ESF-8 operations in support of such an incident vary based on the type of material, not whether the incident was intentional or accidental. Victims of HAZMAT and CBRNE incidents may require unique or special medical care.

HAZMAT and CBRNE incidents may also result in widespread contamination to homes and businesses resulting in an evacuation or shelter-in-place order. Entire communities, including medical facilities, may require evacuation. A HAZMAT or CBRNE incident may become even more complicated if detection of the agent and decontamination of

casualties is necessary before evacuation, triage, transport, and treatment can begin. Contamination from these types of agents may spread by direct contact with a casualty when emergency responders and citizens are not aware of the hazard and fail to wear appropriate personal protective equipment (PPE) when entering the site of the accident.

A biological incident may be based on an accidental release or a deliberate intent to infect. Details on regional response to a biological incident are outlined in the Communicable Disease Annex.

Nuclear/ radiation incidents present similar injuries as seen in other incidents but also present unique medical challenges. The effects of a nuclear detonation cause wide spread blast and burn injuries. Contamination and radiation exposure injury will be subsequent consequences to those who survive the blast and burns. Contamination occurs when radioactive material is deposited on or in an object or a person. Acute Radiation Syndrome, also known as radiation sickness, is a serious illness that occurs when the entire body (or most of it) receives a high dose of radiation, usually over a short period of time.

Explosive incidents can occur in any community at any time from accidental causes or as a result of a terrorist or criminal event. The consequences of an explosion, like those brought on by the other agents addressed in this appendix, can be multiple casualties with complex and technically challenging injuries not commonly seen after natural disasters. The majority of individuals who are mobile and who have sustained injuries will self-report to the nearest hospitals resulting in a surge event occurring at these facilities.

Operations

The SHPR Healthcare Preparedness Manager will serve in a supporting role for the local county emergency operations center regarding ESF-8 functions involving a HAZMAT or CBRNE incident. If a mass casualty incident is declared, the Healthcare Preparedness Manager will support the local response in accordance with procedures outlined in the Mass Casualty Annex and the ESF-8 base plan.

ANNEX F: MASS FATALITY RESPONSE

The following organizations and agencies support efforts of the SHPR region to prepare for and respond to a mass fatality incident.

Local Agencies:	**Emergency Management**
	EMS Systems
	Fire and Police Departments
	Hospitals
	Management Entities
	Medical Examiner's Office
Regional Agencies:	**Southeastern Healthcare Preparedness Region**
State Agencies:	**Dental Society**
	Department of Public Safety
	Department of Law Enforcement
	Division of Emergency Management
	Division of Public Health
	Funeral Director Association
	Office of Emergency Medical Services
	Office of the Chief Medical Examiner
Federal Agencies:	**Department of Defense**
	Department of Health and Human Services
	Department of Homeland Security
	Federal Emergency Management Agency
	National Disaster Medical System (NDMS)-Disaster Mortuary Operational Response Team (DMORT)
	Office of the Assistant Secretary for Preparedness and Response

OVERVIEW

Purpose

This annex describes the procedures and guidelines that allow the SHPR region to coordinate response to a mass fatality incident. This includes mortuary surge capacity issues and methods to respond to and mitigate issues including the following:

- Collection and examination of the dead
- Determination of the nature and extent of injury

- Recovery of forensic, medical, and physical evidence
- Identification of the fatalities using scientific means and certification of the cause and manner of death

Situation

A Mass Fatality Incident (MFI) is defined as any incident involving more dead bodies and/or body parts than can be located, identified, and processed for final disposition by available response resources.

A MFI is generally recognized as being an incident in which the number of fatalities exceeds the local city or county's resource capabilities causing them to request assistance from neighboring jurisdictions. County medical examiner’s offices may seek assistance at the region, state, and federal levels.

Disaster situations may present fatalities ranging from a few victims to mass numbers. Additionally, the event may involve one or more of the following complications:

- Biological agent exposure events resulting in infectious or toxic agent-contaminated victims
- Bomb/blast events resulting in burned and fragmented human remains
- Chemical exposure events resulting in hazardous material contaminated victims
- Radiological exposure events resulting in radiation material contaminated victims
- Mass transit accidents resulting in fragmented human remains
- Weather events resulting in mass drowning or blunt trauma victims related to collapsed structures

These complications can arise regardless of whether the event was an act of nature, a minor or catastrophic accident, a terrorist act, an outbreak of infectious disease, or the intentional release of a weapon of mass destruction.

Planning Assumptions

- The initial resources within the affected disaster area will most likely be inadequate to handle all fatalities at the scene of an event.
- Additional resources (e.g., medical examiners, transportation, cooling units) will be needed to supplement local jurisdictions for collection, examination, determination of cause of death, recovery of evidence, and identification.
- Emergency response personnel may be confronted with situations that may hamper their ability to perform their job function.
- Medico-legal systems will have MFI responsibilities in addition to their normal case load.
- County medical examiner offices, hospitals and other healthcare entities have limited fatality surge space or equipment.
- Federal or military assistance in fatality management may not be available to local jurisdictions in widespread incidents such as a pandemic.

- Those who physically handle remains may be at risk of exposure, requiring universal precautions and proper training for handling the dead.
- It is more important to ensure accurate and complete investigations and identification of the dead than it is to quickly end the response.
- The time to complete fatality management of a mass fatality event may exceed six months to a year.
- Mental health professionals, social service organizations, and religious leaders should be educated in the mass fatality management process to ensure the process is understood and can be properly communicated to the general population.

CONCEPT OF OPERATIONS

The treating or primary care physician signs death certificates, and the County Medical Examiner's Office (MEO) determines the circumstances, manner, and cause of all violent, sudden, or unusual deaths. Within SHPR counties, the MEO also functions as a working county morgue.

In the event of a MFI occurring within a SHPR county, the county MEO will be notified as soon as possible after emergency responders have completed rescue and initial containment of the scene. Official notification will be made as early as possible to allow time for the MEO investigators to begin notification of necessary personnel. The county MEO will make the decision regarding activation of the county's mass fatality plan.

If additional resources (medical examiners, transportation, cooling units) will be needed to supplement local jurisdictions for collection, examination, determination of cause of death, recovery of evidence, and identification during a MFI, the impacted jurisdiction will follow the procedures outlined in the base plan to activate mutual aid and in-place contracts.

SHPR can offer regional support when requested if the following situations occur:

- When requested by an impacted county
- When directed by North Carolina Office of Emergency Medical Services or the Level I Trauma Center

SHPR can serve as a central information repository for resources available to the region. In addition, the impacted jurisdictions can also use SHPR to assist in the coordination of facilities that could potentially be used to temporarily house remains and to serve as alternate morgues. Additional resources include the following:

- Medical examiner/investigators
- Doctors/dentists
- Temporary morgue sites
- Refrigerator vans/storage
- Family Assistance Center (FAC)
- Body bags
- SMAT III
- Mortuaries/funeral homes/ Crematories

- Crisis counselors

ORGANIZATION AND ASSIGNMENT OF RESPONSIBILITIES

Agency/Department/Position	Responsibilities
STATE	
North Carolina Office of Emergency Medical Services	• Provide support in accordance with the State of North Carolina Emergency Operations Plan. • Coordinate and direct the activation and deployment of state resources of medical personnel, supplies, equipment, and pharmaceuticals (with public health as needed) in support of a MFI. • Establish and maintain the cooperation of the various state medical and related professional organizations in coordinating the shifting of EMS resources from unaffected areas to areas of need.
North Carolina Division of Public Health – Public Health Preparedness & Response (PHP&R)	• Provide support in accordance with the State of North Carolina Emergency Operations Plan. • Provide leadership in directing and coordinating state public health assistance in support of a MFI. • Provide guidance and assistance to local public health departments, healthcare entities, and the general public.
North Carolina Division of Emergency Management	• Activate and manage the state's Response Section within the SERT. The section will 1) serve as the direct contact with FEMA for all response operations; 2) ensure that individuals and families have access to state and federal programs in the aftermath of a disaster; 3) develop and maintain partnerships with state, federal and voluntary organizations that deliver resources to disaster victims; and 4) help citizens, state and local officials, and business leaders reduce the impacts of an event that overwhelms local and regional capabilities. • Manage and operate daily state emergency operations center. • Approve requests for activation of state resources in the event of a MFI. • Activate Regional Coordination Centers (RCC) as required. • Provide support in accordance with the State of North

	Carolina Emergency Operations Plan.
REGIONAL	
Southeastern Healthcare Preparedness Region	• Assist in the coordination of ESF-8 resources in support of a MFI. • Serve as a liaison, if requested, between local ESF-8 agencies and the state, coordinating SHPR regional ESF-8 resources during a MFI event. • Conduct a full or partial SMAT activation in support of a community affected by a MFI.
LOCAL	
Hospitals	• Provide support (personnel, equipment, supplies, or temporary morgue) during a MFI.
EMS Systems	• Develop and maintain standard operating guidelines to provide emergency medical services—to include ambulance, transport and/or recovery support—during a MFI. • Identify equipment and manpower limitations and develop mutual aid agreements for needed resources during a MFI.
Public Health	• Coordinate with the proper authorities to establish a temporary morgue, if necessary. • Provide support as needed during a MFI.
Emergency Management	• Develop and coordinate emergency preparedness, response, and recovery operations within the county resulting from a MFI. • If additional resources are needed to supplement local capabilities (for collection, examination, determination of cause of death, recovery of evidence, and identification during a MFI), activate mutual aid and in-place contracts. • Coordinate with the MEO, law enforcement, and American Red Cross to identify facilities for the Family Assistance Centers.
County Medical Examiner's Office (MEO)	• Determine the circumstances, manner, and cause of all violent, sudden, or unusual deaths. • Coordinate with county emergency management to activate all or components of the county's mass fatality plan. • Act as technical advisor to the incident commander in

	making decisions with regards to the recovery phase of operations. • Identify and deploy MEO investigators. • Coordinate with local fire departments, law enforcement, and SMAT III to determine if the MFI site requires decontamination or criminal investigation prior to processing of remains. • Work with both local law enforcement and the American Red Cross to staff a Family Assistance Center. • Lead all efforts involving the temporary storage of fatalities.
Management Entities	• Respond to the requirements of the local incident commander, MEO, and county emergency operations center in support of a MFI. • Develop a behavioral health response infrastructure with community response partners such as the American Red Cross, faith-based organizations, and other Voluntary Organizations Active in Disaster. • Ensure counseling to individuals, families, and responders and identification of people in need of long-term crisis counseling or mental health services. • Coordinate outreach activities that will be consistent with the FEMA Crisis Counseling Program.

ANNEX G: MOBILE DISASTER HOSPITAL

(for future development)

ANNEX H: PATIENT EVACUATION AND TRANSPORTATION

The following organizations and agencies support efforts of the SHPR region to prepare for and provide patient evacuation and transportation operations resulting from a disaster in the region.

Local Agencies:	**Emergency Management**
	EMS Systems
	Fire and Police Departments
	Hospitals
Regional Agencies:	**Southeastern Healthcare Preparedness Region**
State Agencies:	**Department of Public Safety**
	Division of Emergency Management
	Division of Public Health
	Division of Social Services
	Office of Emergency Medical Services
Federal Agencies:	**Department of Defense**
	Department of Health and Human Services
	Department of Homeland Security
	Federal Emergency Management Agency
	Office of the Assistant Secretary for Preparedness and Response

OVERVIEW

Purpose

This annex provides guidance to the region in order to assist the state in the implementation of patient evacuation and transportation. This includes events that demand evacuation and transportation of special medical needs populations as well as patients located within facilities.

Situation

The SHPR region is subject to many potential disasters that may require patient evacuation and transportation. Potential hazards are listed in the base plan as well as in counties' hazard analyses. The following facilities may require patient evacuation and transportation:

- Hospitals
- Long term care facilities
- Licensed and unlicensed assisted living facilities
- Dialysis centers
- Psychiatric treatment facilities
- Homebound patients

The creation of a special medical needs registry will allow emergency managers and ESF-8 planners to accurately assess resource requirements and allow for timely evacuations of medically fragile populations.

Planning Assumptions

- Available resources needed to meet evacuation and transportation requirements may be limited.
- Homebound patients may be a challenge as a result of to the quantity (known and unknown) of individuals as well as their geographical spread across the region.
- In addition to the needs of the general population, those with special medical needs will require special resources during evacuation and transportation.
- The process of fully identifying those with special medical needs may create challenges in the assessment of resources potentially required for evacuation.
- Counties within the region only have a limited number of ambulances; these vehicles will be reserved for primary emergency response during any threat and may not be available for evacuation of the special needs population.
- Some disasters are no-notice events that may require a quick decision to evacuate at any time, day or night.
- Spontaneous evacuations may occur prior to implementation of evacuation orders.
- The evacuation of large numbers of people from vulnerable areas may stress road networks, potentially increasing the time necessary to evacuate the threatened risk area.
- All medical and special needs facilities will develop and maintain a facility emergency operations plan that addresses evacuation and patient transportation as outlined by North Carolina Department of Health and Human Services policy.

CONCEPT OF OPERATIONS

General

The decision for medical evacuation is the responsibility of each facility or local emergency management officials. Evacuations of this nature may be handled at the local, regional, or state level.

County emergency management can review emergency operations plans and appropriate evacuation and transportation annexes for their respective jurisdiction’s medical facilities

(e.g., hospitals, assisted living facilities, nursing homes) and homebound individuals with special medical needs on an annual basis. A disaster plan template is available for assisted living facilities and nursing homes from North Carolina Division of Emergency Management to assist with planning for evacuations.

Medical transportation is managed by county EMS systems within the region. At a minimum, the following considerations must be addressed by medical facilities and emergency services concerning evacuation and patient transport:

- Prioritized dispersion to multiple hospitals/emergency departments in a mass casualty event
- Process for producing, safeguarding, and transmitting patient manifests during an evacuation
- Documents/medications to travel with patient
- Patient demographic information
- Patient clinical information
- Special considerations/equipment
- Staff/family members (caregivers)
- Identified receiving location (available or needed)
- Identified transportation resources (available or needed)
- Labeling and tracking personal equipment (e.g., wheelchairs, oxygen tanks)
- Identified process for patient assessment during transport that may affect placement at receiving locations
- Level of appropriate medical staff to load and accompany patients during an evacuation (e.g., bariatric patients)

During an evacuation, each facility and/or agency will track the movement of their respective patients. This information will be shared with all affected hospitals. Patient transport will be prioritized by triage and coordinated regionally using Continuum. In addition to ambulances, each county within the SHPR region will coordinate buses (e.g. school and/or commercial transport) for mass patient transportation.

In a large-scale evacuation, the availability of trained medical personnel is as essential as transport. SHPR will develop and maintain a comprehensive list of volunteer medical personnel available for support during an emergency, which is accessible through the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR/VHP). Consideration should be given to using medical volunteers to assist and monitor patients during transport.

When an event exceeds the capabilities of the local jurisdiction and the resources available through mutual aid, SHPR can assist in the coordination of response resources. SHPR can facilitate communications, coordinate resources, and perform other required activities between jurisdictions and agencies throughout the SHPR region, other HCCs, and state agencies involved in the response.

ORGANIZATION AND ASSIGNMENT OF RESPONSIBILITIES

Agency/Department/Position	Responsibilities
STATE	
North Carolina Office of Emergency Medical Services	• Provide leadership in directing and coordinating state efforts to provide evacuation and patient transportation. • Coordinate and direct the activation and deployment of state resources of medical personnel, supplies, equipment, and pharmaceuticals (with public health as needed) to support evacuation and patient transportation operations. • Assist in the development of local capabilities for the onsite coordination of all emergency medical services needed for triage, treatment, transportation, tracking, and evacuation of the affected population with medical needs.
North Carolina Division of Public Health – Public Health Preparedness & Response (PHP&R)	• Direct and coordinate the activation and deployment of personnel, supplies, and equipment in response to requests for state assistance. • Provide guidance and assistance to local public health departments, healthcare entities, and the general public.
North Carolina Division of Emergency Management	• Develop and maintain the CRES-SOG. • Activate and manage the state's Response Section within the SERT. The section will 1) serve as the direct contact with FEMA for all response operations; 2) ensure that individuals and families have access to state and federal programs in the aftermath of a disaster; 3) develop and maintain partnerships with state, federal and voluntary organizations that deliver resources to disaster victims; and 4) help citizens, state and local officials, and business leaders reduce the impacts of an event that overwhelms local and regional capabilities. • Lead state efforts to support evacuation and mass patient transport requirements.
REGIONAL	
Southeastern Healthcare	• Assist with coordination of evacuation and patient

Preparedness Region	transport operations as needed. • Obtain and track information regarding healthcare facility status. • Assist in coordinating patient tracking between facilities and jurisdictions. • Facilitate the identification of issues/shortfalls and resource coordination to support evacuation/patient transportation. • Assist local and state governments in development of evacuation/patient transportation priorities. • Identify HCC assets that may be available to transport medical supplies, equipment, and other assets. • Augment or provide needed personnel, equipment, and services upon request.
LOCAL	
EMS Systems	• Track the movement of all patients to whom they provide service. • Be prepared to support other regional facilities and agencies during a disaster under mutual aid.
Licensed Healthcare Facilities	• Develop plans and procedures that address operations, resource requirements, and shortfalls associated with facility evacuation/patient transportation. • Track the movement of all patients to and from their facility. • Be prepared to support other regional facilities and agencies during a disaster under mutual aid.
Emergency Management	• Work with local, regional, and state emergency management, emergency medical, and public health agencies to identify evacuation/patient transportation needs, develop support plans, and address related issues and priorities. • Develop plans for the evacuation and transport of special medical needs/homebound patients within their jurisdictions. • Develop a process for the registration of all special medical needs and homebound patients within their jurisdiction.

ANNEX I: SEVERE WEATHER

The following organizations and agencies support efforts of the SHPR region to prepare for and respond to Natural Disasters in the region.

Local Agencies:	**Emergency Management**
	EMS Systems
	Fire and Police Departments
	Hospitals
	Management Entities
Regional Agencies:	**Southeastern Healthcare Preparedness Region**
State Agencies:	**Department of Public Safety**
	Department of Agriculture
	Division of Emergency Management
	Division of Public Health
	Office of Emergency Medical Services
Federal Agencies:	**Department of Defense**
	Department of Health and Human Services
	Department of Homeland Security
	Federal Emergency Management Agency
	Office of the Assistant Secretary for Preparedness and Response

OVERVIEW

Purpose

The SHPR region is susceptible to many different types of natural disasters such as tornadoes, storms (winter and summer), or flooding. The purpose of this annex is to address procedures and guidelines related to the medical and public health response to these types of events. This includes evacuation and transport of patients, medical special needs, shelter and evacuation, hospital surge capacity, and other issues.

Situation

A natural disaster is the effect of a natural hazard (e.g., flood, severe weather, or earthquake) that impacts life safety, the economy and/or the environment. The most likely natural disasters within the SHPR region are based upon severe weather and its consequences. Regional severe weather may include thunderstorms, downbursts,

lightning, winds, hail, excessive precipitation, tornadoes, hurricanes, blizzards, snowstorms, ice storms, and droughts. Impacts of severe weather may include the following:

- Loss of critical infrastructure to provide electricity, water, sewer, security, fire suppression, and emergency medical care
- Public health issues with food and water safety, sanitation, vector control, immunizations, and controlling infectious diseases
- Evacuation of citizens from homes, long-term care facilities, hospitals, and schools
- Shelter needs for first responders remaining in the impacted area to re-establish critical infrastructure
- Shelter and mass care for populations that did not evacuate or whose homes are uninhabitable as a result of severe weather
- Long term recovery resources and agency support

Assumptions

- The region will continue to experience severe weather that may cause death, injury, and damage or may necessitate emergency evacuation, search and rescue, sheltering, and mass care for at-risk populations.
- Critical infrastructure and key resources, both public works and medical, may be affected for days or weeks.
- The evacuation of large numbers of people from vulnerable areas may stress road networks, potentially increasing the time necessary to evacuate the threatened risk area.
- The state will coordinate significant information-sharing across multiple jurisdictions and between the public and private sectors to assist in key decision-making efforts regarding evacuation, shelter operations, medical support, and dissemination of public information.
- Severe weather may result in numerous displaced people, disruption of normal life support systems, and significant congestion of transportation networks.
- Departments and agencies at all levels of government and certain non-governmental organizations may likely be required to deploy resources on short notice to provide timely and effective mutual aid and/or intergovernmental assistance.

CONCEPT OF OPERATIONS

Effective prevention and preparedness operations, early warning and evacuation, and well-trained and equipped response forces will minimize morbidity and mortality caused by severe weather.

Severe weather response will require the support of state and regional agencies (e.g., North Carolina Division of Emergency Management, North Carolina Office of Emergency Medical Services, SHPR) to coordinate ESF-8 resource requirements.

For planning purposes, ESF-8 support operations for severe weather are divided into two categories, pre-event and post event. The following outlines some of the key aspects that apply to all types of severe weather incidents, highlighting specifics as necessary.

Pre-Event

Pre-event coordination includes the following:

- Develop procedures and processes for monitoring weather conditions and maintaining open communication with the National Weather Service.
- Coordinate with state, regional, and local jurisdictions/agencies responsible for emergency management activities in the event of severe weather to ensure the HCC plans are integrated into and consistent with state, regional, and local plans.
- Develop and maintain lists of key resources and responders critical to evacuation and sheltering of citizens, especially medical and functional needs populations that may need special transportation and sheltering.
- Coordinate with local and state emergency management to assess needs and support medical and functional needs populations.
- Coordinate with local hospitals and long-term care facilities to determine the level of support they may require as a result of severe weather. Include coordination with home health and hospice agencies in the region.
- Coordinate with regional partners to determine the level of support they may require as a result of a natural disaster.

Post Event

Post event coordination requirements are focused on response, re-entry, and recovery. Successful re-entry operations are critical to the rapid restoration of infrastructure and services in the impacted area. Coordination activities include the following:

- Coordinate with city/county /state emergency management, local hospitals and long-term care facilities to determine their ESF-8 resource needs as a result of the storm.
- Maintain contact with state agencies involved in the response and work closely with RCCs to address issues.

SHPR will work with county/state emergency management to determine the resources necessary to provide support of populations with medical and functional needs that may have remained within the impacted area. Additionally, the HCC will assist jurisdictions, agencies, and facilities in identifying resources necessary for their recovery operations. This may include transportation of patients to and from shelters or supporting hospitals (see Patient Evacuation and Movement Annex), patient care, surge operations (see Mass Casualty Annex), emergency medical services, the restoration of critical ESF-8 infrastructure (see Critical Medical Infrastructure and Key Resource Restoration Annex), and/or mass fatality response (see Mass Fatality Annex).

ORGANIZATION AND ASSIGNMENT OF RESPONSIBILITIES

Agency/Department/Position	Responsibilities
STATE	
North Carolina Office of Emergency Medical Services	• Provide support in accordance with the State of North Carolina Emergency Operations Plan. • Direct deployment of SMRS resources as requested. • Direct deployment of HFRATs as requested. • Coordinate and direct the activation and deployment of state resources of medical personnel, supplies, equipment, and pharmaceuticals (with public health as needed) to a disaster-affected area. • Assist in the development of local capabilities for the onsite coordination of all emergency medical services needed for triage, treatment, transportation, tracking, and evacuation of the affected population during a natural disaster. • Coordinate EMS resources from unaffected areas to areas of need. • Coordinate the evacuation of special medical needs populations from the disaster area as requested. • Coordinate the catastrophic medical sheltering response by implementing the State Medical Support Shelter Plan.
North Carolina Division of Public Health – Public Health Preparedness & Response (PHP&R)	• Provide support in accordance with the State of North Carolina Emergency Operations Plan. • Provide leadership in directing and coordinating state efforts to provide public health assistance to the affected area. • Establish monitoring systems for the protection of public health. • Provide guidance and assistance to local public health departments, healthcare entities and the general public. • Investigate disease outbreaks.
North Carolina Division of Emergency Management	• Manage and operate state emergency operations center. • Approve requests for activation of SMRS resources. • Activate Regional Coordination Centers (RCC). • Provide support in accordance with the State of North

	Carolina Emergency Operations Plan. • Activate and manage the state's Response Section within the SERT. The section will 1) serve as the direct contact with FEMA for all response operations; 2) ensure that individuals and families have access to state and federal programs in the aftermath of a disaster; 3) develop and maintain partnerships with state, federal and voluntary organizations that deliver resources to disaster victims; and 4) help citizens, state and local officials, and business leaders reduce the impacts of an event that overwhelms local and regional capabilities.
REGIONAL	
Southeastern Healthcare Preparedness Region	• Assist with coordination of evacuation and patient transport operations as needed. • Coordinate HCC disaster activities during any SMAT deployment or other event where the North Carolina Office of Emergency Medical Services activates the SMRS assets and/or resources. • Augment or provide needed personnel, equipment, and services upon request.
LOCAL	
Hospitals	• Be prepared to provide medical support to the community during severe weather events.
EMS Systems	• Plan for coordination of ambulance activities throughout the region during severe weather events. • Identify equipment and manpower limitations and develop mutual aid agreements for needed resources during severe weather events. • Coordinate with local/regional hospitals concerning receipt of patients during severe weather events. • Coordinate with the county health director and social services director to determine emergency transportation needs for special needs populations.
Public Health	• Provide for inspections of mass care facilities to assure proper sanitation practices are followed. • Provide guidance and assistance to local public health departments, healthcare entities, and the general public. • Provide assistance with food safety, sanitation, vector

	control, immunizations, and controlling infectious diseases.
Emergency Management	• Develop and coordinate emergency preparedness, response and recovery operations within the community.

ANNEX J: SPECIAL EVENTS

The following organizations and agencies support SHPR efforts to prepare for and respond to medical and public health incidents associated with special events occurring within the region.

Local Agencies:	**Emergency Management**
	Management Entities
	Fire and Police Departments
	EMS Systems
	Hospitals
Regional Agencies:	**Southeastern Healthcare Preparedness Region**
State Agencies:	**Department of Public Safety**
	Division of Emergency Management
	Division of Public Health
	Office of Emergency Medical Services
Federal Agencies:	**Department of Defense**
	Department of Health and Human Services
	Department of Homeland Security
	Federal Emergency Management Agency
	Office of the Assistant Secretary for Preparedness and Response

OVERVIEW

Purpose

Special events can bring a large number of people together for a short time, potentially straining ESF-8 resources. These events require planning and coordination prior to execution. This annex provides guidelines and procedures specific to regional ESF-8 support for a special event. In order to meet regional needs, the HCC should be included in regional planning for special events.

Situation

A special event is defined as a preplanned, non-routine activity held at a specific location for a defined period of time that strains planning and response resources. This could include sporting events, concerts, fairs, festivals, conventions, conferences, rallies, and mass gatherings. Emphasis is placed on the community's ability to respond to a large-

scale emergency or disaster or the exceptional demands that the activity places on response services, not on the total number of people attending the event.

A community's special event requires additional planning, preparedness, and mitigation efforts from local ESF-8 agencies that address the following concerns associated with special events:

- Increased demand on existing services
- Increased potential for public health events due to changes in population dynamics, changes in services, and changes in behaviors
- Increased potential for terrorist activities
- Increased media attention

Special events pose challenges for medical and health systems. The incidence of illness and injury at special events is usually higher than one would normally see in a population of comparable size. Even if a community's existing ESF-8 systems can adequately deal with typical levels of disease (including an occasional disease outbreak), the greater number of people associated with special events can place a severe strain on the healthcare system, which compromises the ability to detect, investigate, and respond to a problem.

Major anticipated health risks during special events include the following:

- Heat or cold-related illness
- Foodborne and waterborne illness
- Communicable diseases
- Accidents and injuries
- Illness, injuries, and panic related to intentional chemical, biological, or explosive attacks or severe weather

Planning Assumptions

- The initial resources available for an incident during an event may be inadequate.
- Additional state and federal capabilities may be needed to supplement and assist local jurisdictions.
- Additional transportation may be needed to transport casualties to hospitals.
- The closest healthcare facilities may be rapidly overwhelmed with people who self-reported without undergoing triage and/or decontamination procedures at the incident scene.
- Local ESF-8 agencies and facilities may be unaware of any special event in advance.

CONCEPT OF OPERATIONS

Special events present particular challenges for preventing or minimizing harm to participants, spectators, and event staff. Event stakeholders must be aware of each other's roles, responsibilities, and knowledge of the potential and actual ESF-8 issues.

The FEMA Special Events Contingency Planning Job Aids Manual (March 2005) provides an excellent reference for planning.

Event organizers may consult with ESF-8 agencies when conducting a pre-event health assessment for a special event. The event approval process (as dictated by hosting jurisdictions) should ensure that medical care at the venue is sufficient for the event. In addition, providing onsite first aid or medical care can significantly reduce the demand on EMS systems and the emergency departments at local hospitals in the area.

Planning should include the following considerations:

- Level of care and provider source at, and in support of, the event
- Consultation with medical personnel with experience in similar events to determine the appropriate levels of care to provide
- Consideration of the distance to, and accessibility of, the nearest hospital and its capabilities
- Coordination between venue medical services and those of the local community emergency medical service responders
- Treatment of patients after a CBRNE or other mass casualty incident

Planners should determine the appropriate level of care to be provided, which includes the following:

- Basic life support (e.g. medical responder, Emergency Medical Technician-Basic)
- Advanced life support (e.g. Emergency Medical Technician-Intermediate, Emergency Medical Technician-Paramedic, Registered Nurse)
- Advanced practice provider (e.g. physicians, physician assistants, nurse practitioners)

Early communication between local planners and the HCC can identify shortfalls in medical resources and personnel. When appropriate, HCC staff will provide this information to all regional ESF-8 agencies and facilities. This pre-event notification alerts agencies of the potential need for regional ESF-8 resources. If requested by local or state officials, the HCC staff will assist in the coordination of regional ESF-8 resources to include SMAT II deployment.

ORGANIZATION AND ASSIGNMENT OF RESPONSIBILITIES

Agency/Department/Position	Responsibilities
STATE	
North Carolina Office of Emergency Medical Services	• Provide support in accordance with the State of North Carolina Emergency Operations Plan. • Direct deployment of SMRS resources as required in

	support of a special event. • Coordinate and direct the activation and deployment of state resources of medical personnel, supplies, equipment, and pharmaceuticals (with public health as needed) in support of a special event or mass gathering requirements.
North Carolina Division of Public Health – Public Health Preparedness & Response (PHP&R)	• Provide support in accordance with the State of North Carolina Emergency Operations Plan. • Provide guidance and assistance to local public health departments, healthcare entities, and the general public in support of special event requirements.
North Carolina Division of Emergency Management	• Approve requests for activation of SMRS resources in support of a special event. • Provide support in accordance with the State of North Carolina Emergency Operations Plan. • Activate and manage the state's Response Section within the SERT. The section will 1) serve as the direct contact with FEMA for all response operations; 2) ensure that individuals and families have access to state and federal programs in the aftermath of a disaster; 3) develop and maintain partnerships with state, federal and voluntary organizations that deliver resources to disaster victims; and 4) help citizens, state and local officials, and business leaders reduce the impacts of an event that overwhelms local and regional capabilities.
REGIONAL	
Southeastern Healthcare Preparedness Region	• Coordinate regional SMRS assets as requested by the local jurisdiction. • Participate with local jurisdictions during event planning and response as requested.
LOCAL	
Hospitals	• Be prepared to provide medical support, to include surge operations, as required during a special event.
EMS Systems	• Identify equipment and staffing needed during a special event. • Coordinate with regional hospitals concerning receipt of patients during special events.

Public Health	• Provide for inspections to assure proper sanitation practices and health codes are followed. • Inspect for appropriate storage and removal of liquid waste.
Emergency Management	• Develop and coordinate emergency response and management operations as required to support a special event. This may include organizing and deploying an incident command post. • Participate in an event planning team upon event organizer's request.

ANNEX K: SPECIAL MEDICAL NEEDS SHELTERING

The following organizations and agencies support efforts of the SHPR region to prepare for and provide support to special medical needs individuals as a result of a disaster in the region.

Local Agencies:	**Emergency Management**
	EMS Systems
	Fire and Police Departments
	Hospitals
	Management Entities
	Public Health Agencies
Regional Agencies:	**Southeastern Healthcare Preparedness Region**
State Agencies:	**Department of Public Safety**
	Division of Emergency Management
	Division of Public Health
	Office of Emergency Medical Services
Federal Agencies:	**Department of Defense**
	Department of Health and Human Services
	Department of Homeland Security
	Federal Emergency Management Agency
	Office of the Assistant Secretary for Preparedness and Response

OVERVIEW

Purpose

This annex outlines procedures and guidelines for regional support of Special Medical Needs (SMN) patients and Functional Needs Support Services (FNSS) sheltering operations. This annex does not address issues associated with SMN/FNSS sheltering as a result of coastal hurricane evacuation. Those issues are identified and outlined in the CRES-SOG.

Situation

The SHPR region is exposed to many hazards, all of which have the potential to create a situation in which SMN shelters are necessary. In general, SMN support begins at the local level and transitions to state and federal levels when the capacity to respond at the previous level has been exceeded. It also addresses challenges associated with the care

of SMN patients during a disaster through the identification and registration of these populations before an event.

SMN patients are defined as individuals with the following needs:

- Assistance during evacuations and sheltering because of physical or mental disabilities
- Level of care and resources beyond those available in mass care shelters for the general population

SMN individuals include the following:

- People with minor health/medical conditions who require observation, assessment, and maintenance which exceed the capability of the congregate shelter staff
- People with chronic conditions who require assistance with activities of daily living, or who need more skilled non-acute nursing care but do not require hospitalization

FEMA's interim document Guidance on Planning for Integration of Functional Needs Support Services in General Population Shelters greatly changes the local and regional role of emergency medical services as well as local health and human services provided in general population shelters. Functional Needs Support Services (FNSS) is defined as services that enable individuals to maintain their independence in a general population shelter. FNSS includes the following:

- Reasonable modification to policies, practices, and procedures
- Durable medical equipment (DME)
- Consumable medical supplies (CMS)
- Personal assistance services (PAS)
- Other goods and services as needed

Children and adults requiring FNSS may have physical, sensory, mental health, and cognitive and/or intellectual disabilities and require assistance. Others that may benefit from FNSS include women in late stages of pregnancy, elders, and people needing bariatric equipment.

SMN shelter requirements do not apply to individuals who receive care at an institution (e.g., hospitals, nursing homes or intermediate care facilities for persons with mental retardation). Those individuals require facility-to-facility transfers.

Within the SHPR region, a significant number of SMN individuals are not identified to local emergency management or ESF-8 agencies. The inability of jurisdictions to fully identify special medical needs populations prevents the full assessment of shelter resource requirements.

Planning Assumptions

- Special medical needs populations requiring assistance may vary depending on the impact area and nature of the event and may require regional and/or statewide intervention using resources from across the state.
- The decision to evacuate may occur at any time, day or night requiring the region to shelter SMN individuals.

- Resources within the affected area may be inadequate to support SMN populations.
- Transportation assets may be required for the movement of SMN individuals to areas with sufficient concentrations of support resources and available definitive medical care.

CONCEPT OF OPERATIONS

Caring for SMN individuals is a local government responsibility supported by local public health, regional and state agencies, local emergency management, and voluntary organizations. The responsibility, direction, control, and coordination of functional need support services as well as SMN shelters require a cooperative effort from many agencies within the region. Within the SHPR region, the following local authorities have direction and control over general population shelters, functional need support services, and SMN shelters:

- Local emergency management
- Local public health agencies
- Local management entities
- Local American Red Cross

County emergency management, supported by local public health agencies, the medical community, and local management entities, will work with response agencies to create a SMN registry that will allow emergency managers and ESF-8 planners to accurately assess resource requirements and allow for timely evacuations and sheltering of medically fragile populations. This list will be maintained by the local public health agency and updated at a minimum annually (or more often if necessary). The listing will be shared with all local stakeholders and the SHPR Healthcare Preparedness Manager.

When an event exceeds the capabilities of the local jurisdiction and the resources available through mutual aid agreements, the Healthcare Preparedness Manager can help coordinate support.

The North Carolina Office of Emergency Medical Services serves as the lead ESF-8 agency within North Carolina and is responsible for the structure, operations, management, and staffing of state medical support shelters.

ORGANIZATION AND ASSIGNMENT OF RESPONSIBILITIES

Agency/Department/Position	Responsibilities
STATE	
North Carolina Office of Emergency Medical Services	• Provide leadership in coordinating and integrating state efforts that provide shelter assistance for SMN and FNSS to a disaster-affected area. • Coordinate and direct the activation and deployment of state resources of medical personnel, supplies,

	equipment, and pharmaceuticals (with public health as needed) to support shelter operations in support of SMN and FNSS. • Assist in the development of local capabilities for the onsite coordination of all emergency medical services needed for sheltering special medical needs populations.
North Carolina Division of Public Health – Public Health Preparedness & Response (PHP&R)	• Direct and coordinate the activation and deployment of personnel, supplies, and equipment in response to requests for state assistance. • Provide guidance and assistance to local public health departments, emergency management, healthcare entities and voluntary or faith based organizations in regards to SMN and FNSS operations.
North Carolina Division of Emergency Management	• Activate and manage the state's Response Section within the SERT. The section will 1) serve as the direct contact with FEMA for all response operations; 2) ensure that individuals and families have access to state and federal programs in the aftermath of a disaster; 3) develop and maintain partnerships with state, federal and voluntary organizations that deliver resources to disaster victims; and 4) help citizens, state and local officials, and business leaders reduce the impacts of an event that overwhelms local and regional capabilities.
REGIONAL	
Southeastern Healthcare Preparedness Region	• Assist with coordination of care of SMN and FNSS populations. • Report to North Carolina Office of Emergency Medical Services on shelter requirements in the region. • Serve as a liaison between local ESF-8 agencies and the state, coordinating SHPR ESF-8 resources. • Assist local and state governments in effective development of shelter priorities as they apply to SMN and FNSS. • Identify non-medical resources that may be used to shelter SMN individuals. • Assess ability to augment or provide needed personnel, equipment, and services upon request.

LOCAL/OTHER	
Hospitals	• Assess ability to support other regional facilities and agencies during a disaster under mutual aid agreements.
EMS Systems	• Assess ability to support other regional facilities and agencies during a disaster under mutual aid agreements.
SMAT III	• Assess ability to support other regional facilities and agencies during a disaster under mutual aid agreements.
Public Health	• Assist in the identification and operation of SMN shelters. • Respond to the requirements of the local incident commander or county emergency operations center. • Assist with the identification of special medical needs populations. • Provide for inspections of mass care facilities to assure proper sanitation practices and health codes are followed.
Emergency Management	• Work with local, regional, and state emergency management, emergency medical, and public health agencies (to include the SHPR Healthcare Preparedness Manager) to identify SMN/FNSS shelters and address related issues and priorities.

ANNEX L: STATE MEDICAL RESPONSE SYSTEM

The following organizations and agencies support the State Medical Response System (SMRS).

Local Agencies	**Emergency Management**
	EMS Systems
	Fire and Police Departments (Municipal and County)
	Hospitals
	Management Entities
Regional	**Southeastern Healthcare Preparedness Region**
State Agencies	**Department of Public Safety**
	Division of Public Health - Public Health Preparedness & Response (PHP&R)
	Office of Emergency Medical Services
Federal Agencies	**Department of Defense**
	Department of Health and Human Services
	Department of Homeland Security
	Federal Emergency Management Agency (FEMA)
	Office of the Assistant Secretary for Preparedness and Response

OVERVIEW

Purpose

This annex defines the State Medical Response System (SMRS).

Situation

Local, regional, and state agencies in North Carolina have collaborated to form the SMRS to maintain medical services and strengthen the continuity of healthcare in communities affected by disasters. The following agencies represent the core systems responsible for coordinating health and medical service response during disasters:

- North Carolina Office of Emergency Medical Services (NCOEMS)
- North Carolina Division of Emergency Management (NCEM)
- North Carolina Division of Public Health - Public Health Preparedness & Response (PHP&R)

The SMRS is supported by these agencies to ensure that treatment and prevention strategies are in place and appropriate levels of disease surveillance and medical preparedness are available to communities during disasters.

Planning Assumptions

- Resources within the affected disaster area may be inadequate to triage casualties from the scene and/or treat them in local hospitals.
- Primary medical treatment facilities may be damaged or inoperable. Assessment and emergency restoration to necessary operational levels is a basic requirement to stabilize the medical support system.

CONCEPT OF OPERATIONS

As stated in the base plan, decisions to initiate a request for state assistance in managing medical response events are made on a community-by-community basis by local health authorities in coordination with local medico-legal authorities, elected officials, and emergency management coordinators. Requests for the assistance of the SMRS will follow the processes established in the Medical Resource Management section of the base plan's concept of operations.

As stated above, the state of North Carolina has developed the SMRS in order to maintain medical services and strengthen the continuity of healthcare. The SMRS consists of, but is not limited to, the following components:

- State Medical Assistance Team (SMAT) II
- State Medical Assistance Team (SMAT) III
- Medical Reserve Corps (MRC)
- Specialty Teams:
    - State Mortuary Operations Response Task Force (SMORT)
    - Healthcare Facility Rapid Assessment Team (HFRAT)
- Mobile Disaster Hospital

STATE MEDICAL RESPONSE SYSTEM COMPONENTS

SMAT II

Type II SMATs are hospital-based teams designed to assist in the provision of patient decontamination, mass medical care, alternate care facilities, and mass drug distribution points. North Carolina currently has eight (8) Type II SMAT, each affiliated with a Level I Trauma Center and a HCC.

As part of the SMRS, a SMAT II focuses on hospital-based capabilities (e.g. surgical services) and is responsible for patient treatment and surge capacity needs of communities on the local, regional, and state levels. Response time is mission specific but no later than 24 hours from notification. Specific capabilities include the following:

- Assistance in hospitals
- Assistance in the establishment of a 40-bed alternate care facility
- Assistance in the establishment of a mass immunization/drug distribution center
- Provision of responder treatment and rehabilitation
- Establishment of a field medical station
- Provision of technical decontamination and medical care

In addition to medical professionals (e.g. physicians, nurses, EMS professionals, nurse practitioners, physician's assistants, pharmacists, respiratory therapists), these teams consist of medical support staff (e.g. technicians, administration), mental health professionals (e.g. psychiatrists, licensed clinical social workers), public health professionals, interpreters, and other support staff (e.g. engineers, truck drivers). Also, each SMAT II houses a standardized mobile package that includes the basic equipment needed for a response. Current locations of these teams and their affiliated trauma centers and HCCs are listed below:

Jurisdiction	Trauma Center	Healthcare Coalition
Wake County	WakeMed	Capital Rac
Mecklenburg County	Carolinas Medical Center	Metrolina Healthcare Preparedness Coalition
Durham County	Duke University Hospital	Duke Healthcare Preparedness Coalition
Buncombe County	Mission Hospitals	Mountain Area Healthcare Preparedness Coalition
New Hanover County	New Hanover Regional Medical Center	Southeastern Healthcare Preparedness Region
Pitt County	Vidant Medical Center	Eastern Healthcare Preparedness Region
Forsyth County	WFU Baptist / Moses Cone	Triad Healthcare Preparedness Coalition
Orange County	University of North Carolina Health Care	Mid-Carolina Healthcare Preparedness Coalition

SMAT III

Type III SMATs are county-based teams designed to be the first line of response in support of local agencies in the event of a decontamination or mass medical care event.

North Carolina currently has twenty-nine (29) Type III SMATs, and each team is affiliated with a county EMS system, fire department, or other county-level emergency response agency.

As part of the SMRS, SMAT III can be activated to provide rapid victim decontamination and mass casualty medical care on a local, regional, or statewide level. Response time is mission specific and expected one to six hours from notification. Specific capabilities include the following:

- Provision of medical treatment and triage
- Assistance at hospitals
- Provision of rapid (gross) decontamination
- Provision of responder treatment and rehabilitation

Teams are composed of paramedics, Emergency Medical Technicians, other medical professionals and support staff. Similar to the SMAT II, each SMAT III houses a standardized mobile package that includes the basic equipment needed for a response. Current locations of these teams are listed below:

Jurisdiction	Agency	Jurisdiction	Agency
Buncombe County	Buncombe County	**Orange**	Orange County
Burke County	Burke County	**Person**	Person County
Catawba County	Catawba County	**Randolph**	Randolph County
Cleveland County	Cleveland County	**Surry**	Surry County
Eastern Band of the Cherokee Tribe	Swain County	**Brunswick**	Brunswick County
Gaston	Gaston County	**Wilson**	Wilson County
Henderson	Henderson County	**New Hanover**	New Hanover County
Mecklenburg	Mecklenburg County	**Onslow**	Onslow County
Stanly	Stanly County	**Pender**	Pender County
Watauga	Watauga County	**Pasquotank**	Pasquotank County
Davidson	Davidson County	**Washington**	Washington County

Guilford	Guilford County	**Orange**	Orange County
Halifax	Halifax County	**Person**	Person County
Harnett	Harnett County	**Randolph**	Randolph County
Hoke	Hoke County	**Surry**	Surry County
Nash	Nash County		

Medical Reserve Corps

The Medical Reserve Corps (MRC) in North Carolina consists of county and region-level teams of medical and non-medical volunteers organized to strengthen community preparedness and resilience in response to disasters and local emergencies. During these events, MRC units can provide specialized and general support personnel to local response organizations. There are currently eighteen (18) MRC units, each affiliated either on a local level with county governments (10) or on a regional level with a HCC (8). Together these units provide support to every county throughout the state.

As part of the SMRS, MRC units are deployed to restore medical care and meet medical surge needs. Units pre-identify, credential, train, and activate pools of medical and public health volunteers on a local, regional, or state level. Once requested, units may be activated through NCTERMS by their affiliates in coordination with their MRC unit leaders. For statewide responses, MRC units may be activated by the North Carolina Office of Emergency Medical Services. Response time is mission specific. Specific capabilities include the following:

- Recruiting, credentialing, and training pools of volunteer personnel with specific capabilities
- Provision of operational and administrative support for the following:
    - Local public health/medical initiatives and emergency response
    - Regional SMAT II
    - Statewide disaster response

Volunteers are registered on NCTERMS according to their specific capabilities and credentials. Teams are typically composed of physicians, physician assistants, nurse practitioners, nurses, pharmacists, dentists, veterinarians, mental health professionals, EMS professionals, respiratory therapists, public health professionals, and other individuals without traditional public health/medical skill sets. Current locations of these teams are listed below:

Jurisdiction	Team	Jurisdiction	Team
Metrolina HPC	Metrolina MRC	**Carteret County**	Carteret MRC
Duke HPC	Duke MRC	**Chatham County**	Chatham MRC
Mountain Area Trauma HPC	Mountain Area Trauma MRC	**Durham County**	Durham MRC
Southeastern HPR	Southeastern MRC	**Moore County**	Moore MRC
Eastern HPC	Eastern MRC	**Northeast Counties**	Northeast NC MRC
Triad HPC	Triad MRC	**Onslow County**	Onslow MRC
Mid-Carolina RHC	Mid-Carolina MRC	**Orange County**	Orange MRC
Capital Area HPC	Capital Area MRC	**Wake County**	NC Baptist Men
Alamance County	Alamance MRC		
Brunswick County	Brunswick MRC		

ORGANIZATION AND ASSIGNMENT OF RESPONSIBILITIES

Agency/Department/Position	Responsibilities
STATE	
North Carolina Office of Emergency Medical Services	• Coordinate the deployment of SMRS resources as required. • Provide leadership in coordinating and integrating the overall state efforts that provide medical assistance to a disaster-affected area. • Assist in the onsite coordination of all emergency medical services needed for triage, treatment, transportation, tracking, and evacuation of the affected population. • Establish and maintain the cooperation of the various state medical and related professional organizations in coordinating the movement of EMS resources from unaffected areas to areas of need. • Coordinate with the SERT to provide support for military installations and/or tribal nations. • Coordinate medical sheltering by implementing the State Medical Support Shelter Plan.

North Carolina Division of Public Health – Public Health Preparedness & Response (PHP&R)	• Protect the health and safety of residents and visitors within the state before, during, and after public health emergencies.
North Carolina Division of Emergency Management	• Manage and operate the state emergency operations center. • Approve requests for activation of the North Carolina SMRS. • Activate and manage the state's Response Section within the SERT. The section will 1) serve as the direct contact with FEMA for all response operations; 2) ensure that individuals and families have access to state and federal programs in the aftermath of a disaster; 3) develop and maintain partnerships with state, federal and voluntary organizations that deliver resources to disaster victims; and 4) help citizens, state and local officials, and business leaders reduce the impacts of an event that overwhelms local and regional capabilities.
REGIONAL	
Southeastern Healthcare Preparedness Region	• Assist in the coordination of all region ESF-8 resources during a disaster. • Assist in the coordination of HCC disaster activities during any SMRS deployment or other event where the North Carolina Office of Emergency Medical Services activates the SMRS assets and/or resources. • Serve as a regional liaison between local ESF-8 agencies and the state, assisting in the coordination of HCC ESF-8 resources. • Assist in the coordination of regional SMRS assets and report gaps that would affect deployment. • Coordinate and manage the response of regional SMRS assets.
LOCAL	
Emergency Management	• Transmit requests for assistance through the appropriate branch office to the state emergency operations center.

ANNEX M: PEDIATRIC SURGE EVENT

SEPARATE DOCUMENT

ANNEX N: BURN SURGE EVENT

TO BE DEVELOPED

ANNEX O: CHEMICAL EXPOSURE SURGE EVENT

TO BE DEVELOPED

ANNEX P: RADIOLOGICAL EXPOSURE SURGE EVENT

TO BE DEVELOPED

AUTHORITIES AND REFERENCES

AUTHORITIES

North Carolina General Statutes

Chapter 166A

Chapter 166A titled the North Carolina Emergency Management Act, December 1987, sets forth the authority and responsibilities of the governor, state agencies, and local government for emergency management in North Carolina. Under 166A-5(2), the secretary of the North Carolina Department of Crime Control and Public Safety is made responsible to the governor for all state emergency management activities. The North Carolina Division of Emergency Management fulfills this role for the Secretary.

Chapter 130A

Chapter 130A establishes public health law of North Carolina. § 130A-145 establishes direction for quarantine and isolation authority. The state health director and a local health director are empowered to exercise quarantine and isolation authority.

Executive Orders

Executive order 9

Executive order 9, dated March 3, 2009, establishes the criteria necessary for the North Carolina Department of Health and Human Services to ensure the public health and safety of critically sick and injured patients requiring emergency medical care.

Memoranda of Agreement/Understanding

North Carolina Statewide Emergency Management Mutual Aid and Assistance Agreement

This mutual aid and assistance agreement, dated January 2009, provides agreement for reciprocal emergency management aid and assistance within the state.

State of North Carolina and the American Red Cross

This memorandum of understanding, dated August 23, 1985, provides for cooperation and coordination between the American Red Cross (ARC) and the state of North Carolina and its agencies in the event of technological and natural disasters and emergencies. The ARC is a member of the SERT and actively participates with the division in its emergency preparedness efforts.

The State of North Carolina and the National Disaster Medical System (NDMS)

The federal government and the state agreed on July 9, 1990, to work closely to ensure effective operation of the NDMS within the state. The state, through the North Carolina Division of Emergency Management, agreed to participate in annual exercises of NDMS to test the effectiveness of the plans.

Federal Laws and Directives

Americans with Disabilities Act of 1990, As Amended

This act is a wide-ranging civil rights law that prohibits, under certain circumstances, discrimination based on disability. It affords similar protections against discrimination to Americans with disabilities as the Civil Rights Act of 1964.

Emergency Management Assistance Compact, 1996

EMAC is a national interstate mutual aid agreement that enables states to share resources during times of disaster. Ratified by the 104th Congress, EMAC is a national system used for providing mutual aid through operational procedures and protocols that have been validated through experience. EMAC is administered by the National Emergency Management Association (NEMA).

Emergency Medical Treatment and Active Labor Act (EMTALA),

Enacted under Section 1867(a) of the Social Security Act, within the section of the U.S. Code which governs Medicare. EMTALA is the statute which governs when and how a patient may be (1) refused treatment or (2) transferred from one hospital to another when he is in an unstable medical condition. EMTALA was passed as part of the Consolidated Omnibus Budget Reconciliation Act of 1986, and it is sometimes referred to as "the COBRA law".

Hazardous Materials Transportation Uniform Safety Act (HMTUSA), 1990

Enacted by Congress, this act rewrote the standards for determining when federal law preempts state regulations pertaining to hazardous materials transportation. The pre-emption provision provides for pre-emption of any state requirement that as applied or enforced creates an obstacle to the accomplishment and execution of the HMTUSA of the Hazardous Materials Regulations.

Homeland Security Presidential Directive 3, Homeland Security Advisory System

Creates a Homeland Security Advisory System to inform all levels of government and local authority, as well as the public, to the current risk of terrorist acts. The System involves a five-level, color-coded Threat Condition indicator to correspond to the current situation. Agency-specific Protective Measures associated with each Threat Condition will allow a flexible, graduated and appropriate response to a change in the nation’s level of risk.

Homeland Security Presidential Directive 5, Management of Domestic Incidents

Serves to enhance the ability of the United States to manage domestic incidents by establishing a single, comprehensive National Incident Management System. This

management system is designed to cover the prevention, preparation, response, and recovery from terrorist attacks, major disasters, and other emergencies. The implementation of such a system would allow all levels of government throughout the nation to work efficiently and effectively together.

Homeland Security Presidential Directive 8, National Preparedness

Establishes policies to strengthen the U.S. preparedness in order to prevent and respond to threatened or actual domestic terrorist attacks, major disasters, and other emergencies. The directive requires a national domestic all-hazards preparedness goal, with established mechanisms for improved delivery of Federal preparedness assistance to State and local governments. It also outlines actions to strengthen preparedness capabilities of federal, state, and local entities.

Homeland Security Presidential Directive 9, Defense of United States Agriculture and Food

Establishes a national policy to defend the agriculture and food system against terrorist attacks, major disasters, and other emergencies. The directive lays out policies, including roles and responsibilities, awareness and warning, and vulnerability assessments, to provide the best protection possible against a successful attack on the U.S. agriculture and food system.

Pandemic and All-Hazards Preparedness Act (PAHPA)

Became public law number 109-417 on December 19, 2006 and amends the Public Health Service Act to require the Secretary of Health and Human Services to lead all federal public health and medical response to public health emergencies and incidents covered by the National Response Plan.

The Robert T. Stafford Disaster Relief and Emergency Assistance Act Public Law 93-288, as amended

The Stafford Act is the primary federal disaster relief legislation which allows for federal response and enables grant assistance to be given to individuals and public entities in the event of a major disaster declaration by the president. All grant assistance from the federal government is administered by the North Carolina Division of Emergency Management. Since 1985, over $100 million in disaster relief to state and local governments and private non-profit entities has been administered by the division.

National Earthquake Hazards Reduction Program Reauthorization Act, Public Law 101-614

This act provides grants and technical assistance to states to develop preparedness and response plans and inventories, to conduct seismic safety inspections, update building and zoning codes and ordinances, to increase earthquake awareness and education, and to encourage the development of multi-state groups for such programs.

The National Emergencies Act, (50 U.S.C. 1601-1651)

Passed in 1976 to stop open-ended states of national emergency and formalize the power of Congress to provide certain checks and balances on the emergency powers of the president. The act sets a limit of two years on states of national emergency. It also imposes certain "procedural formalities" on the President when invoking such powers.

44 CPR Parts 59-76, National Flood Insurance Program and Related Regulations

These regulations establish the minimum federal requirements that must be adopted by local governments to regulate new construction, substantial improvements, repairs and rehabilitation to structures within the flood hazard areas of local jurisdictions. It also establishes the policy for the insurance regulations and amounts of coverage available.

Clean Air Act Amendments of 1990, Public Law 101-549

This act helps prevent air pollution and reduces the pollutants currently in the air. Fixed facilities' chemical accident protection programs and risk management planning should be integrated into the state's EOP activities under SARA Title III.

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LOCAL

- All county emergency operations plans
- All hospital operations plans
- All hospital critical resource plans
- All county public health plans
- EMS systems protocols, policies, and guidelines

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ACRONYMS

AAR	After Action Reports

ARC	American Red Cross
CBRNE	Chemical, Biological, Radiological, Nuclear, Explosive
CCP	Crisis Counseling Program
CHC	Community Health Center
CI/KR	Critical Infrastructure/Key Resources
CISM	Critical Incident Stress Management
CMS	Consumable Medical Supplies
CRES-SOG	Coastal Region Evacuation and Sheltering Standard Operating Guide
DD	Developmental Disabilities
DHHS	Department of Health and Human Services
DME	Durable Medical Equipment
DMH	Division of Mental Health
DMORT	Disaster Mortuary Operational Response Team
DPH	North Carolina Division of Public Health
EEI	Essential Elements of Information
EM	Emergency Management
EMAC	Emergency Management Assistance Compact
EMTALA	Emergency Medical Treatment and Active Labor Act
EMT-B	Emergency Medical Technician – Basic
EMT-I	Emergency Medical Technician – Intermediate
EMT-P	Emergency Medical Technician – Paramedic
EOC	Emergency Operations Center
EOP	Emergency Operations Plan
ERR	Emergency Response and Recovery
HPC	Healthcare Preparedness Coordinator/Manager

ESAR/VHP	Emergency System for Advance Registration of Volunteer Health Professionals
ESF	Emergency Support Function
FAC	Family Assistance Center
FEMA	Federal Emergency Management Agency
FEMA-ERT	Emergency Management Agency Emergency Response Team
FNSS	Functional Needs Support Services
GP	General Population
HAZMAT	Hazardous Materials
HIPAA	Health Insurance Portability and Accountability Act
HPP	Hospital Preparedness Program
HVAC	Heating, Ventilating, and Air Conditioning
LHD	Local Health Departments
LME	Local Management Entity
LRC	Local Receiving Sites
MAA	Mutual Aid Agreements
MCI	Mass Casualty Incident
MEO	Medical Examiner’s Office
MFI	Mass Fatality Incident
MHTD	Multi-Hazard Threat Database
MOU	Memorandum of Understanding
MR	Medical Responder
MRC	Medical Reserve Corps
NC DETECT	North Carolina Disease Event Tracking and Epidemiologic Collection Tool
NC HAN	North Carolina Health Alert Network

NCDEM	North Carolina Division of Emergency Management
NCDOT	North Carolina Department of Transportation
NCEDSS	NC Electronic Disease Surveillance System
NDMS	National Disaster Medical System
OEMS	Office of Emergency Medical Services
PAS	Personal Assistance Services
PH	Public Health
PHCC	Public Health Command Center
PHE	Public Health Epidemiologist
PHP&R	Public Health Preparedness & Response
POD	Points of Dispensing
PPE	Personal Protective Equipment
PSAP	Public Safety Answering Points
HCC	Healthcare Coalition
RHC	Rural Health Center
RN	Registered Nurse
RRT	Rapid Response Team
RSS	Receipt, Staging, Storing
SARS	Severe Acute Respiratory Syndrome
SAS	Substance Abuse Services
SERT	State Emergency Response Team
SITREP	Situation Report
SMAT	State Medical Assistance Team
SME	Subject Matter Expert
SMN	Special Medical Needs

SMORT	State Mortuary Operations Response Task Force
SMRS	State Medical Response System
SMSS	State Medical Support Shelters
SNS	Strategic National Stockpile
SOP	Standard Operating Procedure
SORT	Special Operations Response Team
TIC	Toxic Industrial Chemical
UHF	Ultra High Frequency
VHF	Very High Frequency
VOAD	Volunteer Organizations Active in Disasters
WMD	Weapons of Mass Destruction