Tab 12 – Mass Patient Care System / Shelter

Barren River District Health Department's role in Mass Patient Care System/shelter is limited to Communicable Disease & Environmental Surveillance. The Red Cross is the ESF-6 lead for general shelters. Whenever a Mass Patient Care System/shelter is set up the local & state health departments are responsible for monitoring and maintaining the public's health. In order to accomplish this BRDHD will take the lead role in surveying the health, environment, & medical status of people in the Mass Patient Care System/shelter. Several discrete and easy-to-follow steps are outlined below which will allow BRDHD to maintain vigilance and control over the public health situation in the shelter.

NOTE: Before an official Mass Patient Care System/Shelter is opened in our district the site has to be inspected and approved by a Public Health Environmentalist.

Steps for Setting up Shelters

Steps to follow in setting up and maintaining environmental and medical surveillance in sheltered populations:

I. **Identify where people are sheltered**
A.   Obtain information from State Health Operations Center / State EOC / Local EOC or Emergency Management Agency on shelters they know of *(Phone Number and/or contact person).Annex F (or ESF-6) in each County EOP will have locations that American Red Cross has identified for mass shelters.*
B.   Compile a list of shelters with addresses, directions, and phone contact information.

II. **Prepare cover letter and documents for shelter staff**
A.   Using Word, insert the names and contact information for the primary and secondary BRDHD contacts on the BRDHD Contact Sheet/Cover Letter. Can handwrite or do electronically (recommended).
1.   Primary contact will be either Environmental or Regional Epidemiologist/CD team nurse.
2.   Whichever discipline takes primary contact role; the other discipline should serve as secondary contact.
B.   Insert 24-hour BRDHD contact information also.
C.   Make sufficient copies of BRDHD Contact Sheet and Medical advice for people managing the shelters for the shelter as well as for distribution to individual families who might be sheltering evacuees if the shelter (church, civic organization) deems this appropriate.
D.   Make sufficient copies of shelter guidance documents for distribution to all shelters in BRDHD jurisdiction. These are for shelter staff so for small shelters one or two copies should be adequate. Allow more copies as shelter size increases.

1.   Food Service Guidelines For Emergency Shelters,
2.   Shelter Infection Control Practice Guidelines, and

3.   [Identifying and Preventing TB in Shelters](#)

III. **Prepare adequate copies of all other documents for use with the shelter residents:**

A.   [Medical & Public Health Needs Assessment Form](#) (1 for each resident)

B.   [Natural Disaster Morbidity Report Form](#) (I for each sick resident)

C.   [BRDHD Environmental Surveillance Form for Shelters](#) (1 each shelter)

D.   [Dear Shelter Resident](#) (Welcome letter from BRDHD to residents)

IV. **Protocol for first visit to shelter**

I.   Call first, if possible, to arrange a time for the initial visit, otherwise visit the shelter directly.

II.   Meet with shelter staff.

1.   Take along documents listed in II A & D, and III A-C above.

2.   Discuss with staff the goals and responsibilities of the health department with respect to the residents and shelter and offer our assistance and service.

✓   Monitoring health of residents and the community.

✓   Detecting and controlling disease events and other public health events.

✓   Making sure residents are in a safe environment.

✓   Plugging residents into system to access resources they might need (e.g., DCBS, MH/MR, Medicaid)

3.   Provide shelter staff with documents in II A (and sufficient copies for II C. purposes above) and go over with them.

4.   Identify specific contact persons at the shelter and record their 24-hour contact information.

III.   Make sure [Medical & Public Health Needs Assessment](#) Form is filled out for each resident - if manpower is limited; do at least for those with health/medical needs. Please ask the shelter healthcare providers to fill the [Natural Disaster Morbidity Report Form](#) for those who seek medical assistance.

IV.   Conduct environmental assessment using [Environmental Surveillance Form for Shelter.](#)

V.   Conduct shelter medical surveillance assessment using [Natural Disaster Morbidity Report Form](#) & [Aggregate Natural Disaster Morbidity Report Form](#)

VI.   Address any environmental or health concerns identified:

1.   *Environmental* – plan to resolve problem by specific date (immediately if warranted).

Disease – Isolate and/or refer to physician as needed, follow usual disease investigation, confirmation, reporting, and intervention procedures.

VII.   In case of any death, use the Disaster-related Mortality Surveillance Form- Complete one form per decedent.

VIII.   Submit completed forms to KY DPH:

Via email: chfsdphdoc@ky.gov   OR

H:\Disaster Preparedness\All Hazard Plan\BRDHD All Hazards Plan\BRDHD All Hazards Plan 2022\12 - Tab and Appendices-Mass Patient Care

Via fax: Primary   (502) 696-5852   Secondary (502) 564-4387

V. **Ongoing surveillance**

The purpose of this reporting mechanism is to:

A.   Set up a regular system of contact between Barren River District Health Department and shelters,

B.   Provide a standardized method of monitoring shelters for disease or other public health issues, and

C.   To have a system of verification that we are monitoring all known shelters to the best degree possible.

Implementation:

a)   A communicable Disease Nurse/Epidemiologist with an Environmentalist should visit each shelter at least twice weekly per week - more frequent for shelters housing over 50 individuals. Complete surveillance forms each time.

b)   Conduct environmental and medical surveillance each time.

c)   Submit completed forms Aggregate Natural Disaster Morbidity Report Form to KY DPH on a daily/24 hour basis:

Via email: chfsdphdoc@ky.gov   OR

Via fax: Primary   (502) 564-0477   Secondary (502) 564-4387

The information gathered should be reviewed by BRDHD CD Team/Regional Epidemiologist/ ERRT members to monitor disease trends, look for potential outbreak situations, and to intervene in potential outbreak situations at the earliest point to avoid further spread of disease.

If disease, injury, or other health issues arise, usual disease investigation, confirmation, reporting, and intervention procedures to be followed. The steps could include but not limited to things like refer patient(s) to physician, obtain clinical and/or lab confirmation, submit KY's Reportable Disease Form to the Surveillance Branch or enter into KY-EPHRS, conduct contact investigation and intervene as warranted like prophylaxis of close contacts etc. To be particularly alert for diseases with high impact on certain populations (e.g., Pertussis, influenza, measles) and unusual diseases that may arise due to the exposures of the population (e.g., West Nile Virus, chemical exposure effects, and even the possibility of malaria).

Follow-up:

Should diseases of concern be noted, the information will be collected into an Access database saved in the CD team folder on the H drive, and will be reported to Department for Public Health via KY-EPHRS.

Depending on the disease these patients will be followed up as per guidelines received from DPH and CDC. Should the patient be in any healthcare setting, we would monitor the situation through communication with Hospital Infection Control Practitioners, and make appropriate recommendations for Isolation/Quarantine. In situations like Active

Tuberculosis we would follow up patients with Direct Observed Therapy (refer to Kentucky State Protocol for TB, BRDHD TB Program Guidelines)

In case of questions or emergency, do not hesitate to contact **the Division of Epidemiology and Health Planning at the regular day time number (502) 564-7243 or Reportable Disease (after hours) line, 888-9-REPORT, or (502) 564-3418.**

VI. Additional Notes
A. Remind shelters not to accept homemade food items, such as canned goods.
     B. Be sure that the sewage system is adequate.
     C. Check that the ice is not contaminated.
     D. Keep diapering areas away from food preparation areas.
E. Make sure ample hand washing is emphasized and adequate hand- washing facilities are available.

If you have an outbreak or suspicious illness of any sort, handle as you would in your normal daily operation reporting cases through the normal channels.

Message to LHD Staff for monitoring all shelter activations across the BRDHD jurisdiction

Public Health Monitoring in Shelters:
In order to meet our public health mission to monitor the health and welfare of all people in BRDHD jurisdiction, we need to track the health of individuals in shelters that may open up across the BRDHD jurisdiction. To do this, we have to do several things:

1.   Survey our community regularly to identify new shelters as they open. Any facility that self-defines as a shelter, or that is "sheltering" individuals, qualifies as a shelter.
2.   Report any new shelters to the KY DPH Department Operations Center (DOC) via email at CHFSDPHDOC@ky.gov with the subject line "**Shelter Opening**". Please submit shelter name, sponsoring organization, address, phone number, and contact name for the shelter.
3.   Approach shelter administration and medical staff about the surveillance process including the initial and daily environmental shelter assessments and daily morbidity report forms.
4.   Assign an Environmentalist to conduct an initial Environmental Shelter Assessment upon opening of the shelter followed by daily environmental assessments until KY DPH DPHPS advises fewer assessments. Document violations and follow up to rectify violations.
5.   Instruct shelter medical staff on correct use of the individual morbidity report form and aggregate morbidity report form.
6.   Arrange a process and point of contact to ensure that morbidity data is collected.
7.   Collect an aggregate form from EACH shelter daily and then fill in an OVERALL aggregate morbidity report form with data from ALL shelters in your jurisdiction for

H:\Disaster Preparedness\All Hazard Plan\BRDHD All Hazards Plan\BRDHD All Hazards Plan 2022\12 - Tab and Appendices-Mass Patient Care

submission to the state DOC daily. (Alternatively, you could collect individual encounter forms from a shelter daily and complete the aggregate form for them).

Please submit all environmental assessment and morbidity (disease or injury) surveillance forms to the CHFS Department Operations Center via email at CHFSDPHDOC@ky.gov or via fax at 502-564-0477. If emailing, please put, "Shelter Surveillance" or "Shelter Environmental Assessment" in the Subject Line for quick reference in the DOC.

Medical advice for people managing the shelters

Many people seeking shelter may require medical assistance due to conditions that pre-existed the event and those that may be a result of the event in affected areas.
As a result, careful attention to the medical needs of these persons should be a priority upon their admittance to a temporary shelter here in the Commonwealth. In addition, care should be taken in the shelter to prevent the spread of disease in a congregate living setting.

Upon arrival, all new residents should be given a brief health screening, which includes:
1)   A health history:
●   Location of previous residence
●   Known existing health conditions and medications
●   Type of exposure to unclean water and length of exposure, especially if non-potable   water or fluids were ingested
Immunization history (if known), especially concerning tetanus vaccination
●   Existing wounds
●   Recent symptoms, such as fever, diarrhea, vomiting or bad cough
●   Signs and symptoms of dehydration
2)   Vital signs
3)   Directed physical inspection for:
●   Open sores
●   Skin rashes
If those entering shelters have fever, cough, rash, oozing open sores, vomiting, diarrhea, or signs or symptoms of dehydration, they should be evaluated with a more thorough medical work-up. Folks who usually receive medications for chronic illness should also receive medical attention soon after arrival, especially if they are running short on or are out of medicines. To help with drug costs, pharmaceutical patient assistance programs can be considered. If persons have open wounds, which have been directly exposed to, floodwaters and five years have elapsed since their last tetanus vaccination; they should receive another tetanus booster. Tetanus boosters can be obtained through local health departments.

Persons who ingested contaminated fluids may be at risk for bacterial and viral dysenteries, hepatitis A, and other diseases, which are transmitted oral-fecally, so shelter personnel should be looking out for signs and symptoms of these diseases.

Guidance for preventing infection control in shelters includes:
●   Separating beds/cots by at least 3 feet
●   Providing appropriate hand washing facilities--- complete with anti-bacterial soap, warm, water and disposable towels
●   Encouraging frequent hand washing
●   Discouraging sharing of personal items and eating/drinking/smoking after others

Alternate Care Sites (ACS)

I. Introduction and Background
An Alternate Care Treatment Facility (ACF) is a fixed or field location where medical care ranging from episodic medical services to in-patient hospital care is provided. These facilities are commissioned when a community's routine health care resources are overwhelmed by patient demand usually the result of some extraordinary event such as a disaster, pandemic or other circumstance.

ACFs (also known as Alternate Care Sites) may also be part of a Special Medical Needs Shelter, especially in an extended sheltering situation. ACF may be established at sites where no medical care is usually provided or at medical facilities where the usual scope of medical services does not include large-scale urgent care or traditional inpatient services. Most ACFs will be selected from existing sites of convenience, although temporary structures may be erected by responding partners such as the federal government. ACFs are only to be established during emergencies or anticipated high-risk events (e.g. political conventions).

Establishment of operational ACFs may be necessary as part of Barren River District's medical response to disasters or other public health events. ACFs may have utility when:

1)   Surges in patients overwhelm regional ambulatory care and hospital capacity to adequately care for those in need and timely evacuation to other regions is not possible. Examples: epidemic, large scale toxic inhalation.

2)   Damaged medical infrastructure results in regional ambulatory care and hospital capacity which is insufficient to adequately care for those in need and timely evacuation to other regions is not possible. Examples: earthquake without large numbers of serious injuries, flooding.

3)   Combination of 1 and 2. Examples: earthquake with many serious injuries, nuclear device detonation

ACF models recognize that hospitals are the focal point for the care of critically ill patients. However, pandemic preparedness is enhanced by using multiple models of ACFs in an integrated system. Among tactical considerations for use of ACFs are:

● 	Expansion of ambulatory care by creating ACF facilities for non-infected patients;
● 	Establishment of ACFs as primary triage sites and influenza clinics to offer initial assessment and limited supportive care for suspected influenza patients;
● 	Using ACFs for convalescent care for recovering influenza patients who are unable to care for themselves at home;
● 	Challenges posed to establishing ACFs that can safely provide additional mechanical ventilation;
● 	Addressing the shortage of trained personnel for ACFs.*

The shortage of trained personnel for ACFs may be addressed by VA Hospitals through the Disaster Emergency Medical Personnel System.

II. Purpose and Objectives
Alternate Care Facility Objectives (Select objectives may not be applicable for some events):

1)	To deliver medical care for a surge of patients who have disaster-related acute illnesses or injuries (non-immediate life-threatening) and who cannot be adequately and timely cared for by a healthcare system.
2)	To deliver urgent care for both disaster-related and –unrelated medical conditions to offload Emergency Departments (ED) and ambulatory care clinics, so that these sectors can maximize care for other patient needs.
3)	To deliver sufficient non-complex care which is traditionally provided in inpatient settings to offload acute care hospitals to maximize care for more seriously ill patients with potentially survivable conditions.
4)	To triage large numbers of potentially exposed people (e.g., radiation, pathogen, toxic substance), and provide appropriate level of evaluation, treatment, and referrals/follow-up.
5)	To deliver needed in-patient care in communities whose hospitals have been compromised.

III. Planning Assumptions
a.	Emergency Support Function 8 Health and Medical (ESF-8) will facilitate the planning for ACF. The planning group should consist of public health, Emergency Management, Hospitals, medical societies, EMS, and other appropriate community partners.
b.	Plans will be flexible and able to adapt to changing community needs.
c.	Plans will ensure that people in the community will receive equitable services.

d.   Local communities may not have available resources due to event consequences to field or support an ACF. Regional, State or federal assistance may be needed to establish and/or maintain operations.

e.   Each county will not have the capability to establish an ACS.

f.   A realtor will assist in determining a location for an ACS, however, precise instructions must be given for requirements (i.e. HVAC, space, location).

g.   The American Red Cross is responsible for general shelters and special needs shelters (SpNS) in all counties. SpNS will house the patient and caregiver.

h.   Presenting family members will be allowed to remain together when possible.

i.   People presenting themselves at ACFs will be provided with the level of care the facility is designed to provide. Cases outside the scope of care will be triaged to the appropriate level of care if available.

j.   Level of care will include relevant information, appropriate assessments/evaluations, diagnosis and treatment, and community referrals.

k.   Infection control is a priority in planning, facility layout and procedures.

l.   Medical care will be provided by the appropriate licensed staff. Care provided by non-licensed staff may be provided under properly authorized protocols and medical oversight. Medications may be available on-site, their control and distribution will be governed by the physician practice act or pharmacy laws of the jurisdiction.

m.   Local pharmacies will have an adequate stockpile of needed medications to support SpNS and ACS.

n.   Hospitals may have a limited cache of supplies on hand to support an ACS.

o.   Local health care providers/institutions may have activated surge capacity plans either at the request of police, emergency management, emergency medical services, and or public health officials.

p.   Alternate Care Facilities will operate within the Incident Command (ICS)/National Incident Management System (NIMS) and plans will include the use of appropriate documentation and job action sheets.

IV. Authority

KRS 39B.010(1), KRS 39B.030(3), and KRS39C.050(3), and applicable Kentucky Administrative Regulations requires the development and maintenance of a local emergency operations plan which sets forth the local government organizational structure, policies, procedures, and guidelines for the management and coordination of all disaster and emergency response in the Barren River District.

KRS 214.020 authorizes the Barren River District Health Department as an agent and extension of the Cabinet for Families and Health Services and Department for Public Health, to take such action and adopt and enforce such rules and regulations as it deems efficient in preventing the introduction or spread of such infectious or contagious disease or disease within the state. Consistent with his/her legal responsibilities to comply with KRS 214.020, the Health Department Commissioner or designee may designate specific individuals to coordinate specific activities as required by the event.

The Barren River District Health Department Director directs implementation of its Emergency Response Plan in cooperation/agreement with the local Division of Emergency Management.

V. Scope

Alternate Care Facilities are not intended to augment a small surge in everyday healthcare system need. ACFs should only be used for readily apparent events of high consequence or unconfirmed, but highly suspected events that will lead to significant medical surge. ACFs should be activated as the need arises. The deployment could be during a declared emergency by local hospitals and/or Emergency Medical Services (EMS) and/or Emergency Management or as the event warrants the asset deployment.

Prior to deployment of ACFs, regional attempts at healthcare system surge capacity should be exhausted. If people with acute medical needs can receive adequate care in an existing medical facility within a reasonable period, then alternate care facilities should not be deployed. Efforts to support augmentation of the healthcare system's capacity should be prioritized in hopes of forestalling the need for ACFs.

VI. Concept of Operations

Alternate Care Facilities will:
1.   Be managed using ICS.
2.   Be a continuum of care ranging from triage to in-patient hospital care. The level of care is dependent on event needs and local capabilities.
3.   Use a consistent approach for the assessment and triage of people with symptoms.
4.   Refer individuals to the appropriate community-based agency or healthcare facility for additional care, if required.
5.   Provide access to self-care information for all people in a form appropriate for their needs.
6.   Provide treatments, including the administration of medications, as warranted within the clinical guidelines.
7.   Provide supportive care strategies, including community referrals, as needed.

VII. Responsibilities

A.   Kentucky Department for Public Health (KDPH)

KDPH, as the lead public health agency in the state, is responsible for protecting, maintaining, and improving the health of all Kentucky citizens. There is a strong state-local partnership wherein KDPH provides leadership and direction to front-line public health and healthcare entities.

B.   Kentucky Department of Emergency Management

The Kentucky Department of Emergency Management (KyEM) will establish a State EOC and support local resource management through local emergency management in coordination with the Kentucky Department for Public Health (KDPH).

C.   **Local Emergency Management Director**
Local Emergency Management will establish an Emergency Operation Center (EOC) to coordinate resources, to include delivery. Send requests to the State EOC.

D.   **Local Advisory Committee**
A local Advisory Committee should be developed to plan locations, staffing and deployment protocols for ACF. Membership could include: public health, community-based healthcare providers, hospitals, clinics, emergency medical services, emergency management, law enforcement, public works, and representatives of tribal communities, local community agencies and other stakeholders.

The regional Healthcare Emergency Area 4 Response Team (HEART) put together a committee to work on an ACS plan.

E.   **BRDHD**
Inspect Alternate Care Sites for environmental and communicable disease concerns. Coordinate resource requests for regional staff/equipment, if necessary.

F.   **Lead Agency**
The decision to open and operate an alternate care facility may be made by a responding agencies. The parties designated to open and operate alternate care facilities for the region are:

●   Any of the 10 hospitals in the region (in conjunction with Emergency Management)
●   Any EMS services in the region (in conjunction with Emergency Management)

Support agencies will include:
●   Fire departments
●   American Red Cross
●   Lifeskills
●   United Way
●   Salvation Army
●   Coroner's office
●   BRDHD
●   Law enforcement

VIII. Triggers for Opening an Alternate Care Facility
The decision to open an alternate care facility will be based on the severity of the situation and its impact on existing health care services.

Criteria may include:

●   World Health Organization (WHO) declaration of a pandemic

● Federal, state and/or local emergency declaration and emergency executive order for situation.

● Confirmation of a suspected chemical exposure or widespread outbreak of disease in a neighboring area.
● Reports from local primary care providers that they can no longer assess and treat people appropriately in a timely manner (e.g. patients are unable to be seen in clinician's office and are diverted to local EDs or other non-influenza-like illness appointments).

● Hospitals have implemented their surge treatment plans.

● Proportion of emergency department visits attributable to exposure or disease outbreak exceeding a predetermined percentage.

● Proportion of exposure or disease outbreak cases requiring hospitalization exceeding a predetermined percentage.

● If the Planning Section of Emergency Support Function 8 (ESF-8) predicts that any of the following criteria may be met by more than 75 percent of the hospitals within the same zone during the next 48-hour operational period:
a. 50 percent of Emergency Department beds are occupied with patients awaiting acute, non-elective hospital admission and their average waiting time in the ED is anticipated to be more than 24 hours, or;
b. More than 50 percent of patients with potentially life-threatening illness/injury will not receive stabilizing care within 30 minutes, or;
c. More than 75 percent of patients in the Emergency Department waiting rooms will not be seen by a clinician within 12 hours.

IX. Development of Alternate Care Facilities
A. Level of Care
The agency (or agencies) that establish the ACS will also be responsible for determining who will have access to care based on available resources and personnel.

For planning purposes, the level of care provided at the alternate care facility is based on the anticipated needs of the community and available resources for staffing and supplying the alternate care facility.

The following chart in Appendix-Tab 12 outlines what level of care each patient ideally should receive.

X. Site Selection

Criteria for location and type of facility:

Each County Emergency Operation Plan has facilities that may be utilized for ACS sites.

Ideally, ACFs should be located less than one mile from acute care hospitals. Possible ACF sites include:
▪   Aircraft hangars
▪   Churches
▪   Community/recreation centers
▪   Convalescent care facilities
▪   Fairgrounds
▪   Government buildings
▪   Hotel/motel
▪   Meeting halls
▪   Military facilities & National Guard armories
▪   Same day surgical centers
▪   Schools
▪   Sport facilities/stadiums

Space will be needed for the following functions:
▪   Initial Screening area
▪   Waiting Area
▪   Worried Well/Symptom Free Education Area
▪   Registration Area for Patients with Symptoms
▪   Detailed Triage Area
▪   Medical Care Area
▪   Medication and Education Area
▪   Sanitation and Disposal Capabilities
▪   Wheelchair and Handicap Accessibility

Based on the level of care provided space may also be needed for:
▪   Pharmacy
▪   Lab
▪   Support Areas, i.e. behavioral health, family services
▪   Referrals, temporary morgue

Infrastructure requirements
▪   Climate controlled enclosed space
▪   Perimeter security
▪   Waste removal (to include biomedical waste)
▪   Electrical power source and distribution
▪   Potable water
▪   Forklift for off-loading and set up

- Local transportation
- Ice
- Latrines/showers for staff and patients

Additional requirements for each facility
- Communications support
- Food service for staff and patients
- Medical oxygen
- Laundry services
- Mortuary support
- Refrigeration

XI. Equipment and Supplies
(found in Appendix-Tab 12 Shelter Equipment and Supplies)

Patients' own medications should be brought with them to the alternate care site, or acquired from their dispensing pharmacy. The medications listed above are for use in patient care protocols until patient's own medications arrive, or in emergency situations when the biophysiological reactions to influenza infection threaten the life of the patient.

XII. Maintenance of ACS
It is expected that an establishment of an Alternate Care Site will exceed the public health system. The protocol for maintaining the Alternate Care Site will be through the County Emergency Operation Center (EOC) who will work with the State EOC.

XIII. Patient Tracking and Monitoring
In case an American Red Cross (ARC) shelter is opened for emergency sheltering then the ARC will be responsible for tracking the clients of the shelter. However the Communicable Disease (CD) Team is responsible for disease surveillance in those shelters and the information will entered in the Natural Disaster Morbidity Report Form, Aggregate Natural Disaster Morbidity Report Form and the data will be tabulated into an excel spreadsheet for further analysis and management. In situations where a healthcare facility or facilities open an alternate care site(s) then the healthcare facility that established the ACS will be responsible to track and monitor their own patients. It is assumed that WebEOC would be utilized by the

In situation of a radiological exposure: BRDHD will establish a registry (list) of people who might have been exposed to radiation from the incident. The Kentucky Department for Public Health's Radiation Health Branch, the CDC, and Agency for Toxic Substances and Disease Registry will assist with determining how much radiation people were exposed to and follow people for as long as necessary to see whether they develop health effects from their radiation exposure or from the stress of being involved in an incident.

In situation where it is a communicable disease issue, the Communicable Disease (CD) Team will manage the isolation, quarantine, post-exposure prophylaxis as required, and the information collected in appropriate forms will be logged into an Excel spreadsheet for tracking, monitoring, managing and analysis purposes.

XIV. Command Structure

The lead agency will develop a command and control structure for the ACS that can be integrated with the existing local emergency management command structure. ICS format should be adhered to when completing command structure chart. A copy of the organizational chart should be given to all staff and posted in the alternate care facility.

XV. ACS Facility Layout

A sample ACS layout is found in Appendix B – Tab 12.

XVI. Staffing

Staffing at ACS may come from a variety of agencies, to include:

● Hospitals
● Private physician's offices
● Paramedics
● College/university nursing departments (staff and students)
● Mental health workers (Lifeskills, Rivendell)
● CERT volunteers

The staff required for the alternate care facility will fall into several categories:
1) Administrative Services: to include incident management structure, records management, and communications infrastructure.
2) Medical Care: to include assessment and triage, providing direct care to patients, and development of care and/or discharge plans.
3) Education: to include education on prevention and providing lay home care/self-care, and just-in-time training for health care workers and volunteers at the alternate care facility.
4) Support Services: to include behavioral health, interpreters, referrals, family assistance, and housekeeping services.
5) Transportation Services: to include transportation of patients to and/or from the alternate care facility.
6) Infection Control/Occupational Health: to include training in infection control and monitoring workplace safety.
7) Security: to include protection of people, building structure, and supplies.

AHRQ Staffing Requirements for a 50 bed Alternate Care Site

Position	AM / Day Shift (12 hours)	PM / Night Shift (12 hours)
Physician	1	On-call

Physician Assistant or Nurse Practitioner	1	1
Registered nurses and/or Licensed Practical Nurses	6	4
Nursing Assistants and/or Nursing Support Technicians	4	2
Medical Clerks (secretaries)	2	1
Respiratory Therapist	1	1
Case Manager	1	0
Social Worker	1	0
Housekeeping Personnel	2	1
Patients Transporters	2	1
Total	**21**	**11**

Agency for Healthcare Research and Quality. Disaster Alternate Care Facilities: Selection and Operation. http://www.ahrq.gov/prep/acfselection/dacfrep.htm

XVII. Infection Control

Each alternate care facility must establish occupational health and safety, and infection prevention and control policies and procedures to minimize transmission and protect people. The safety section on the organizational chart is responsible for infection prevention and control measures at the site.

In general, prevention and control measures at the alternate care facility should include:

●	Providing education.
●	Ensuring hand hygiene supplies (i.e. alcohol-based hand rubs) are readily available and used.
●	Posting signs about routine infection prevention and control measures (i.e. hand hygiene, cough etiquette).
●	Providing guidance on appropriate use of personal protective equipment (PPE) and infection control practices.
●	Establishing and maintaining cleaning and disposal procedures and a regular cleaning schedule for workspace and equipment that will support the operation of the alternate care facility.
●	Working with other health care workers in the community to implement and reinforce an awareness campaign about routine infection prevention and control practices that can prevent the spread of illness.

XVIII. Transportation

The County Emergency Manager (EM) thru ESF-1 coordinator (City/County Street and Maintenance Manager) will be the primary responsible source for transportation needs for all healthcare needs. See specific County ESF-1 plans (BRDHD H:Drive/Disaster Preparedness/State and Local Plans…) for additional information and specific transportation agencies previously contracted by each County Emergency Manager.

Contact information for at-risk populations are noted in the County ESF-1 annexes as well as shown in the following state-wide urls (Human Services Transport Brokers listed by Region: https://transportation.ky.gov/TransportationDelivery/Pages/Human-Services-Transportation.aspx) and transportation providers by County (https://transportation.ky.gov/TransportationDelivery/Pages/Public-Transportation-Providers.aspx).

County EM thru ESF-8 liaison County EM (Barren River District Health Department and County EMS are the lead agencies for ESF-8) will coordinate local support agencies and local resources within the county healthcare activities before, during, and after the disaster. These agencies and local resources include: City and County Public works, road departments, public transportation, city and county school transportation assets, and faith based organizations.

ESF-8 coordinator shall request assistance and resources with ESF-1 Coordinator of the County. It is the ESF-1 responsibility to provide/utilize resources and determine transportation requirements establishing priorities and coordinating with adjoining counties in the joint use of transportation. ESF-1 will provide ESF-8 transportation assets that include estimates of the people with special needs requiring transportation, staging points, central pick up spots, and refueling points provided by ESF-8.

ESF-1 Coordinator will activate contracts that allow for equipment surge to meet the demands of healthcare evacuation needs and implement emergency equipment rentals. Various agencies include: Western Kentucky University Transportation System, City and County Road Department, City and County Boards of Education, City Police and County Sheriff Offices, Human Society, Community Action of Southern Kentucky, private transportation contractors and companies, and various Faith Based organizations.

Kentucky board of Emergency Medical Services will assist in coordinating needed resources through vehicles, equipment, and personnel for transporting casualties and patients during an emergency or disaster.

For ambulance services to receive Medicare reimbursement for taking patients somewhere other than a hospital, an 1135 waiver is needed. This wavier would allow for reimbursement in scenarios where transport to an alternate care site is required because of damage to a hospital.

The Kentucky Army and Air National Guard may provide, if available, personnel and equipment to support the triage, treatment, decontamination, transportation, evacuation, and tracking of patients and casualties during an emergency or disaster.

XIX. Security and Traffic Control
Emergency Management will be responsible for procuring the needed security / traffic control.

H:\Disaster Preparedness\All Hazard Plan\BRDHD All Hazards Plan\BRDHD All Hazards Plan 2022\12 - Tab and Appendices-Mass Patient Care

Physical security of the ACF staff, equipment and the facility is essential. Physical security points include the following:

●   Entry and exit points to the area (e.g., the city block), if practicable.
●   Access and egress to the building.
●   High-risk or high-value areas within the building, such as the temporary morgue and pharmacy.

XX. Demobilization of ACS

Demobilization of the alternate care facility will begin when predetermined closing triggers or progress milestones have been reached and ends when existing healthcare facilities are able to handle the surge. Public notice must be published announcing the closing date of the alternate care facility and providing information for the ongoing care of patients.

Planning to demobilize usually begins with an assessment of the center operation's progress and a determination of approximately when various services will be completed or no longer needed. From this assessment, facility operation management can begin planning for the closing of the alternate care facility in close cooperation with public health, healthcare and other community partners. A coordinated and integrated approach must be taken to prevent any disruption in the care of patients when the alternate care facility closes.

H:\Disaster Preparedness\All Hazard Plan\BRDHD All Hazards Plan\BRDHD All Hazards Plan 2022\12 - Tab and Appendices-Mass Patient Care