Central Minnesota Health Care Preparedness Coalition



Coalition Response Plan

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# Introduction

Disaster coordination, defined by the National Incident Management (NIMS), is the process of systematically analyzing a situation, developing relevant information, and informing appropriate command authority of viable alternatives for selection of an effective combination of available resources to meet specific objectives.

## Response Plan Purpose

The CMHPC Response Plan (Response Plan) will guide the operations of the CMHPC using a health care multi-agency coordination (HMAC) group approach. The Response Plan provides general guidance and operational checklists for notification, activation, response, and recovery to all-hazards events that threaten the CMHPC member agencies and/or result in illness or injury to the population within the CMHPC’s boundaries and the health and medical care system.

This document outlines the functions of the CMHPC during a response, and the potential for activation of the health care multi-agency coordination (HMAC) group. Information and resource sharing are the primary response drivers during an incident, that exceeds the capacity and capability of health care systems. The Response Plan is meant to provide guidance only and does not substitute for the experience of the personnel responsible for making decisions at the time of the incident.

## CMHPC Mission

The Central Minnesota Health Care Preparedness Coalition serves our communities, in collaboration with other partners, to coordinate emergency preparedness, response, and recovery activities.

## Scope/Authority

Both the Preparedness and Response Plan are designed as supporting tools and are not meant to replace or interfere with an organization’s emergency operations plans (EOPs), or the jurisdictional command and control authorized by state and local emergency management agencies. This Plan applies to the response team members of the CMHPC when an incident occurs that is beyond the individual organizations’ ability to manage the response. It is limited to agreements and documents signed by the Central Minnesota Health Care Preparedness Coalition (CMHPC) member organizations.

The CMHPC will support public health and medical response and recovery to include, but not limited to:

* Providing regional coordination of planning, training and exercising for Central Region health and medical entities;
* Providing health and medical situational information to support a regionally coordinated response;
* Facilitating a health care multi-agency coordination (HMAC) group;
* Addressing the appropriate capability targets as defined by Emergency Management, Public Health and Health care.

The Central Minnesota Health Care Preparedness Coalition has no specific legal authority. Each entity represented in the CMHPC has discipline specific authority and will integrate that authority to support coordination and leverage planning and response within agreements or statutory authority including:

* MN State Statute - Chapter 12: Emergency Management
* Minnesota State Statute - Chapter 145A: Community Health Boards
* Minnesota State Statute – Chapter 145: Public Health Provisions
* EMSRB State Statute - Chapter 144E: Emergency Medical Services Regulatory Board
* EMSRB Rules - Chapter 4690: Ambulance Services
* Homeland Security and Emergency Management (HSEM) “MN Emergency Operations Plan”
* Centers for Medicare and Medical Services (CMS)
* Clinical Laboratory Improvement Amendments (CLIA)
* Health Insurance Portability and Accountability Act (HIPPA)
* Emergency Medical Treatment & Labor Act (EMTALA)
* Occupational Safety and Health Administration (OSHA)
* The Join Commission (TJC)
* Health Care Facilities Accreditation Program (HFAP)
* Local authority as embodied by ordinance, EOPs, or mutual agreements
* Voluntary agreements for regional coordination of health and medical response activities

For additional details regarding the coalition Memo of Understanding, By-laws, and other agreements, coalition members have access to the: [Central-West Central Health Care Coalitions Website](https://www.cwchealthcarecoalitions.org/).

## Administrative Support

The Response Plan will be reviewed biennially, or as needed, by the CMHPC Advisory Committee following exercises and real-world events.

| **Date** | **Changes Made** | **Changes made by** | **Approved by** |
| --- | --- | --- | --- |
|  | Complete plan rewrite  | Don Sheldrew, RHPC |  |

## Plan Assumptions

The following assumptions apply to the CMHPC Response Plan:

* All responses are local. Local resources are used first, regional resources will be accessed second, state resources third, followed by a federal request as needed. Federal resources may not be available for 72-96 hours. Members will coordinate their needs with jurisdictional EOC who may defer medical needs to the CMHPC.
* Health care organizations will take internal steps to increase patient capacity and implement surge plans before requesting outside assistance.
* Impacted facilities will activate their Emergency Operation Plan (EOP) and staffing of their facility operations center.
* CMHPC members will report status on situational awareness.
* Processes and procedures outlined in the Plan are designed to support and not supplant any member emergency response efforts.
* This document is a supplement to each CMHPC member’s or partner’s Emergency Operations Plan that was developed consistent with the National Incident Management System (NIMS).
* CMHPC members are expected to maintain the capability to manage emergencies independent of support from the CMHPC.
* Communications, information, and resource sharing among CMHPC members or partner agencies during a response will be managed in accordance with existing operating procedures, mutual aid, and other agreements.

# Central Minnesota Health Care Preparedness Coalition (CMHPC)

Minnesota health and medical facilities have a long history of working together, including regional emergency preparedness planning. CMHPC regional planning coordinated the purchase of equipment, joint training and exercises, plan writing, and resource level assessment and acquisition. The CMHPC utilizes a Health Care Multi-Agency Coordination (HMAC) group structure during responses. State and regional health care coalition response coordination occurred for:

* SARS preparedness – 2002
* Operation Northern Comfort (Katrina) – 2005
* Flooding – 2006, 2007, 2008, 2009, 2011, 2016, 2018
* Wadena Tornado - 2010
* H1N1 – 2010
* State Government Shutdown - 2011
* Ebola virus readiness – 2014
* COVID-19 Outbreak - 2020
* Ongoing training, exercising, and workshops

Membership and governance structure of the CMHPC can be found in the CMHPC Preparedness Plan and the Central West Central website at: <https://www.cwchealthcarecoalitions.org/login/>.

## Concept of Operations

Multi-Agency coordination allows government and private agencies to work together more efficiently and effectively. This coordination occurs across the different disciplines involved in incident management, across jurisdictional response lines, and across levels of government.

The CMHPC provides logistical support for members to coordinate, and integrate with local emergency management, local public health, public safety, emergency medical services, and the Minnesota Department of Health, during a response. Activation of the HMAC is incident driven. Minor incidents may only require a regional response that can be supported by the Regional Health Care Preparedness Coordinator (RHPC) and other CMHPC staff. Larger scale incidents may require more resources and complete activation of the HMAC. This document discusses both the RHPC Response and HMAC operations.

## Role of the CMHPC in Response

The CMHPC HMAC supports the coordination between health care, emergency medical services, public health, emergency management, and other partners for a health-related event or incident to:

* Support incident management ESF-8 priorities with the collaborative effort of multiple agencies.
* Facilitate logistical support, resource-tracking and victim tracking/family reunification.
* Coordinate critical medical resource allocation decision-making based on recommendations from local Emergency Operation Centers (EOCs), Emergency Medical Services Multiagency Coordination (EMS MAC), CDC, MDH, and other subject matter experts.
* Facilitate information sharing and situational awareness among the CMHPC members by using CMHPC resources as outlined in the activation and operations section of the plan.
* Support health care evacuation activities in collaboration with CMHPC partners.

## Member Roles and Responsibilities

Each supporting agency has signed a letter of intent stating they agree to facilitate integrated planning, response, and recovery activities critical to an effective response to an event or emergency with public health and medical implications in the Central Region area.

CMHPC members agree to support health and medical response and recovery within the parameters of statutory requirements, jurisdictional Emergency Operations Plans (EOPs), and as outlined in the bylaws, and memorandum of understanding (MOU). The agreements include:

* Providing regional coordination of planning, training, and exercising for health and medical entities.
* Providing health and medical situational information to support a regionally coordinated response.
* Facilitating health and medical resource sharing through HMAC coordination.
* Addressing the appropriate capability targets as defined by emergency management, public health, and health care.

### Emergency Medical Services

Twenty-four emergency medical services (EMS) agencies in the Central Region provide 911 response, treatment, and transportation. EMS agencies use a common incident response plan for consistency of framework and terminology. Each EMS agency has an individual dispatch center for coordinating response. During a major incident, an EMS Multi-Agency Coordination Center (EMS MACC) may be established to support logistical and operational needs with the region. During a health incident, EMS agencies, and/or the Regional EMS Coordinator will consider the need to:

* Notify the RHPC of an incident and/or request the HMAC be activated.
* Communicate situational and resource awareness to the RHPC when requested.
* Coordinate efforts through an EMS MACC.
* Help facilitate the delivery of health and medical services, personnel, and supplies within the region.
* Collaborate with health care facilities during the request, receipt, and distribution of the strategic national stockpile (SNS) or other state/federal assets.
* Coordinate/activate and EMS Strike Team.
* Determine EMS asset needs.
* Obtain EMS Essential Elements of Information.
* Participate in a health care multi-agency coordination (HMAC) group if activated.

### Hospitals

Each hospital is responsible for maintaining facility surge capacity plans. When the facility surge plans are exceeded, or if multiple hospitals are involved in a multi-casualty response, a twenty-four seven phone number can contact the Regional Health Care Preparedness Coordinator (RHPC) who can assist with situational awareness and virtual coordination through the Minnesota System for Tracking Resources, Alerts, and Communication (MNTrac). During a health incident, hospitals will consider the need to:

* Notify the RHPC of an incident and/or discuss activation of the HMAC.
* Respond to any requests made by the CMHPC as outlined by the CMHPC By-laws and Memorandum of Understanding.
* Respond to MNTrac alerts and announcements, including participating in the MNTrac Command Center if requested.
* Communicate with coalition members, local emergency management, and supporting organizations on incident status.
* Participate in health care multi-agency coordination (HMAC) group if activated.

### Public Health

There are fourteen public health agencies in the Central Region that provide community health services designed to protect and promote the health of the general population within the community. Each public health agency operates locally within county emergency operations plan and will coordinate with other agencies, or regionally, if a public health incident occurs in multiple jurisdictions. During a health incident public health will consider the need to:

* Notify the RHPC of an incident and/or discuss activation of the HMAC.
* Notify other local and state partners, as necessary.
* Assist other public health in behavioral health support as needed.
* Collaborate with health and medical facilities during the request, receipt, and distribution of the strategic national stockpile (SNS) or other regional/state/federal assets.
* Participate in a health care multi-agency coordination (HMAC) group if activated.

### Emergency Management

Every city and county within the fourteen-county Central Region has an emergency manager responsible for preparing, responding, and recovering their jurisdiction from disasters. During a health incident, emergency managers will consider the need to:

* Notify the RHPC of an incident and/or discuss activation of the CMHPC HMAC.
* Support area hospitals and other health care agency implementation of their emergency response plans for surge capacity.
* Collaborate with health and medical facilities during the request, receipt, and distribution of the strategic national stockpile (SNS) or other state/federal assets.
* Support regional cooperation for health-related resource sharing and allocation.
* Participate in a health care multi-agency coordination (HMAC) group if activated.

### Other Health and Medical Coalition Members

Long-term care, home health care, hospice, and other centers for Medicare and Medicaid medical service (CMS) providers also provide the health and medical care within the community and Central Region. Every licensed health care organization has federal requirements for disaster planning and are identified in the overall regional health care response planning. Considerations for other health and medical agencies are to:

* Notify the RHPC of an incident and/or discuss activation of the HMAC if there is an incident that impacts your facility and the region.
* Support area health care facility’s implementation of their emergency response plans for surge capacity.
* Collaborate with public health and/or health care facilities during the request, receipt, and distribution of the strategic national stockpile (SNS) or other state/federal assets.
* Participate in a health care multi-agency coordination (HMAC) group if activated and requested.

 More detailed roles and responsibilities are identified in the individual coalition members’ emergency operational plans.

# Coalition Response Organizational Structure

Coordination between Coalition members helps create a common operating picture and provides the architecture to respond effectively and efficiently, often with scarce resources. HMAC coordination can support regional responses prior to requesting state resources. An HMAC will provide a reasonable span of control as information is gathered and response plans are determined. It is understood that the HMAC group:

* Does not supersede municipal, county, or state emergency operation plans.
* Does not supersede facility plans.
* Does not direct local efforts or control local resources.
* Is a function for information and resource sharing.

The mission for the CMHPC HMAC is to provide a:

* Structure for information sharing to provide representational situational awareness.
* Method for coordinating or sharing health-related policy decision-making at each local jurisdiction, to ensure that jurisdictions are aware of regional policies, and to enable consistency of region-wide decision-making.
* Framework for coordination of critical health and medical resource allocation decision-making.

This mission will be fulfilled by receipt of information from and recommendations by local county or municipal emergency operations centers and other coordinating entities such as the Emergency Medical Services Multi-Agency Coordination (EMS-MACC), Minnesota Department of Health (MDH), as well as other responding local and state agencies.

# Response Capability Concept

The Federal Emergency Management Agency (FEMA) identifies 15 Emergency Support Functions (ESFs) to provide the structure for coordinating Federal interagency support if needed to an incident. They are mechanisms for grouping functions most frequently used together to provide Federal support to States both for declared disasters and emergencies under the Stafford Act and for non-Stafford Act incidents.

ESF #8 is the Emergency Support Function that include public health, medical services (including EMS, hospital, LTC, etc.), mental health services, and mass fatality management. The following links provide additional information regarding the [Robert T. Stafford Disaster Relief and Emergency Assistance Act](file:///G%3A%5CCathyHockertProjects%5C2019MetroRegion%20ResponsePlan%5CRobert%20T.%20Stafford%20Disaster%20Relief%20and%20Emergency%20Assistance%20Act) and the Federal Emergency Management Agency (FEMA) [Emergency Support Functions](https://www.fema.gov/media-library/assets/documents/25512).

The schematic on the next page identifies the multiple communication and support efforts that could be involved in supporting Emergency Support Function (ESF) #8. Various agencies have agreed to collaborate their efforts creating a health and medical coalition depicted by the black dotted line. Both emergency management and the Health Care Coalition have the ability to reach back to Federal and State partners. The coalition can also support county and local agencies upon request.



## Coalition Health Care Multi-Agency Coordination (HMAC) Group Response Assumptions

The HMAC group response structure promotes cooperation and coordination, but recognizes the autonomy, operational authority, and unique characteristics of each jurisdiction (at facility, local, regional, and state levels). All jurisdictions/entities supporting the CMHPC will collaborate in good faith to make decisions that are in the best interest of their facility/agency and region.

### Planning Assumptions

* Coalition members will respond as detailed in their emergency response plans.
* Coalition members will coordinate closely to ensure continuation of critical services.
* Emergency response will require the participation of many coalition members, and the coordination with multiple communities, governments, health care and first responder agencies.

### Operational Assumptions

* Timely and accurate information sharing at all phases of a regional incident is necessary for situational response and recovery.
* An incident can happen with little to no notice or may only become apparent over time. Immediate resources to communicate, coordinate, and respond collaboratively are necessary.
* The medical response may overwhelm the health care system without an integrated cooperative response.

# Coalition Response Operations

The following are recommended actions for notifying the RHPC or activating the HMAC in support of a localized or regional incident or event which may have significant impacts on the Coalition health care infrastructure. Based on the nature and severity of the incident, the RHPC staff will determine the coalition notification level and need to activate the HMAC.

## Stages of Incident Response

**ADVISORY**: Notice that incident is taking place, maintain awareness; no response required

The coalition will function in a decentralized nature during normal day-to-day activities. As an incident or event occurs with potential or actual impact to coalition members, the coalition members may be notified of an advisory, alert, or activated status.

**ALERT**: Notice to stand ready for activation; identification of potential resources needed; no response required

## Advisory, Alert, or Activation Status

Coalition members should notify others of a potential or current incident when one of the following occur:

**ACTIVATION:** Response Required

* A health care organization evacuation is imminent.
* An evacuation of a geographic location affecting Coalition members.
* There is a critical shortage of medical and/or ancillary personnel

to care for patients (capacity).

* There is a shortage of medical supplies.
* A health care organization is damaged or compromised.
* Critical utility and back-up systems are in use or not operational.
* A local emergency and/or all-hazard incident is occurring.
* A statewide or federal emergency is declared.

## Incident Recognition and Triggers

Awareness of an incident occurring may come from a variety of sources including coalition members and/or partners. Coalition members will notify the RHPC through their appropriate committee representative, or directly if the situation warrants. In addition, the coalition member should notify their local emergency manager for situational awareness or if there is a potential need for support. Any impacted coalition member may call to discuss activation of the HMAC. The decision to activate an HMAC should be based on one or more of the following criteria:

* Assistance is required beyond an organization’s current capabilities.
* Multi-jurisdictional impact / outbreak.
* The incident or event will affect two or more coalition members in the region.
* The incident or event will affect coalitions outside of the region.
* Scarce resources may be required in multiple facilities.
* Communication capability is limited.
* The incident or event will last multiple operational periods (more than 12 to 24 hours).
* Activation is requested by another health care coalition or jurisdiction.

## Activation

Following incident recognition, the HMAC will coordinate to determine the level of activation required from monitoring to a fully staffed response.

Essential Elements of Information (EEI) is communicated to Coalition and others

Decision is made whether status is Advisory, Alert, or Activation status

RHPC notifies HMAC Representatives

Incident Occurs—RHPC is notified of Incident

## HMAC Alert and Notification

Following the determination to activate an HMAC by the RHPC and Coalition representatives, the following activities need to occur:

* The Minnesota Department of Health will be notified.
* Emergency Management in the affected area will be notified.
* The disciplines represented in the HMAC will notify their respective coalition members and partners of notification. For example, the Public Health representatives of the HMAC will notify their respective public health coalition members and partners via their pre-agreed upon plans and methods.
* Neighboring coalitions may need to be notified by the RHPC if the situation has that potential for escalation outside of regional borders or if additional resources or assistance is needed.
* The RHPC will notify all hospitals affiliated clinics and skilled nursing facilities.
* When the HMAC is activated, the initial communication to regional partners and MDH will include HMAC contact information (including but not limited to the phone number and email address).
* The HMAC may use a pre-designed Survey Monkey survey to gather a Situation Report from Coalition members. If this cannot be completed by Survey Monkey, the information will be gathered by phone or email.

See: Essential Elements of Information/Situational Awareness

## Mobilization

The HMAC will mobilize virtually via phone, MNTrac Coordination Room, WebEx, phone, or physically at a pre-identified site if warranted.

# Incident Operations and Coordination Activities

Based on the principles in the Medical Surge Capacity and Capability (MSCC) Management System, the coalition will use a tiered and scalable approach to coordinate with the varied health care organizations in the Central Region, and to align with other response groups in the region operating under the Incident Command System (ICS).

When activated, roles and responsibilities will be assigned by the RHPC or others, as necessary. See [FEMA Incident Action Planning Guide – January 2012 – Page 6: *Planning P*](https://www.fema.gov/media-library-data/20130726-1822-25045-1815/incident_action_planning_guide_1_26_2012.pdf)

## Initial Coalition Actions:

Each HMAC representative will implement the following procedures to fulfill their functions:

#### Briefings:

* Identify how and when briefings are held
* Gather information and provide current situation update, probable future situation report
* Describe current issues
* Introduce new issues
* Address questions and offer clarification

#### Decisions:

* Review criteria to establish priorities
* Prioritize incidents, if necessary
* Support allocation of regional Health and Medical resources, if necessary
* Notify involved agencies and facilities if a Joint Information Center is opened in the region
* Consider implementation strategies for resource and information requests
* Identify and determine operational period

#### HMAC Documentation:

* Develop and communicate an HMAC Incident Action Plan for each operational period
* Meeting notes and decisions will be recorded and communicated to appropriate staff and external partners
* Decisions requiring financial commitments (including staff time) will be recorded
* Situational reports will be compiled as needed
* ICS Forms will be used as needed

## Ongoing Coalition Actions

During the incident response, the HMAC will continue to gain situational awareness and respond to requests for support. If the HMAC is open for an extended period of time, the RHPC may request the support of non-impacted coalition members to fulfill roles within the HMAC. This request would be made utilizing the resource request process.

## Information Sharing

Based on the scope and scale of the incident, appropriate essential elements of information will be collected from local, regional and state partners to support the response needs. This section describes information sharing that will take place between Health Care Multi-Agency Coordination group (HMAC) before, during and after an incident. The HMAC has developed reportable conditions to be provided to the RHPC. The RHPC, as well as the HMAC, if activated, will aggregate individual coalition member information and provide status reports to the MDH and other jurisdictional partners as needed in order to facilitate regional and /or statewide response decisions. In turn, if MDH or jurisdictional partners need additional information from coalition member organizations they may request HMAC to gather that information of members either through email, phone, conference call, meeting or any other source.

### Information Access and Data Protection

Information access is limited to coalition members and additional stakeholders as necessary. Coalition documents and plans are For Official Use Only (FOUO) and contain no Protected Health Information (PHI). Systems used by the coalition members include privacy procedures, access limitations and protection of data created within for the unlikely event exchange of sensitive information is required.

# Resource Coordination

During times of scarce resources, medical surge, and/or evacuation measures, there may be situations where resource sharing/acquisitions may be coordinated through the Coalition. The Coalition maintains a regional cache of health care supplies that may be needed to supplement the resources available for Coalition members. The Coalition is responsible for maintaining, monitoring, allocation and distribution control of all the inventory items in the cache as well as the acquisition and disposal of equipment.

## Identification of Needs

The Health Care Multi-Agency Coordination group (HMAC) will coordinate to support the coalition for the following:

* Identify available health care resources from accessible caches and through appropriate request process
* Identify mutual aid processes for health care resources
* Consult on issues relating to over allocated resources
* Identify assets that the coalition has the authority to allocate
* Identify regional mobile medical assets and caches of medical equipment and supplies
* Implement processes to identify and utilize trained, credentialed staff to assist with patient care or other duties during surge operations

## Resource Management Implementation

* Coordinate assistance for resources from locally available caches when requested and available
* Assist coalition members with implementation of mutual aid processes upon request
* Allocate locally controlled assets through the coalition
* Assist local, state, and Federal incident management with coordination of resource requests from coalition members, as requested
* Utilize alternate sources of resources (e.g., emergency supply chains and private vendor support for critical resources such as equipment, supplies, space or other resource) if requested and available

## Managing and Resupplying Coalition Resource Cache

* Implement the processes to track, record, and effectively inventory available resources for health care organization use during emergency operations
* Coordinate with the appropriate agencies for the resupply of specific caches (e.g., Strategic National Stockpile)
* Implement the processes for the rapid resupply of depleted resources if, and when available
* Implement the processes to replace outdated supplies
* Consult on the financial processes for the reimbursement of depleted resources based on the type of incident (e.g., emergency declaration) or through routine processes

## Coordination with Public Health Partners

In order to request support services, guidance and/or resources for public health related emergencies, the RHPC will communicate with the public health representatives on the following elements:

* Surveillance services
* Epidemiological investigation
* Public health laboratory services
* Guidance on prevention measures for injury, infectious disease, and other major health threats during an incident
* Alternate care sites, as needed

## MNTrac System

Minnesota system for tracking resources, alerts and communications (MNTrac), is the statewide system, used on a regular basis by hospital, EMS, and long-term care facilities. Central Region hospitals update the system frequently during mass casualty situations, and Long-Term Care facilities update monthly.

The purpose of the system is to provide situational awareness to assist hospitals, the Regional Health care Preparedness Coordinator (RHPC), EMS, Public Health and others for:

* Regional notifications, alerts, and incident communications
* Availability of beds and services, including isolation beds and Alternative Care Facilities (ACF)
* Determining availability of critical equipment and supplies, including, ventilators, antidotes, decontamination units and personal protective equipment (PPE) etc.
* Movement of patients/residents
* Coordination of EMS

**Also see:** MNTrac Document Hub for Patient Evacuation Job Aid and Facility User Aids

**Demobilization**

As the response comes to an end, the HMAC, in collaboration with supported organizations, and MDH, if activated, will determine the need to demobilize the HMAC. Demobilization may occur in a tiered fashion as certain functions/organizations return to normal operations or all at once. Intentions to demobilize should be communicated to all applicable stakeholders. Notification of demobilization may occur via MNTrac or email.

The HMAC members, in collaboration with partners, should consider the following criteria when determining the need to demobilize the HMAC:

* Projected end of an outbreak
* Ability to provide inpatient care without surge activities
* Ability to provide emergency services without surge activities
* Ability to provide emergency services without mutual aid (EMS)
* Resumption of normal operations is imminent/completed

Planning for demobilization shall be considered throughout the HMAC activation period. All paperwork created in the response process will be collected, collated, and reviewed for inclusion in the After-Action Review (AAR). Copies of paperwork that identify any expenses incurred, such as resource allocation, time sheets, and receipts, will be shared with the local emergency manager in the effected county (if the local EOC is activated). All paperwork collected will be scanned and saved in an electronic file labeled for the event.

An after-action review will be conducted to identify what went well and opportunities for improvement. The HMAC staff will create a survey monkey survey to gather feedback from all participants and incorporate the data collected in the regional AAR. At the organization level, participants in the activity will complete an individual evaluation and submit same to the organization emergency preparedness representative. The facilitator will compile the information obtained from the individual participants and submit a report via SurveyMonkey and be prepared to discuss same during the face-to-face or regional conference call After-Action meeting. Organizations impacted are asked to create their own organization-based AAR and provide a copy to the region.

# Recovery Operations

The coalition must work together to restore the regional health care delivery system quickly to meet the needs of the public. Individual health care facilities are required to have an emergency operation plan with the inclusion of a continuity of operations plan.

The role of the coalition depends on the size and scope of the disaster. The coalition may:

• Facilitate communication with regional and state partners

• Work with local emergency management officials, as necessary

• Aid in the regional patient tracking process

## Continuity of Operations

The ability of the coalition to support its’ members in a response relies on the availability of coalition staff as well as the involvement of members supporting the coalitions’ activities. Processes in place to support the continuity for the coalition HMAC include:

* Regional Health care Response Team
* Redundant communications
* Coalition to coalition relationships
* Administrative and financial support
* Alignment between coalition and individual organization plans

**Also see** the Continuity of Operations Plan in the CMHPC Preparedness Plan

## Redundant Communications

As discussed in the communications plan, the coalition can utilize multiple forms of communications. The primary means of communications during a response will be the MNTrac system, however, if MNTrac is unavailable, the coalition may use WebEx or other communication software. To obtain bed availability or situational awareness, the coalition can use SurveyMonkey in the absence of MNTrac.

Redundant radio communications include 800 MHz, VHF/UHF, and Ham Radio. Depending on the situation, talk groups or channels will be assigned and communicated to membership via MNTrac, email, or direct phone calls.

**Also see:** - Communications Plan in the CHMPC Preparedness Plan

## Coalition to Coalition Relationships

The CMHPC works closely with its other Health care Coalition partners. This relationship allows for sharing of resources, personnel, and information. In a response, if the HMAC is activated, the RHPC can immediately notify other RHPCs of the activation and request any support needed.

The development of working relationships with other coalitions ensures that in a response, if the incident exceeds the capacity of the coalition or if it has the potential to impact any other region, the RHPC can reach out to his/her peers in other regions. This includes asking the peer to, at a minimum, be a liaison between coalitions, support with MNTrac use, and communicate with Minnesota Department of Health. Coalition peers have access to the MNTrac contacts which would help facilitate the availability of the peer RHPC to support the region in a response.

## Alignment Between Coalition and Individual Organization Plans

Coalition members have access to both the coalition Response plan and the Preparedness plan. These plans are housed on the coalition website and in MNTrac Document Hub. The coalition senior advisory committee approves all coalition plans. This process allows for facility level plans to align with the coalition plans to ensure a smoother response and greater awareness of the roles and responsibilities of all entities

# Appendices

Central Minnesota Health Care Preparedness Coalition plans, appendices, and resources are meant to provide guidance to members of the Central Minnesota Health Care Preparedness Coalition members. As with other component of the plans, the documentation is intended as guidance only and does not substitute for the experience of the personnel responsible for making decisions at the time of the incident.

1. Medical Surge Plan

The Central Minnesota Health care Preparedness Coalition’s (CMHPC) Medical Surge Plan outlines the support role that the Regional Health care Preparedness Coordinator (RHPC) plays during a medical surge event at a CMHPC member facility. This plan will integrate region-wide medical, health and community resources before, during and after an emergency which exceeds the ability of the health care system.

## Assumptions

* In order to manage medical surge, during incidents, only the most acutely injured or ill should be treated at hospitals. Clinics and other medical facilities (i.e. surgery centers) may be requested to assist if needed.
* The CMHPC HMAC may be activated to assist with surge capacity, patient transportation needs, staffing needs, resource sharing and requests, and communications. Regional staff will work in cooperation with the appropriate Hospital Command Centers and Local or State Emergency Operations Centers. See CMHPC Regional Coordination Plan.
* Facility level Crisis Standards of Care plans may need to be implemented with the Medical Surge Plan to address shortages of equipment, supplies, pharmaceuticals, beds, personnel, and sources of transportation.
* Central Region Hospitals have Emergency Operations Plans (EOPs) that address medical surge capacity and capabilities and activation and operation of Alternate Care Sites (ACS). The HMAC can support medical surge or ACS plans as needed.
* This plan does not cover isolation or quarantine which are not medical surge conditions; they are public health containment measures used to control the spread of communicable diseases which may occur in single, cluster or larger patient quantities.
* Risk communications and resource management procedures are described in the Communications Plan.

## Crisis Standards of Care

As defined by the Minnesota Department of Health – Science Advisory Team, Crisis standards of care (CSC) is when health care systems are so overwhelmed by a pervasive or catastrophic public health event it is impossible for them to provide the normal, or standard, level of care to patients. In situations like this, a formal declaration by state government would occur to recognize health care systems are in crisis operations that may last for some time. MDH supports CSC planning as it is impossible to predict the timing and severity of a future outbreak and waiting for the disaster to strike would be too late.

In recognition of this potential, a Science Advisory Team, composed of physicians, public health, ethicists, facility operations, and others subject matter experts were asked to anticipate what resource shortages might occur, and potential changes health care systems may need to implement in response. A current situation where crisis standards of care were enacted was for the 2020 COVID-19 response, where health care worker Personal Protective Equipment (PPE) became scarce.

 As resource demands begin to exceed supply, health care systems begin to move from conventional, to contingency measures, and finally to crisis standards as seen in the table on the next page.

### Allocation of resources along the care capacity continuum

As incident demand/resource imbalance increase the risk of morbidity/mortality to patient increases.

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Conventional** | **Contingency** | **Crisis** |
| Space | Usual patient care space fully utilized | Patient care areas re-purposed example: post anesthesia monitored units used for ICU care | Facility damaged/unsafe or non-patient care areas (classrooms etc.) used for patient care |
| Staff | Usual staff called in and utilized | Staff extension (brief deferrals on non-emergent service, supervision of broader groups of patients, change in responsibilities, documentation, etc.) | Trained staff unavailable or unable to adequately care for volume of patients even with extension techniques |
| Supplies | Cached and usual supplies used | Conservation, adaptation, and substitution of supplies with occasional re-use of select supplies | Critical supplies lacking, possible reallocation of life-sustaining resources |
| Standards of care | Usual care | Functionally equivalent care | Crisis standards of care |
| **Normal Operating Conditions** |  |  | **Extreme operating conditions** |

For the full MDH Crisis Standards of Care CONOPS, ethical, legal, EMS, and health care facility considerations, go the MDH website at<https://www.health.state.mn.us/communities/ep/surge/crisis/index.html>.

## Planning for Medical Surge

The intent of the CMHPC Medical Surge Plan is to add specific Medical Surge tenets to be used by the HMAC to coordinate the response to a medical surge event. The CMHPC Response Plan outlines the HMAC Activation, Information Gathering process, HMAC Operations, and additional details about the response.

### Immediate Bed Availability (IBA)

* IBA is a means to provide appropriate levels of care to all patients during a disaster by availing 20% of staffed beds to higher acuity patient within four (4) hours of a disaster and identifying and providing the appropriate care for lower acuity patients. Each hospital in the CMHPC will adjust their facility Medical Surge Plans to accommodate the 20% increase by off-loading patient, early discharges, increasing staff, etc.
* The CMHPC will be asked to demonstrate the capability of all the hospitals in the region to both deliver appropriate levels of care to all patients as well as to provide no less than 20% immediate availability of staffed beds within a few hours of notification of the event.
* Real time data and capacity will be assessed as needed by MNTrac alerts and using a pre-designed Survey Monkey survey. See also Essential Elements of Information.

### Emergency Medical Services (EMS)

* The CMHPC includes the Regional EMS Coordinator to streamline planning efforts. EMS would also be included in the HMAC upon activation. EMS agencies within the region are encouraged to plan and train with other coalition members. They are invited to participate in training and exercises.

## Types of Medical Surge

### RHPC Role in Pandemic and Infectious Disease Response

* With PHPC, consider activation of the HMAC to:
	+ Disseminate information from Minnesota Department of Health to the members.
	+ Coordinate with Public Health Departments.
	+ Establish periodic briefings to assess impact on Coalition, including:
		- Current capacities and needs.
		- Reporting and monitoring of influenza like illnesses.
		- Assess status of staffing and patient load at coalition hospitals.
		- Anticipate needs for upcoming period.
* RHPC can assist with communications and information sharing under the direction of MDH and LPH.
* Encourage healthcare facilities to activate their facility pandemic plan.
* RHPC can assist with resource requests for coalition.

### RHPC Role in a Mass Casualty Incident (MCI), Pediatric Surge, or CBRNE/HAZMAT Event

* The RHPC can evaluate the response and activate the HMAC if needed. The HMAC can assist with:
	+ Bed availability within the region and with neighboring regions
	+ Resource requests and allocation
	+ Situational awareness
* Refer facilities to their MCI/Medical Surge Plans as assist as requested.
* The RHPC (with or without HMAC Activation) can provide general support for Coalition members as requested.

### Facility Evacuation or Facility Shelter-in-Place

* Facilities within the CMHPC are asked to have their own plans in place for Evacuation or Shelter-in-Place. The RHPC will support the facility as needed, to include the activation of the HMAC.

## Resources for Medical Surge – Mobile Medical Team

* A Minnesota Mobile Medical Team (MN-MMT) is a group of volunteer medical and support professionals who have received training and practice in providing acute medical care in a mobile field environment. When a community experiences a tornado, flood, or other incident that temporarily overwhelms its ability to provide health care services, the MMT can deploy either with the equipment needed to establish a range of clinical services (Type I) or without equipment to support staffing needs in existing care facilities (Type II). There are currently two MMTs organized under one model that could respond to incidents in Minnesota.
* If a CMHPC member wants to request the MN-MMT, they should call their local emergency management (EM). Local EM will refer that request to the Minnesota Department of Homeland Security and Emergency Management (HSEM) or State Duty Officer who will pass the request to the Minnesota Department of Health (MDH). MDH will pass the request to the MN-MMT Leadership to finalize the request and plan for activation.
* Regional Caches and Supplies
* The Region does have a cache of supplies and equipment that coalition members can request.

A full description of the Minnesota Mobile Medical Teams is provided on the Central/West Central website.

1. Burn Surge Plan

In the event of a medical surge burn incident, the MN State Burn Surge Plan calls on each region to initially treat and stabilize burn victims for up to 72 hours if transportation to MN Burn Centers is not feasible. This burn surge appendix provides a regional framework to support and supplement the MN Statewide Burn Surge plan. This appendix identifies the Central Healthcare Preparedness Coalition’s response to a medical surge event involving severe or life-threatening burns.

See the full Minnesota Burn Surge Plan and list of burn surge facilities at the MDH website: <https://www.health.state.mn.us/communities/ep/surge/burn/burnsurgeplan.pdf>

As outlined in the statewide plan, if the incident requires more resources than Minnesota is capable to provide, requests can be made to both the Great Lakes Healthcare Partnership (GLHP) and the ABA Midwest Region for assistance (Statewide Plan Appendix C: Interstate Burn Unit Resources).

Each jurisdiction with the region has conducted a Hazard Vulnerability Assessment (HVA) and at a minimum reviews it annually. The HVA looks at hazards that could lead to an increased risk to individual and community physical health.

Risk factors assessed include but not limited to:

Pipelines

Refineries

Wildfire risk

Terrorism

Transportation risks

Lack of burn resources

In addition, specific known activities within each region are assessed. Each year the coalition takes the time to review these HVA’s and look for any changes. The coalition reviews individually first, then as a group the region reviews so all are aware of any changes.

## Concept of Operations

The State of Minnesota currently has two Burn Centers acknowledged by the American Burn Association (ABA), which are Hennepin County Medical Center (HCMC) and Regions Hospital. Both certified burn centers are outside of the Central Region and located with the Metro Region. During a burn surge incident, the initial receiving facility will collaborate and communicate with the burn centers. If, at some point, the MN Burn Centers are unable to accept the number of patients referred to them, the statewide Burn Surge plan will be activated. Normal day to day operations are the goal of this plan, this plan will only be activated when local resources are exhausted and the MN Burn Centers are unable to provide immediate care for burn patients. The Central region has identified a facility that would be considered as a Burn Surge facility. Initial receiving facilities may be directed to transfer burn patients to burn surge facilities for up to 72 hours as burn centers work amongst themselves and in conjunction with out-of-state burn centers to accommodate the number of patients needing medical care from a burn center.

See Link to the MN Statewide Burn Surge plan and Communication Plan.

## Initial Receiving Hospital

The initial receiving hospital will provide initial stabilization and treatment to burned patients, as directed by their medical director or through advisors at one of the MN Burn Centers. Although burn patients should be transferred to the appropriate burn center as soon as possible, the extent of the incident and the availability of burn bed resources may exceed capacity of the burn center. If this occurs, patients may be transferred to an alternative location, such as a Burn Surge Hospital. Transportation arrangements should be coordinated by the initial hospital and the receiving facility, utilizing agreements with their Emergency Medical Services (EMS) partners.

The Regional EMS Coordinator would be notified immediately through the HMAC process and would assist in coordinating resources as well as obtaining any additional assets if local resources were outstripped.

Recognizing that burn patients would potentially require at a minimum advanced life support (ALS) assets. The Central Region does have several ALS services. In addition, there are times when air transportation would be advantageous, and two services operate within the region. Additional air transportation assets would be available through Regional EMS if needed.

## Regional Burn Surge Hospital Identification

Minnesota has identified Burn Surge Facilities (see MN Burn Plan). The Central healthcare preparedness coalition has identified a burn surge hospital to be utilized in a surge event. In coordination with the MN Burn Center, patients may be transferred from the initial receiving hospital to the Burn Surge facility who will provide treatment until more definitive care options are available. All burn victims will be triaged for transfer to specialty care based on the American College of Surgeons Burn Center Referral Criteria outlined in the statewide plan (Appendix E). The Burn Surge facility will be responsible to care for the burn patients in the event of a statewide surge. This responsibility can last up to 72 hours. The MN Burn Center will work with state partners to coordinate care and transportation of burn patients according to the MN State Burn Surge Plan. The burn surge facility within the Central Region is: St. Cloud Hospital 1406 6th Ave N. St. Cloud, MN 56303 Phone: 888-387-2862

Per the Minnesota Burn Surge Plan, the ABA verified Burn Centers may provide telephone/telemedicine expertise to assist BSFs caring for victims. Additionally, if all burn specialty staff are overwhelmed during the response, the HCCs can ask MDH-CEPR to request telemedicine support from the GLHP and the ABA Midwest Region.

## Role of the Regional Health Care Preparedness Coordinators (RHPC)

During a burn surge event, the RHPCs in the state will be notified of the activation of the MN Burn Surge plan by the Metro Regional Healthcare Resource Center (RHRC). The RHPC will communicate with regional partners and together, a decision will be made if the HMAC needs to be opened, either physically or virtually. The HMAC will be available to assist with resource requests as needed during the surge event, however, they will not be directly involved in patient care activities and will not coordinate patient movement. If there is a request for identification of available beds within the region or in neighboring regions, the RHPC will initiate bed tracking within MNTrac. The information obtained will be shared with the appropriate partners. The HMAC will communicate with regional partners according to the regional communication plan.

Prior to an event the RHPC also assesses the HVA’s within the region and discuss with local facilities any changes in risk.

The RHPC also in contact with regional facilities regarding any specific resources helpful in a burn situation. Currently, the region does NOT have a cache of additional burn supplies beyond what the major level II facility has for normal operations. Additional support and supplies would be gathered within the region first and secondly asks of other coalitions would be needed in a larger event.

## Training and Exercise Recommendations

It is important that first responders, EMS personnel, and first receiving hospitals have appropriate education and training to increase their knowledge, skills and abilities for the initial treatment and supportive care for the burn-injured patients. The CMHPC will make all attempts to assist in coordinating training opportunities. Each hospital within the CMHPC will be provided with one Advanced Burn Life Support (ABLS) Handbook. All efforts to facilitate or notify facilities of training opportunities will be provided by the RHPCs.

The Minnesota Department of Health maintains just-in-time training resources online: https://www.health.state.mn.us/communities/ep/surge/burn/ index.html. These include videos, quick references to determine burn depth and surface area, order sets, and Resource and Triage Cards in the Patient Care Strategies for Scarce Resource Situations. All BSFs should use the Burn Care Supply recommendations outlined in the statewide plan for planning purposes.

The HMAC may be activated to support a burn surge response. Also see the sections on Communications and HMAC activation.

1. Pediatric Surge Plan

This appendix applies to a mass casualty event with many pediatric patients. It is designed to support the Central Minnesota Health Care Preparedness Coalition (CMHPC) response activities by addressing the specific needs of children and the medical care of a pediatric patient. This plan does not replace any existing facility policies or plans. It is designed to support the facility level plans by providing pediatric specific resources and information.

Also see the Minnesota Pediatric Surge Plan located on the MDH website at: <https://www.health.state.mn.us/communities/ep/surge/pediatric/pedsurgeplan.pdf>

## Scope

The CMHPC Regional Pediatric Surge Plan is designed to provide the communication processes and the procedure for inter-regional and interstate transfer as related to pediatric patients. This pediatric surge appendix provides a regional framework to support and supplement the MN Statewide Pediatric Surge plan. The Plan is designed to:

* Support safe pediatric transfer decision making
* Discuss and identify standardized care guidelines available for facilities
* Provide tools to ensure regional communication processes are in place
* Support the tracking of pediatric patients throughout the incident
* Identify the pediatric tertiary care centers/specialty care centers
* Assist with the decompression from pediatric tertiary care centers/specialty care centers in order to make additional critical care beds available for acutely ill/injured pediatric patients

## Risks/Vulnerabilities

As of 2018, the total population in the CMHPC region was estimated to be 765,725. Within this, 5.7% are under the age of 5 and 21.6% are under the age of 18. (See CMHPC All Hazards Plan pages 14-21, Attachment A: Coalition Demographics and Map). In 2018, there were 9,876 vehicular accidents where at least one school bus was involved. In all there were 603 school buses directly involved in these crashes ([www.dps.mn.gov](http://www.dps.mn.gov)). School buses travel throughout the CMHPC every day and many students rely on bus transportation to get to and from school in addition to school events. The CMHPC has 19 hospitals within the region and an event that impacts the regions pediatric population would have a major impact on the ability of health care services to provide care. With a pediatric population of approximately 216,000 in the region and the limited amount of health care resources, the regions facilities will be very reliant upon the neighboring health care facilities as well as the pediatric specialty facilities in the state. Depending on the location, transport time could be lengthy.

The table below (2018 data) identifies the number of pediatric specific resources available at each facility:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name of Facility | # Pediatric Beds | # PICU Beds | # NICU Beds | Pediatricians on staff |
| First Light (Welia) | **1** | 0 | 0 | Yes |
| Fairview Lakes | 4 | 0 | 0 | Yes |
| Fairview Northland | 2 | 0 | 0 | Yes |
| Melrose Hospital | 2 | 0 | 0 | Yes |
| Monticello Hospital | 2 | 0 | 0 | Yes |
| St. Cloud Hospital | 14 | 4 | 30 | Yes |
| St. Joseph’s Hospital | 6 | 0 | 0 | Yes |

\*\*\* The remaining facilities in the Central Region do not have pediatric beds\*\*\*

The Central region has 31 pediatric beds, with many of them at one or two locations. There are no Pediatric Trauma Centers located within our coalition and St. Cloud Hospital being a level II facility with both a PICU and an NICU would be the closest for many facilities. During a surge event, even this asset may not provide everything needed. During surge events, other regions will need to assist with appropriate pediatric bed placement. The other regions that could help will be the metro, northeast and southeast regions, depending on the location of the incident.

The following table identifies additional pediatric centers within the State of Minnesota:

|  |  |  |
| --- | --- | --- |
| **TRAUMA DESIGNATION** | **HOSPITAL NAME** | **HCC CONTACT** |
| Level I | Children’s of Minnesota, Minneapolis | Metro Health & Medical Preparedness Coalition612-873-9911 |
| Level I | Hennepin County Medical Children’s Hospital |
| Level I | Regions Hospital/Gillette Children’s Specialty Healthcare |
| Level I | Mayo Clinic Hospital Eugenio Litta Children’s Hospital | Southeast Minnesota Disaster Health Coalition855-606-5458507-255-2808 |
| Level I | Essentia Health St. Mary’s Medical Center | Northeast Healthcare Preparedness CoalitionJo Thompson 218-269-7781Adam Shadiow 218-428-3610 |
| Level II | North Memorial Health Hospital | Metro Health & Medical Preparedness Coalition612-873-9911 |

## Access and Functional Needs

Health care facilities and the coalition consider planning for individuals with Access and Functional needs in all plans. The pediatric population requires special equipment and resources. A list of available resources for planning and response considerations is provided at the end of this plan.

### Estimated disabilities

The following chart reflects 2019 data estimating disabilities among the pediatric population in the Central Region.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | All Disabilities | Hearing difficulty < 17 years | Vision Difficulty < 17 years | Cognitive Difficulty < 18 years | Ambulatory Difficulty <18 years | Self-Care difficulty <18 years |
|  | < 5 | 5-17 | <5 | 5-17 | < 5 | 5-17 |  |  |  |
| Benton |  21  | 508 |  19  | 42 | 2 | 94 | 428 | 40 | 94 |
| Cass | 50 | 290 | 37 | 37 | 17 | 28 | 220 | 19 | 45 |
| Chisago | 48 | 411 | 41 | 44 | 7 | 61 | 301 | 60 | 149 |
| Crow Wing | 69 | 569 | 68 | 54 | 51 | 56 | 512 | 38 | 97 |
| Isanti | 47 | 448 | 47 | 52 |  | 33 | 378 | 18 | 105 |
| Kanabec | 5 | 265 |  | 30 | 5 | 37 | 220 | 18 | 42 |
| Mille Lacs | 53 | 344 | 12 | 13 | 41 | 13 | 302 | 30 | 95 |
| Morrison | 3 | 372 | 3 | 32 |  | 21 | 315 | 91 | 110 |
| Pine | 17 | 248 | 1 | 22 | 16 | 30 | 204 | 8 | 42 |
| Sherburne | 134 | 989 | 91 | 139 | 107 | 105 | 601 | 56 | 224 |
| Stearns | 64 | 1287 | 25 | 143 | 53 | 189 | 958 | 117 | 258 |
| Todd | 23 | 204 | 10 | 20 | 13 | 43 | 170 | 36 | 53 |
| Wadena | 8 | 221 |  | 17 | 8 | 86 | 1702 | 71 | 79 |
| Wright | 72 | 1216 | 72 | 154 |  | 90 | 1021 | 147 | 388 |
| **Totals** | **614** | **7372** | **426** | **799** | **320** | **886** | **5800** | **749** | **1781** |

 Data collected from: [*http://w20.education.state.mn.us/MDEAnalytics/Data.jsp*](http://w20.education.state.mn.us/MDEAnalytics/Data.jsp)

 Information obtained 08/30/2019 (Blank spaces were unreported)

## Pediatric Plan Activation

Activation of the pediatric surge plan could occur in two ways:

* An incident occurs within the Central region resulting in a pediatric surge and a hospital within the region notifies the Regional Healthcare Preparedness Coordinator (RHPC);
* A pediatric surge event occurs outside the Central Region and the RHPC is notified through a contact via a MNTrac alert or direct contact from the RHPC in a different region.

When an incident occurs resulting in pediatric victims, the initial response should follow local surge plans. Local hospitals and EMS agencies should assess:

* Scope and magnitude of the incident,
* Estimate the influx of patients and the real or potential impact on the local health care system,
* Consider special response needs (e.g., infectious disease, hazardous materials, etc.), and
* Need for Internal emergency response plan activation.

The referring hospital will notify the pediatric trauma center they typically utilize and advise them of the situation. If the designated pediatric trauma center activates their internal surge plan, they are responsible to request activation of the Minnesota Pediatric Surge Plan by contacting their HCC as delineated in their regional coordination plan. The pediatric trauma center will assume the role of the State Coordinating Pediatric Trauma Center (SCPC).

Activation of the statewide Minnesota Pediatric Surge Plan is done as outlined in the Concept of Operations of that plan, again located on the MDH website at: <https://www.health.state.mn.us/communities/ep/surge/pediatric/pedsurgeplan.pdf>

## Pediatric Plan - Roles and Responsibilities

### ****Initial Receiving Hospital/Health Care Facility****

It is expected that all hospitals providing emergency care maintain a standardized basic level of preparedness and ability to deal with traumatic injury. Per the Minnesota Pediatric Surge Plan, the State Coordinating Pediatric Trauma Center may provide telephone/telemedicine expertise to assist stabilizing hospitals caring for victims. Additionally, St. Cloud Hospital does have pediatric specialties on staff to access along with pediatric behavioral health capabilities. Facilities could also consider accessing city and county Human Service departments, local schools and non-profits located in their communities for additional assistance outside of medical care of needed. Central regional healthcare staff can also be tasked with looking for services as well.

The initial receiving facility determine the need to:

* Activate their organizations emergency operations plan
* Attempt to obtain resources through its normal and contingency methods (such as special agreements with other facilities within its parent organizations)
* Assess the response needs and communicate with the pediatric trauma center for guidance
* Notify the health care coalition of the situation and identify any specific needs from the coalition

### Designated Pediatric Trauma Center

The designated pediatric trauma center will determine the need to:

* **Assess the situation and if deemed necessary activate their facilities surge plan**
* **Provide guidance to the initial facility regarding stabilization of patients**
* **Notify the HCC of the need to activate the states Pediatric Surge plan**

### ****Health Care Coalition****

The health care coalitions will determine the need to:

* Activate the Coalition Health Multi-Agency Coordination Center (HMAC)
* Issue a MNTRAC Alert and/or set up a regional conference call or coordination room
* Create a Patient tracking room within MNTrac
* Initiate a bed availability request statewide
* Monitor MNTRAC periodically
* Identify needs, and coordinate movement of available healthcare resources
* Connect with MDH DOC or CEPR 24/7
* Maintain situational awareness of healthcare status.
* Facilitate deployment of disaster stockpiles.

The coalition does not maintain a specific cache of pediatric supplies, but will coordinate with MDH and other regions for additional resource needs as able.

### Additional Resources for Pediatric Surge Planning

For additional pediatric planning resources, see the MDH Pediatric Surge Plan and Toolkit at: <https://www.health.state.mn.us/communities/ep/surge/pediatric/index.html>.

1. Fatality Management Plan

The following, outlines the role of the Central Minnesota Health Care Preparedness Coalition (CMHPC) in response to a mass fatality incident (MFI), and provides guidance to CMHPC members for their facility planning.

## Fatality Planning Assumptions

The following assumptions apply to this fatality management plan.

* Local Emergency Management is responsible for Fatality Management Operations.
* Fatality Management Operations will occur in accordance with local Emergency Operations Plans (EOPs) and contracts with the local Medical Examiners and/or Coroners. Refer to local EOPs for details.
* The Coroner or Medical Examiner must be notified of any death where the cause of death is other than natural (i.e. accident, homicide, and suicide). Minnesota state statutes list additional circumstances when the county coroner or medical examiner must be notified (See *Minnesota Statutes Section 390.11, Subdivision 1. Reports of death.* *“All sudden or unexpected deaths and all deaths that may be due entirely or in part to any factor other than natural disease processes must be promptly reported to the coroner or medical examiner for evaluation. Sufficient information must be provided to the coroner or medical examiner.”*)
* Mass Fatality Incident (MFI) is an emergency management term used to identify an incident involving more dead bodies and/or body parts than can be located, identified, and processed for final disposition by available response resources.
* The Central Region may be activated to assist with the response. See: Appendix E: Coalition Activation, Response, Demobilization Checklists for more information.

## Role of the Regional Healthcare Preparedness Coordinator (RHPC) in Fatality Management

* Assist CMHPC members in Fatality Management Operations
* Anticipate storage needs for a surge of human remains
* Guide development of hospital mass fatality plans. Refer to Attachment A: Fatality Plan Components for information related to hospital-based fatality management operations.
* Procure mortuary storage equipment
* Family Assistance Center (FAC)
* An FAC may be setup to provide for the support of family members. Local Public Health and local Emergency Management are the lead agencies for an FAC.
* The RHPC or the Central Region Healthcare Multi-Agency Coordination (HMAC) may assist with the FAC but providing situational awareness, communications, or other support. See Chapter 1: CMHPC Regional Coordination Plan.
* Mental and Behavioral Health Support
* Mental Health and Behavioral Health are available to the CMHPC members. The RHPC can assist with requesting these resources.

## CMHPC Fatality Management Plan Components

### Process for Identification of Remains

* To the extent possible, remains and associated personal effects should be identified.
* When identification is not possible, a good augmentation plan ensures a unique designation is assigned to each body and/or body part. This system of designation should also be used for personal effects; effects and remains are given the same number only when it is absolutely certain the remains and effects are associated with each other.
* When multiple remains are involved, articles of identification are not to be removed from the body until an alternative method (toe tag, etc.) has been attached to that body.

In some circumstances, the augmentation plan may need to provide a place for next of kin to identify the remains. This space should not have multiple bodies in it during the identification; it should provide privacy for family members to view the remains.

### Security

* The remains and the personal effects must be kept secure while in the custody of the medical facility. Existing morgues may be adequate. If not, plans should reflect alternative locations and methods of providing security.
* Plans must clearly spell out when and to whom remains and personal effects can be released. When the death is not a coroner’s case, it will probably be appropriate to release the personal property of the deceased to the next of kin. For coroner’s cases, all personal property must be given to the coroner/medical examiner, who will arrange for its return to appropriate members of the family.
* Logs and other forms will be helpful in keeping track of which remains are in custody, where the remains are located, and when remains have been released to the custody of another.

### Coordination

* During a mass fatality incident, coordination could be required among several agencies, organizations and individuals. Examples include:
* Office of the coroner/medical examiner.
* Law enforcement agencies.
* Emergency medical services.
* Physicians who have cared for the deceased in the past.
* Government representatives (city, county, state, federal).
* Members of the family of the deceased.
* Mortuaries.
* Media.
* Volunteer organizations.
* Mass fatality incident plans must ensure accurate, appropriate, consistent information is provided to each group in a timely way.

### Storage

* Remains and personal effects must be kept in ways that provide security, dignity, and safety. Remains should be stored in ways that do not have an adverse effect on identification, post-mortem examination, or rituals and religious services for the deceased.
* Vinyl or plastic pouches provide a barrier between the body and hospital / mortuary personnel, and are recommended when the cause of death is an infectious disease. In traumatic or disfiguring deaths, pouches facilitate storage and transfer. When several bodies are present in one location, pouches offer a degree of privacy and a sense of dignity.
* Temperature controls are an important consideration when choosing a storage facility. Ideally human remains should be stored between 38-42 degrees Fahrenheit. This slows changes to the body that affect the outcomes of medico-legal investigations, post mortem examinations, and embalming/restoration (if this option is selected by family members).
* Freezing distorts the physical appearance of the body, requires a thawing period before certain examinations and procedures can be completed, and causes inter-cellular damage and changes to tissue color. These may compromise subsequent exams, interpretations of injuries, and embalming/restorative efforts. In limited circumstances, freezing may be required to stop post-mortem changes and allow certain procedures to be performed (e.g. jaw bone removal to assist in identification). Freezing may be considered when bodies have been dead for a considerable time and extensive decomposition (without mummification) has taken place, such as if a body has been submerged in water for several days.
* Stacking of bodies must be avoided. Stacking shows a lack of respect for the people who have died, it can cause distortion of features (which make identification and restoration more difficult), and it is harder to access and move bodies that have been stacked. Shelves or racks increase the number of bodies that can be stored per square foot of floor space in a temperature-controlled room or container.

Minnesota Department of Health (MDH) helps maintain a disaster portable morgue unit that was purchased with Federal Emergency Management Agency (FEMA) program funds, and supports a Disaster Mortuary Emergency Response Team that could be activated during a mass fatality incident.

1. Coalition Activation, Response, Demobilization Checklists

The Central Region Health Care Preparedness Coordinator (RHPC) will operate consistent with Emergency Operations Coordination Annex when contacted with a request from a coalition member to provide support or activation of the HMAC Coordinating group. The following pages provide checklists that identify specific notification, activation, and coordination action considerations for the primary coalition member participants. Please note, respective disciplines should utilize existing methods of information sharing amongst their disciplines and jurisdictions as outlined in their local or agency/organization plans.

|  |  |
| --- | --- |
| Activation | Check |
| Notify all HMAC Coordinating group members of incident |  |
| Confirm receipt of information to HMAC members |  |
| Contact MDH Consultant Supervisors (PHEP, HPP respectively) |  |
| If supervisors are not available call MDH EPR 1-651-201-5735 |  |
| Create Coordination Center Room on MNTrac |  |
| Invite Coordination Entity + MDH Supervisor of HSPP and PHEP to Coordination Center Room |  |
| Identify additional resource members necessary for response |  |
| Invite resource members to Coordination Center Room |  |
| Begin incident check-in list (ICS Form 211) |  |
| Begin individual activity logs (ICS Form 214) |  |
| Response | Check |
| Establish response structure/roles (ICS Form 203) |  |
| Identify response objectives (ICS Form 202); including demobilization trigger |  |
| Establish communication plan (ICS Form 204 & 205) |  |
| Complete incident briefing (ICS Form 201)  |  |
| Determine incident briefing schedule |  |
| Share incident briefing schedule with appropriate partners |  |
| Share incident briefing with appropriate partners as pre-determined intervals |  |
| Repeat as necessary for duration of incident |  |
| Re-evaluate demobilization readiness |  |
| Demobilization | Check |
| Choose closing date/time for operations |  |
| Complete demobilization checkout (ICS Form 221) |  |
| Provide final incident briefing indicating close date/time to partners |  |
| Close Coordination Center Room on MNTrac |  |
| Finalize and submit all ICS Forms |  |
| Conduct on-site/virtual debriefing |  |
| Set date for After Action Meeting |  |
| Review supplies/resources |  |
| Replenish supplies as necessary |  |

1. HMAC Activation Checklist by Discipline

### HMAC: RHPC Response

|  |  |
| --- | --- |
| HMAC Activation – RHPC Actions | Check |
| Coalition member contacts RHPC who collects initial information: |  |
| * Person calling
 |  |
| * Agency/Facility
 |  |
| * Incident location
 |  |
| * Incident type
 |  |
| * Brief Description
 |  |
| * Point of contact
 |  |
| * Support needed
* Supplies, Assets, information sharing
 |  |
| * Use MNTrac to notify all coalition members of the incident and need for activation of HMAC
 |  |
| * Create coordination center room in MNTrac
 |  |
| * Invite HMAC group and MDH EPR Supervisor to coordination center room
 |  |
| * Identify and invite additional SME’s and resource members necessary for response
 |  |
| * Complete and distribute incident briefing (ICS form 201)
 |  |
| HMAC Member Actions | Check |
| Provide the following information to participants in the coordination center room: |  |
| * Current situation (discipline perspective) whether actively involved or monitoring
 |  |
| * Current external (community) situation
 |  |
| * Are other partner disciplines activated, EMS-MACC, Strike team, etc.
 |  |
| * Anticipated or actual support needs (supplies, equipment, personnel, facility support)
 |  |
| * Agency point of contact (name) and contact information and backup contact to allow for follow up
 |  |

### HMAC – Hospital, LTC, Other Health care

|  |  |
| --- | --- |
| Coalition Member Activation of HMAC | Check |
| Prior to contacting the RHPC to discuss support activities, identify the following: |  |
| * Person calling:
 |  |
| * Agency/Facility:
 |  |
| * Incident location:
 |  |
| * Incident type:
 |  |
| * Designated point of contact:
 |  |
| * Support needed (supplies, assets, information sharing, etc.)
 |  |
| Contact the CMHPC RHPC 24/7 320-654-2720 and provide the following information:“This is [Your facility/organization name] requesting RHPC or HMAC assistance”Your callback information if calling by phone and backup notification method |  |
| HMAC Member Actions | Check |
| Provide the following information to participants in the coordination center room: |  |
| * Current situation (discipline perspective) whether actively involved or monitoring
 |  |
| * Current external (community) situation
 |  |
| * Are other partner disciplines activated, EMS-MACC, Strike team, etc.
 |  |
| * Anticipated or actual support needs (supplies, equipment, personnel, facility support)
 |  |
| * Agency point of contact (name) and contact information to allow for follow up
 |  |
| * Continue providing discipline informational updates and essential information as requested
 |  |

### HMAC – EMS

|  |  |
| --- | --- |
| Coalition Member Activation of HMAC | Check |
| Prior to contacting the RHPC to discuss support activities, identify the following: |  |
| * Person calling:
 |  |
| * Agency/Facility:
 |  |
| * Incident location:
 |  |
| * Incident type:
 |  |
| * Designated point of contact:
 |  |
| * Support needed:
* Supplies, Assets, information sharing, etc.
 |  |
| Contact the RHPC 24/7 at 320-654-2720 and provide the following information:“This is [Your facility/organization name] requesting RHPC or HMAC assistance”Your callback information if calling by phone and backup notification method |  |
| Expected RHPC Actions | Check |
| The RHPC actions may include: |  |
| * Notify all coalition members of the incident and activation of HMAC
 |  |
| * Confirm information received to HMAC
 |  |
| * Create coordination center room in MNTrac
 |  |
| * Invite HMAC and MDH EPR Supervisor to coordination center room
 |  |
| * Identify and invite additional SME’s and resource members necessary for response
 |  |
| * Complete and distribute incident briefing (ICS form 201)
 |  |
| HMAC Member Actions | Check |
| Provide the following information to participants in the coordination center room: |  |
| * Current situation (discipline perspective) whether actively involved or monitoring
 |  |
| * Current external (community) situation
 |  |
| * Are other partner disciplines activated, EMS-MACC, Strike team, etc.
 |  |
| * Anticipated or actual support needs (supplies, equipment, personnel, facility support)
 |  |
| * Agency point of contact (name) and contact information to allow for follow up
 |  |
| * Continue providing discipline informational updates and essential information as requested
 |  |

### HMAC - Public Health

|  |  |
| --- | --- |
| Coalition Member Activation of HMAC | Check |
| Prior to contacting the RHPC to discuss support activities, identify the following: |  |
| * Incident location
 |  |
| * Incident type
 |  |
| * Designated point of contact
 |  |
| * What support you need (examples):
* Supply equipment support
* Information sharing support
* Monitoring
 |  |
| Contact the Central Region RHPC 24/7 at 320-654-2720 and provide the following information:“This is [Your agency name] requesting RHPC or HMAC assistance”Your callback information if calling by phone and backup notification method |  |
| HMAC Member Actions | Check |
| Provide the following information to participants in the coordination center room: |  |
| * Current situation (discipline perspective) whether actively involved or monitoring
 |  |
| * Current external (community) situation
 |  |
| * Anticipated or actual support needs (supplies, equipment, personnel, facility support)
 |  |
| * Agency point of contact (name) and contact information to allow for follow up
 |  |

### C5: HMAC – Emergency Manager

|  |  |
| --- | --- |
| Coalition Member Activation of HMAC | Check |
| Prior to contacting the RHPC to discuss support activities, identify the following: |  |
| * Person calling:
 |  |
| * Agency/Facility:
 |  |
| * Incident location:
 |  |
| * Incident type:
 |  |
| * Designated point of contact:
 |  |
| * Support available or needed:
* Supplies, Assets, information sharing, etc.
 |  |
| Contact the RHPC 24/7 at 320-654-2720 and provide the following information:“This is [Your county/city name] providing/requesting RHPC or HMAC assistance”Your callback information if calling by phone **and backup notification method** |  |
| HMAC Member Actions | Check |
| Provide the following information to participants in the coordination center room: |  |
| * Current situation (discipline perspective) whether actively involved or monitoring
 |  |
| * Current external (community) situation
 |  |
| * Are other partner disciplines activated, EMS-MACC, Strike team, etc.
 |  |
| * Anticipated or actual support needs (supplies, equipment, personnel, facility support)
 |  |
| * Agency point of contact (name) and contact information to allow for follow up
 |  |
| * Continue providing discipline informational updates and essential information as requested
 |  |

### HMAC – Other Coalition Member or Regional Partner

|  |  |
| --- | --- |
| Coalition Member Activation of HMAC | Check |
| Prior to contacting the RHPC to discuss support activities identify the following: |  |
| * Incident location
 |  |
| * Incident type
 |  |
| * Designated point of contact
 |  |
| * What support you need (supply, equipment, support, information sharing support, monitoring)
 |  |
| Contact the RHPC 24/7 at 320-654-2720 and provide the following information:“This is [Your organization name] requesting RHPC or HMAC assistance”Your callback information if calling by phone **and backup notification method** |  |
| HMAC Member Actions | Check |
| Provide the following information to participants in the coordination center room: |  |
| * Current situation (discipline perspective) whether actively involved or monitoring
 |  |
| * Current external (community) situation
 |  |
| * Anticipated or actual support needs (supplies, equipment, personnel, facility support)
 |  |
| * Agency point of contact (name) and contact information to allow for follow up
 |  |

1. RHPC On-Call Staff: Operational Checklist

|  |
| --- |
| The RHPC on-call is a 24/7 staffed position that serves as an initial point of contact for the Coalition. The major responsibility of this individual is to assist with the identification of an incident for the CMHPC participants and to assist with initial notifications.**Purpose:**  Provide guidance for addressing the responsibilities of the RHPC On-Call staff during day to day activities and during initial response to an incident. |
| RHPC Responsibilities: | Check |
| Remain available with communication devices on a 24/7 basis while on call. |  |
| Receive initial notification of potential incident parameters and document findings on Form 201 if appropriate |  |
| Gather additional information if needed on incident parameters (refer to communications annex for numbers):* EMS through the EMS MACC
* Local Public health or MDH
* Healthcare facilities
* Primarily affected facility(s)
* Other organizations as needed
 |  |
| Assess incident parameters for potential impact of one or more coalition members to:* Safety of personnel, patients, residents at the facility(s)
* Continuity of operations for the facility(s)
* Potential for surge operations at the facility(s)
* Requirement for support (information or resources) at the facility(s)
* Make determination if this is an incident for a coalition response based upon the above parameters.
 |  |
| Activate the HMAC, if necessary, utilizing MNTrac, email, or other communication platform as appropriate.  |  |
| Send notification to all coalition participants (MNTrac, WebEx, Email, or other platforms as appropriate)* Include brief description and notification category in message title
* Include brief description of incident parameters as known.
* Include desired response from recipients (participate in conf call, update bed availability, etc.)
* Provide information on next expected update if known.

Note: Almost all initial notifications should be accompanied by a request for coalition members to provide a designated POC for MNTrac and to update their situation and resource status in MNTrac as appropriate. |  |
| The RHPC on-call personnel should consider carrying at all times, hard copies of the following forms for rapid access:* Form 201
* HMAC member phone numbers
* MNTrac Alert template
* Situation Update Teleconference Template
* Communications Plan or contact list
* Coalition Response Plan
 |  |

1. Essential Elements of Information/Situational Awareness

This annex identifies what elements of information sharing that will take place between Coalition members and HMAC Group before and during an incident. The HMAC has developed reportable conditions to be provided by Coalition members that would be aggregated and provided in status reports to the MDH, Coalition members and other jurisdictional partners as needed in order to facilitate local, regional, or statewide response decisions.

Table 1 provides examples of the types of common elements of information and situational awareness information that could be requested from health care organizations, the target audience to receive that information, and how the target audience would likely provide or receive the information.

| Type of Information Collected | Method of Information Collection/Dissemination | Target Audience |
| --- | --- | --- |
| Health or medical Provider reporting lack of necessary resources. | Survey Monkey, MNTrac, Email, Phone  | CMHPC, EMS, HMAC, MDH |
| Health care organizations reporting lack of surge capacity (high patient counts). | Survey Monkey, MNTrac, Email, Phone  | CMHPC, HMAC, MDH, Other Health Organizations, other state health care coalitions |
| Health care organizations reporting high rates of absenteeism of staff members that it is impacting normal operations. | Survey Monkey, MNTrac, Email, Phone  | CMHPC, HMAC, MDH |
| National vendors reporting that they are unable to fill supply request/resource request on back order. | Survey Monkey, MNTrac, Email, Phone  | CMHPC, HMAC, MDH |
| Organization emergency causing change of operations (diversion). | MNTrac | CMHPC, EMS, HMAC, MDH |
| Facility bed availability for patient relocation or transport diversions. | Survey Monkey, MNTrac | CMHPC, HMAC, MDH |
| Patient tracking information | MNTrac, Phone, Email | CHMPC hospitals, LTC, MDH |
| Facility specific bed type availability (influenza, mental health, trauma, surgical). | Survey Monkey, MNTrac | CMHPC, HMAC, EMS, MDH |

1. Planning P and Operational Planning Guidance

The link to [Incident Action Planning Process “The Planning P”](https://training.fema.gov/emiweb/is/icsresource/assets/incident%20action%20planning%20process.pdf) provides operational planning guidance for use during an incident.

1. CMRHPC Cache Resource Request and Allocation

The Central Minnesota Healthcare Preparedness Coalition (CMHPC) maintains a regional cache of healthcare supplies that may be needed to supplement facility supply shortages during an incident. The CMHPC is responsible for maintaining, monitoring, allocation and distribution control of all the inventory items in the cache. As members of the coalition, health care partners have signed the Memorandum of Understanding which states that when available, members agree to assist in resource sharing and acquisition. The resources include durable medical equipment, health care supplies and personnel.

RHPCs will:

* Manage and coordinate requests for supplies.
* Assist in arranging for distribution of supplies in a safe, timely, and efficient manner.
* Maintain the regional cache by reusing, recycling, and disposing of expired surplus cache supplies safely and economically.
* Share resource acquisition information to coalition partners where group buying will allow for decreased costs to coalition members.

## Resource Request

A CMHPC Member or Partner may request products from the regional cache when the following terms are met:

* The facility has utilized their own resources/suppliers and/or local emergency management and the supplies are unavailable within the time frame needed.
* The facility has contacted outside vendors/suppliers and/or local emergency management to request the product and the product is unavailable.
* The facility has contacted the RHPC with a specific need.
* The facility has completed a requisition form with the following:
	+ The product needed and the amount needed.
	+ The anticipated date that the facility will be replacing product used.
	+ The transportation means requested and the time the product is needed by.
	+ A signature from the receiving facility and a signed copy returned to the RHPC.

It is understood the request may not be filled completely due to availability, other requests, and/or the State of Minnesota requirements.

## Allocation

During times of scarce resources, RHPC will initiate an emergency voting process with the CMHPC Advisory Committee. If this cannot be accomplished, the HMAC will determine the allocation and distribution process.

## Distribution

The goal of the CMHPC is to have regional assets deployed within four (4) hours of request.

* The requesting facility will pick up the items or arrange pick up with a courier of their choice (as indicated on the Request Form).
* RHPC may be able to assist in transporting the products in extreme cases. The RHPC will coordinate the distribution of all regional cache items.
* Items in the cache may not be the same model as requested – this may require additional training at the requesting facility. Any additional training and/or fit testing is the responsibility of the requesting facility.
* During large scale or multi-location events, the regional cache will be disseminated based upon coalition needs and may be impacted by guidance through the Minnesota Department of Health. The items contained within the cache are purchased using federal funds and are subject to recall through State or Federal mandate.

## Cache Maintenance

Items in the cache are maintained in a clean, dry, and secure environment. Access to the cache is available 24/7 through the RHPC.

* RHPCs review the regional cache supplies, maintains an inventory log, and updates and maintains the inventory on MNTrac at least annually.
* Any items that are outdated or expired past the manufacture’s recommendations will be stored for future consideration of distribution and use in a supply-crisis or pandemic. (*For example: Recent guidance (3/11/20) by the Center for Disease Control (CDC) has indicated that, in recognition of the supply-crisis currently being experienced globally, due to the COVID-19 Pandemic, certain expired N95 masks may be used to protect healthcare workers.*)
* Equipment and supplies will be maintained per manufacturer guidelines or to the best of the host facilities capabilities.

## Coalition Equipment/Supply Request Form

|  |
| --- |
| Borrower’s Information |
| Date:  | Time:  |  |  |
| Name:  |  |  |  |
| Street Address:  | City:  | State:  | Zip:  |
| Representative:  | Title:  |  |  |
| Phone Number:  | E-Mail:  |  |  |
| Lender’s Information: |
| Name:  |  |  |  |
| Street Address:  | City:  | State:  | Zip:  |
| Representative:  | Title:  |  |  |
| Phone Number:  | E-Mail:  |  |  |
| Supply Information: |
| Type:  | Manufacturer:  | Model Number:  |
| Amount Requested:  | Amount Loaned:  |  Total Amount Loaned:  |

### Agreement to Replace Supplies

For the supplies received from the Lender, the Borrower agrees to replace and/or return to the lender the identical supplies listed on page one.

### Time for Replacement

Borrower agrees to replace and/or return said supplies on or before \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Date).

### Transportation

The borrower and lender shall document the means of transporting the resources:

### Agreement

* The undersigned agree, as borrower and lender, to remain fully bound by this agreement until return and/or replacement of the above listed supplies.
* Any modification or change in terms of this agreement will be requested in writing by the borrower, and shall be valid and binding only after the lender has responded in writing to the borrower, notwithstanding the refusal of the modification or change in terms by the lender.
* It will be the responsibility of the borrower to have any appropriate training, policies and procedures in place for the requested items at their facilities.
* The borrower will hold harmless the Central and West Central Minnesota Healthcare Coalition and CentraCare for any discrepancies, injuries, product failures, including, but not limited to, any and all liabilities associated with storage, distribution, or usage of the supplies received by borrower, including any products received that are expired or past the manufacturers recommended parameters.
* Pursuant to page 3, paragraphs C and D of the “Resources Request and Allocation Process” document, as of 3/12/20, all supplies after this date should be presumed to be expired or past the manufacturers recommended parameters. The borrower is hereby on-notice of these circumstances and chooses to request and accept these supplies.
1. **Effective Date**

This agreement shall take effect as a binding instrument only when signed by all parties and shall be construed, governed and enforced in accordance with the laws of the State of Minnesota.

1. **Signatures**

**Borrower**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Lender**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Annex I: Additional Information

Additional supporting and operational response documents are located both on [Central-West Central Health Care Coalitions Website](https://www.cwchealthcarecoalitions.org/), and MNTrac Document Hub. Some of the information includes:

* List all tools and documents.

### MNTrac Document Hub

* List all tools and documents.