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|  | WESTERN WI HEALTHCARE EMERGENCY READINESS COALITION RESPONSE PLAN REGION 4, V5 |
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|  | Chair: James C. Newlun  Revision Date  **6/2/22** |

**Document Updates**

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| **Version #** | **Update** | **Date of Update** | **POC** |
| 2 (V2) | Entire document revised, too numerous to list all changes | Jan 2019 | HERC Coordinator |
| 3(V3) | - Numerous edits throughout the document  - Added 2.3.1.2 Pandemic Response  - 2.3.1.7 Recovery Phase / Return to Pre-Disaster State:  o Under immediate goals. WWIROC will establish a Disaster Recovery Team; Removed item #4  o Under WWIROC requesting assessments; Maintenance equipment, removed item #3  **\*Note: the region MOU is due to resigning, update plan when completed**  **-** Annex 3, Pediatric Annex was added, P. 34 | April 2020 | HERC Coordinator |
| 4(V4) | - Numerous edits throughout the document  - Annex 2 (Long Term Care) has been replaced with EEI list. LTC Annex is removed until developed  - Appendix 1 (Essential Elements of Information List) has become Annex 2, excel sheet of EEI’s inserted, P. 31  - Annex 4 is the Burn Surge Annex  - All Appendices have been removed | May 2021 | HERC Coordinator |
| 5 (V5) | - Sample EMResource alert message added, Section 2.3.1.4., P. 14  - Western Regional Ops Center (WROC) has been replaced with Western WI Regional Ops center (WWIROC). Throughout the document  - The coalition will utilize eICS in response to all incidents it is activated for. Added, Section 2.3.1.6, P. 16  - Annex 5 is the Highly Infectious Disease Annex, P. 35 | April 2022 | HERC Coordinator |
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**Preface**

The Western WI Healthcare Emergency Readiness Coalition Response Plan (WWHERCRP) is an overall coordination plan among participating entities that describes how:

* Medical (both acute care and non-acute care hospitals), emergency medical services (EMS), public health, emergency managers, and other first responders will coordinate and communicate during a disaster.
* Medical and healthcare resources will be coordinated, shared, and prioritized among healthcare facilities.
* Patient movement will be coordinated among participating hospitals and the WWIROC during an emergency.
* Regional decisions affecting medical and healthcare issues will be made as a collaborative effort.

The WWHERCRP does not supersede existing facility, local, regional, or state level emergency response operational plans; rather, it supports these existing plans and serves as a tool for coordination among participating organizations and the first responder community. The WWHERCRP establishes the Western Wisconsin Region Operations Center (WWIROC). The WWIROC is composed of healthcare professionals who understand the operations, capabilities, and needs of hospitals and medical issues that may arise during an emergency or disaster incident. Healthcare professionals supporting the WWIROC are pre-determined individuals who represent hospitals, emergency services, or other healthcare professionals. Additional expertise from other disciplines, including public health, poison control, HazMat, or public information may be brought in as needed.

When activated, the WWIROC operational staff may consist of:

* WWIROC Lead Coordinator (who also serves as the initial point-of-contact for County Dispatches)
* Two hospital representatives, one from the clinical side and one from hospital operations/administration.
* Medical Director or designee
* RTAC Coordinator
* One public health representative, or one EMS representative, or other subject matter expert(s) based upon the incident. An additional hospital coordinator may also be placed in this position if the situation warrants additional assistance.

The WWIROC provides the analytical, coordination, and communication capability needed for hospitals and other healthcare organizations to be able to effectively respond to any type of emergency event. When activated, the WWIROC operates out of the Tri State Ambulance or Regional Communications Center or Tomah Health. Tri-State Ambulance and Tomah Health both provide the infrastructure and technology needed to support emergency response operations and assists the WWIROC with gathering accurate information about the incident. All members of the WWIROC team will collaborate to make decisions that are in the best interests of the region. Working in coordination with emergency management and other first responders, the WWIROC will make decisions based on the following criteria:

* The first priority for all decisions will be life safety.
* The primary consideration when making decisions regarding transportation and patient placement must be what is best for patients and residents.
* All decisions and protective actions will support regional response operations, regardless of discipline or jurisdiction, as decided upon in coordination with affected incident commanders/EOCs or a public health liaison.

During an emergency, the WWIROC will serve as a center for collecting and disseminating current information about healthcare resources and needs (including equipment, bed capacity, personnel, supplies, etc.), assist with developing priority allocations, tracking disbursement of resources, and other relevant healthcare response matters. If authorized to activate, the WWIROC may be given purchasing authority, once incorporated, which will allow it to directly procure the resources needed to support healthcare response and recovery operations. The WWIROC will serve as a central point of contact between healthcare facilities and other governmental and non-governmental response agencies as necessary. Resource requests between healthcare organizations will follow the rules and guidelines established in the Hospital Mutual Aid Agreement Memorandum of Understanding between Hospitals in the Western Healthcare Region 4, see Annex 1 (Western Health Care Coalition Hospital Memorandum of Understanding). The WWIROC will also communicate and coordinate with hospitals to reach out to neighboring regional hospitals, and with other local, state and federal agencies.

For the WWHERCRP to be operationally viable, a comprehensive training and outreach program is required to identify and prepare WWIROC team members and other first responders on the roles and responsibilities of the WWIROC. Supporting policies, procedures, and plans must be developed or revised to reflect the concepts of coordination, alert and notification, and response and recovery processes described in this WWHERCRP. Senior leadership support from healthcare organizations is essential to the successful implementation of this plan and the future emergency response and recovery capabilities of the region.

1. **INTRODUCTION**

The goal of the Western WI Healthcare Emergency Readiness Coalition Response Plan (WWHERCRP) is to provide for mitigation, planning, response, and recovery to minimize medical and healthcare issues during a disaster affecting the Western Healthcare Region 4. The WWHERCRP is an overall coordination plan among participating entities that describes how:

* Medical (both acute care and non-acute care hospitals), emergency medical services (EMS), public health, emergency managers, and other first responders will coordinate and communicate during a disaster.
* Medical and healthcare resources may be shared and prioritized among healthcare facilities.
* Patient allocation may be coordinated among participating hospitals during an emergency.
* Regional decisions affecting medical and healthcare issues may be made. The WWHERCRP does not supersede existing facility, local, regional, or state level emergency response operational plans; rather, it supplements these existing plans and serves as a tool for coordination among participating organizations and the first responder community.
* The policies and procedures described in the WWHERCRP work within the concept of operations described in hospital, city, county, Western Regional Healthcare Coordination Plan, State Emergency Operations Plans (EOPs).

The WWHERCRP supports the concepts and operations detailed in the individual jurisdiction EOPs and the emergency operations plans for the hospitals included in the following counties:

Buffalo, Crawford, Jackson, La Crosse, Monroe, Trempealeau, Vernon, Ho-Chunk Nation

* The WWHERCRP supports regional response efforts by providing a centralized location that response agencies (such as emergency management and/or emergency operations centers (EOC)) and hospitals can contact to obtain information on the status of hospitals and the medical community and their resources, as well as to obtain advice on medical and healthcare issues.
* During ALL emergency situations the HERC Coordinator needs to be notified as soon as possible to ensure the entire region is alerted of situation, regardless of the extent. This is to ensure the coalition has situational awareness.

**1.1 Purpose of Plan**

The purpose of the Regional Hospital Coordination Plan:

* Provide a unified incident management approach among the participating responding healthcare agencies and organizations in the region.
* Ensures a mechanism is in place for centralized coordination with local, regional, state, and federal emergency management organizations.
* Provides a mechanism for an integrated healthcare response with other disciplines.
* Establishes a mechanism for collecting and disseminating information regarding the availability of and need for healthcare resources, including but not limited to equipment, supplies, hospital bed capacity, personnel, specialty treatment capabilities, fatality management capabilities, transportation/evacuation capabilities, and alternate care site capabilities.
* Coordinate’s healthcare resources and personnel from outside the region to respond to or recover from the incident, if necessary.
* Provides a structure for healthcare agencies and organizations to communicate and coordinate response and recovery efforts.
* Facilitates the sharing of resources and personnel among healthcare agencies and organizations in the region.

**1.2 Scope**

This plan can be used during any disaster or emergency, including those caused by technological, human, or natural agents of sufficient scale to overwhelm the normal medical response capabilities of a hospital and require assistance from other hospitals, hospital systems, public health resources (such as the Strategic National Stockpile (SNS)), or other first responder organizations (such as emergency management, law enforcement, fire, EMS, public works).

This plan applies to all hospitals within the counties within the Western WI HERC Region 4. However, other counties and hospitals from outside of Region 4 may need to be utilized to assist when this plan is activated. Region 4 resources may have to be engaged in incident response and recovery activities depending on the incident. The COALITION authority is limited to those compacts and other documents signed by the members and does not supersede jurisdictional or agency responsibilities and/or requirements.

* 1. **Situations and Assumptions**

1. A member organization or the community as a whole can be affected by an internal or external emergency situation that has impacted operations up to and including the need for a facility to evacuate.

2. Impacted facilities have activated their emergency operations plan and staffing of their facility operations center.

3. Local resources will be used first, and then State resources, followed by a federal request as needed, however State and Federal resources may not be available for 72-96 hours. State, and possibly Federal, resources may be staged closer to an impact area to avoid delays.

4. The increased number of area residents and staff needing medical help may burden and/or overcome the health and medical infrastructure. This increase in demand may require a regional response and/or subsequent city, county, state, and/or federal level of assistance.

5. Facilities will communicate their medical needs to the COALITION and non-medical needs to the jurisdictional emergency operations center, unless otherwise documented in a facility emergency plan to communicate their needs through ESF-8 at the EOC. If coordinated, the COALITION could supplement ESF-8 staff at the EOC. The ESF-8 liaison will communicate with COALITION members to update the status of an incident and request support for needed resources with other ESF partners.

6. Healthcare organizations will report status on situational awareness but will assume to be able to handle the incident on their own as much as possible before asking for assistance.

7. Healthcare organizations will take internal steps to increase patient capacity and implement surge plans before requesting outside assistance.

8. Processes and procedures outlined in the response plan are designed to support and not supplant individual healthcare organization emergency response efforts.

9. The use of National Incident Management System (NIMS) consistent processes and procedures by the COALITION will promote integration with public sector response efforts.

10.Except in unusual circumstances, individual private healthcare organizations retain their respective decision-making sovereignty during emergencies.

11.This plan is based on certain assumptions about the existence of specific resources and capabilities that are subject to change. Flexibility is therefore built into this plan. Some variations in the implementation of the concepts identified in this plan may be necessary to protect the health and safety of patients, healthcare facilities, and staff.

* 1. **Administrative Support**

The WWHERCRP will be managed and maintained by the WWHERC Regional Coordinator, under the authority of the Executive Board. Participating hospitals, emergency management agencies, EMS agencies, and public health departments are responsible for updating their respective EOPs. The WWHERC Regional Coordinator will update this plan following an exercise or at least once annually. The WWHERCRP will be reviewed and accepted by the COALITION and a copy will be made available to all participating healthcare facilities and jurisdictional EOCs.A tracking log will be inserted after the cover page to provide notification of what, when and by whom changes were made to the plan.

1. **Concept of Operations**

This section delineates roles and responsibilities of the COALITION and members, including: how they share information, coordinate activities and resources during an emergency, and plan for recovery.

**2.1 Introduction**

The process outlined below describes the basic flow of a response to disaster and emergency situations with the steps and the activities that may need to be accomplished. Not all steps and activities will apply to all hazards.

**2.2 Role of the Coalition in Events**

- Promote common operating picture through shared information

- Assist with resource management between partner entities, particularly within the healthcare sector for healthcare resources Support Patient Tracking

- Support Evacuation activities

- Support Shelter-in-Place activities

- Assist with linkage with the local EOC and serve as the intermediary for healthcare and information sharing

- Identify time-sensitive performance metrics for COALITION Response (e.g., notification of incident to COALITION members; Bed Availability Reporting; Time to Setting up Field Triage; Time to appropriately distribute casualties; Time to stage Transportation Resources to Transport Casualties; Time to Update Patient Tracking Info at Intervals; and Time to Staff a Family Assistance Centers.

**2.2.1 Member Roles and Responsibilities**

The following provides a general overview of the roles and responsibilities of the partner agencies and organizations during a response. More detailed roles and responsibilities are defined under the functional areas of the Plan.

- Hospitals – in the event of a large-scale incident, all hospitals will evaluate current capabilities and all current patients to determine who may be discharged or transferred to another facility for the duration of the incident. At which time those patients that were transferred can be returned to their original facility for continued treatment or final discharge. Hospitals need to ensure any current MOUs with associated medical facilities are current and in good standing. These agreements should cover a wide range of disciplines to include, but not limited to; medical transport, clinical or hospital facilities, and Long-Term Care (LTC) facilities. Keep in mind that when transferring patients to other facilities, supplies, staff, notification of family and capabilities at receiving facilities must be addressed prior to transfer.

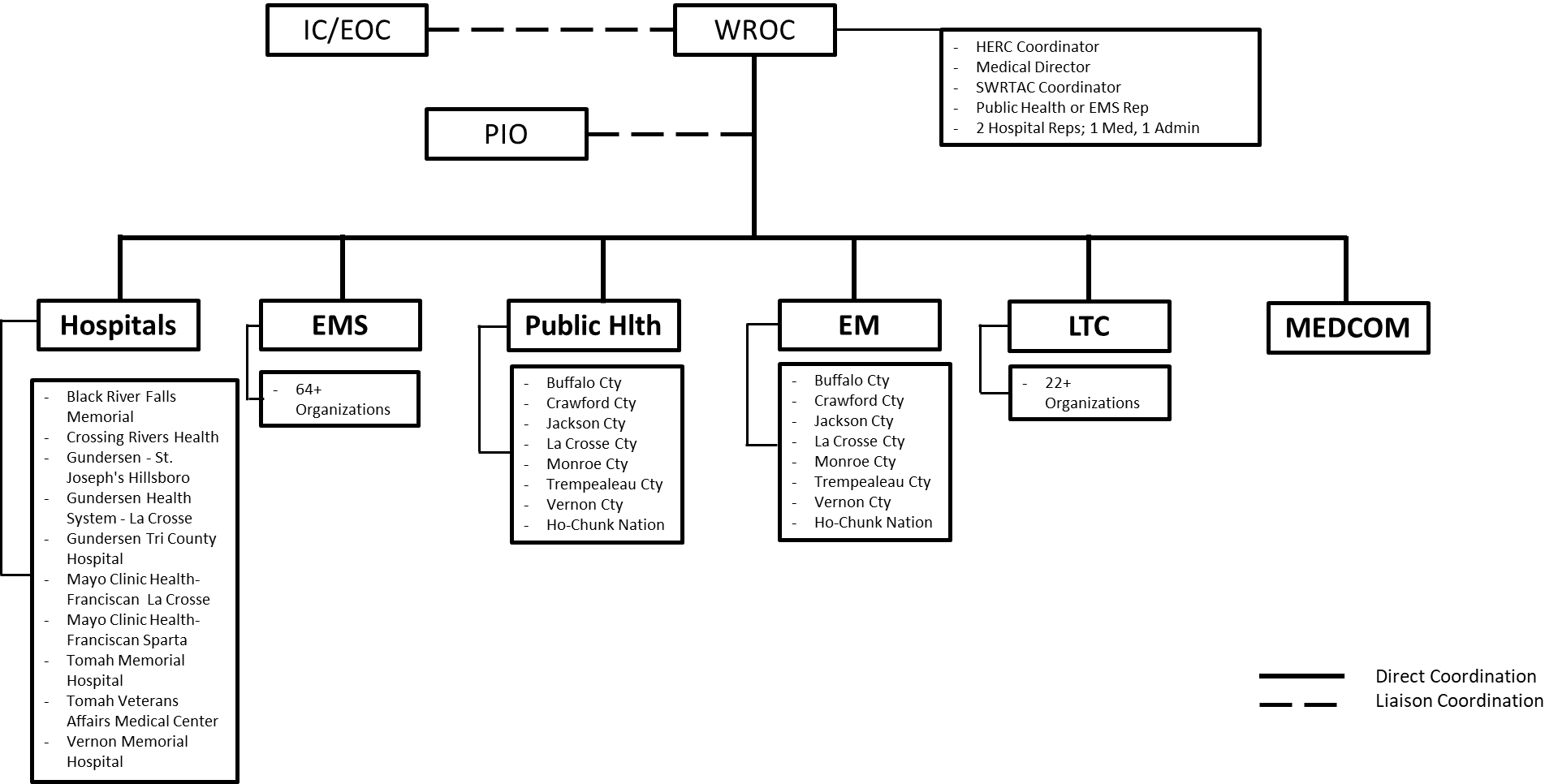
- Emergency Medical Services (EMS) – all EMS and transport agencies within the affected area of the incident should be notified as soon as possible of the incident for staff planning and response coordination. Upon arrival of the incident site EMS will ensure a Transportation Officer is appointed to coordinate movement of all casualties at the site. If the incident commander has appointed one, coordination must be made for all movement. Any mutual agreements between agencies should be activated and coordinated to ensure “routine” response to coverage area is maintained at all times. Should the agency affected by the incident need additional support or capabilities, that agency must notify all incident commands and emergency operations centers of their need to ensure additional help is coordinated and requested in a timely manner.

- Emergency Management – all emergency management offices, county or facility, will operate their facility per their policy and procedures. The agency responsible for the incident has the lead and all others will support as needed based on requests from the lead EM agency. If EMS has not established a Transportation Officer for all patient movement, the incident commander will do so immediately to ensure careful coordination is being made with all available hospitals. It is the intent of the WWIROC that it will maintain situational awareness (SA) of all patient tracking concerns to include bed availability throughout the region and report to the lead EM on the status and potential shifts in support. The EM responsible for the incident will make its’ requests based on the situation and follow standard protocol for all requests needed for the incident.

- Public Health – has a wide range of response options that it is responsible for. Depending on the nature of the incident, Public Health (PH) can respond in a variety of ways; for example, it can establish family Assistance/Information Centers or be the lead agency in combating an outbreak of a disease that requires a large number of staff and resources to address and contain the outbreak. Based on the outbreak, PH will require assistance from many organizations and could be augmented by State and Federal agencies to address the situation. PH will respond based on current plans, state and federal guidance, policies and procedures it currently has in place to address each specific situation.

- Long-Term Care – is responsible for maintaining their response plans as current as possible to address a multitude of situations as they occur. Due to the significant number of resident’s each facility has when combined in a region, great care and coordination must be maintained at all times. Great care and thought must be given to the evacuation of each facilities residents in the event of an incident that requires them to evacuate their facility. LTC facilities can also support incidents that do not directly affect them, but can be a resource multiplier when it comes to housing individuals from affected hospitals in their area that need to open up additional beds for incoming casualties from large scale incidents.

**2.2.2 Coalition Response Organizational Structure**



WWIROC Staffing:

The WWIROC is a team of five to six appropriately trained individuals who have an in-depth understanding of hospital organizations, hospital operations, and regional hospital capabilities and resources. Each discipline identified in the WWIROC organizational structure will assign and provide a representative(s) to serve on the WWIROC on a rotational basis. The assigned individuals representing the hospitals maybe members of a hospital emergency preparedness or security staff, administration, or clinical/medical staff.

When activated, the WWIROC operational staff will consist of:

• WWHERC Regional Coordinator as WWIROC Coordinator (who also serves as the initial point-of-contact for County Dispatch)

• Two hospital representatives, one from clinical and one from hospital operations/administration.

• WWHERC Medical Director, could serve as the clinical representative for hospitals

• WWHERC SWRTAC Coordinator

• One public health representative, or one EMS representative, or other subject matter experts based upon the incident. An additional hospital coordinator may also be placed in this position if the situation warrants additional help.

• Emergency Management representative if available

The SME’s that form the COALITION & WWIROC work together to:

• Share information on an incident that may have medical ramifications to healthcare providers

• Develop recommended protective actions and guidance

• Respond to questions and provide advice to hospitals and other response agencies regarding medical issues, capabilities, status, and capacity

• Identify and assist in requesting, obtaining, allocating, and track resources needed by hospitals

• Support the protection of the healthcare infrastructure

• Provide a single point of data collection/dissemination for healthcare

• Provide healthcare situational awareness to other disciplines

* 1. **Response Operations**

Under these section/subsections, we will address the actions taken by the coalition and its members before, during, and following an event.

* Purpose of the Western Region Operation Center:
  + The Western Region Operations Center (WWIROC) is a regional coordination entity supported by participating hospitals and response organizations that coordinates communication and decision-making (including resource allocation, resource tracking and coordination of resource needs) related to medical issues. The WWIROC is composed of subject matter experts (SMEs) from the medical and public health communities, including hospitals (both administrative and clinical), emergency medical services, and public health. Additional expertise, such as poison control, hazardous material (HazMat), fire, emergency management, and law enforcement will be brought in or consulted as necessary.
    1. **Stages of Incident Response**

See section 2.3.1.2 Activation of WWIROC.

* + - 1. **Incident Recognition**
* A request to activate or monitor by a Coalition member or partner (local Emergency Management, EMS, Long Term Care, Hospital, Local Public Health)
* Multi-jurisdictional incident or outbreak
* Awareness through open-source media, notification by a partner, notification by a local, state, or Federal entity
* An incident in an area with few resources, such as Buffalo County
* An incident large enough to require resource sharing including:
  + Strategic National Stockpile
  + Deployment Epidemiologic Investigation
  + Large facility Evacuation, either hospital or private business due to illness or injury
* A substantive alert message requiring action from public health and/or healthcare (e.g., Health Alert Network) such as:
  + A natural disaster (e.g., widespread tornado or flooding)
  + A biological attack
  + A chemical attack or spill, a biological disease outbreak (e.g., pandemic influenza)
  + A radiological threat or incident
  + A credible terrorist threat or actual terrorist incident

**WWIROC Responsibilities:**

Region 4 has designated the WWIROC as the communication as the regional coordination center for medical disaster planning and response.

All WWIROC representatives must complete training on WWIROC operations.

WWIROC Responsibilities Include:

* Communicating and coordinating with other EOCs and first responders to provide information on the operational status of hospitals and the needs and capabilities of hospitals and other healthcare facilities
* Providing information to hospitals regarding the incident and the needs and capabilities of other hospitals and response agencies
* Identifying and meeting the healthcare needs of the region
* Monitoring EMResource system for resource status’
* Monitoring WISCOM radio system
* Monitoring bed availability through EMResource and assisting in identification of patient destinations to equitably manage patient load Coordinating hospital staff and equipment under the Western Region Healthcare MOU
* Assist in providing appropriate transfer to healthcare facilities based on both patient needs and hospital capacity and capability

**2.3.1.2 Pandemic Response**

A pandemic is a public health threat that could overwhelm existing public health, public safety, and health care system infrastructures in the region. Managing the human health consequences of an influenza pandemic will require coordination and collaboration among local response partners, and state and national assistance.

The purpose of the public health pandemic response is to provide a coordinated community response to a pandemic in the region in an attempt to limit illness and death, preserve continuity of essential government functions, and minimize social disruption and economic losses. This section represents actions that can be utilized for a pandemic response. The actions outlined here may also be extrapolated, where appropriate, for other highly contagious, severe pathogens or other biological events.

Guiding Principles

• Protection of citizens of the region, health care workers and their patients, first responders, and long-term care employees and their residents;

o Protection of their health and safety

o Maximize the workforce available to maintain day-to-day operations

o Minimize influenza spread and reduce impact on public health

• Continuity of day-to-day operations;

o Continue day-to-day business operations to the maximum extent possible

throughout all stages of the pandemic

o Limit daily operations when necessary or upon direction by higher authority

• Execution of Public Health pandemic response;

o Communicate and coordinate pandemic preparedness and response to all

stakeholders of the coalition

o Support the efforts of public health authorities in mitigating the consequences of a pandemic

Actions

• If this has region wide affect; establish a working group or consortium to discuss required actions based on current state and federal published guidance.

• Establish a broader based working group involving emergency management, hospitals and their systems, EMS and the coalition

• Based on current state and federal policies and procedures for the current pandemic, compare to and adjust county plans as appropriate

* Establish gating criteria for resumption of pre-pandemic operations

• Request support as appropriate for the current situation

• Refine policies and procedures as the situation progresses

* All coalition members should adjust policies as needed and monitor/order PPE as needed for staff and patients

**2.3.1.3 Activation of WWIROC**

Activation of the WWIROC can only be done after the approval of the Executive Board has been briefed and agrees with the activation. This action could involve subcontracts for various members of the coalition and agreement must be in place prior to activation.

There are four increasing levels of activation:

**Phase 4** – Normal Operations – During this phase, the focus is on general situational awareness. The WWIROC Regional Coordinator monitors external intelligence information and shares accordingly. The WWIROC is not activated at this point.

**Phase 3** – Significant Incident – During this phase, an incident has occurred that could affect the WWHERC response agencies. The primary focus is on gathering more information about the incident. The WWIROC Coordinator periodically contacts other first response agencies (e.g., public health and/or emergency management) or affected healthcare facilities to obtain additional information to determine if the situation has escalated and/or if further WWIROC action is warranted. The WWIROC Regional Coordinator may request periodic conference calls with the other WWIROC members and other first response agencies to get more information on the incident and share situational awareness with healthcare providers.

**Phase 2** – Partial Activation – During this phase, the threat of a regional medical emergency is imminent and hospitals or first response agencies are submitting initial requests for support/information to the WWIROC. The WWIROC Regional Coordinator notifies the other WWIROC members who are also on call and coordinates a process to respond to initial requests, to provide advice and recommendations to healthcare facilities, and/or to assess current hospital capabilities and anticipated needs/gaps. During a partial activation, the members of the WWIROC may operate virtually from their individual locations (using all communication methods available), from an appropriate EOC, or some combination thereof.

**Phase 1** – Full Activation – During this phase, the WWIROC will coordinate and implement actions to aid healthcare facilities and support response operations in the region. If the emergency warrants, the WWIROC will assist with coordination of resource requests between hospitals and to/from hospitals to other response agencies. During this stage, the WWIROC requires the support and communication capabilities of an appropriate “host” EOC.

**2.3.1.4 Alert and Notification:**

The WWHERC Regional Coordinator (or designee) is notified to activate the WWIROC by a jurisdiction of authority. The WWIROC Regional Coordinator may be notified of an event by:

(1) Central County Dispatch;

(2) Receiving a message directly from a member of the response community, such as emergency management, law enforcement, fire, etc.;

(3) Through a hospital/healthcare facility; and/or

(4) Becoming aware of an incident from another source (e.g., news media, etc.).

An EMResource alert should be posted as soon as possible providing as much known information as possible. See the sample message to assist with the development of the initial alert message.

“Enter the known information in regards to the event that is taking place; what is the event (car crash, train wreck, tornado, etc…), enter the number of known casualties, location, what hospital/facility is posting the alert.” The WWIROC is activated, an immediate contact number is 608-751-0698, other phone numbers will be posted as they become available.

**2.3.1.5 Mobilization; Incidents That May Activate the WWIROC**

The WWIROC may be activated when an incident occurs that has or will have substantive impact to the hospital or medical communities in region 4’s or surrounding regions. Substantive impact is defined as any consequence or activity that overwhelms or has the potential to overwhelm the day-to-day operational capacity of any hospital or medical facility.

Regional incidents that may initiate the notification of the WWIROC Regional Coordinator include:

* Law Enforcement/Fire/EMS incidents
* Large scale event at La Crosse Regional, or private, county, city airports
* Volk Field and Camp Williams Air National Guard Base, or Fort McCoy base
* Other incidents in or outside the State of Wisconsin that would have an impact to our hospital operational or infrastructure
* HazMat Team Operations for a significant event
* Mass Casualty Incident that will consume a majority of assets within a localized region
* Change in status of Homeland Security or Local Threat Condition that identifies a creditable threat is imminent.
* Any suspected terrorist activity confirmed by local law enforcement
* At the request of an Office of Emergency Management (OEM) or Emergency Management Agency (EMA) Hospital incidents
* Any incident or internal crisis at a hospital in the Western Healthcare region that impacts the hospital’s capacity or capabilities (e.g., HazMat contamination, power outage, water problem, etc.)
* Response to or investigation of any biological incident
* Any obvious health hazards (e.g., water contamination, unhealthy air conditions, food contamination, etc.)
* Activation of NDMS to move patients from an incident and a Casualty Collection Point
* Pandemic or other forms of outbreaks causing significant distress for the healthcare system

**2.3.1.6 Incident Operations Direction, Control, and Coordination**

While the WWIROC has no jurisdictional oversight or authority over the region, the WWIROC will work with governing entities, such as the Incident Commander, EOCs, emergency management, and public health, in coordinating response, mitigation of adverse effects, preparedness, and planning to ensure emergency incidents do not adversely affect the quality, capacity, and continuity of healthcare operations for the region. The WWIROC will follow NIMS and ICS principles and interact with local, state, and federal response agencies through the affected county EOCs. In most cases, the WWIROC will communicate with an EOC through an ESF 8 representative or through a public health/medical liaison. The WWIROC recognizes its unique role and responsibilities to the general public and the medical community, and will respond to community and regional medical emergencies by providing regional coordination for many aspects of medical response. This includes but is not limited to transportation, medical surge capacity and capabilities, notifications, updates, patient tracking, and facility requests for resources. Upon activation, the WWIROC will begin utilizing the electronic Incident Command System (eICS). To track the event situation and communicate with regional partners. This system will be the primary tool for the coalition to track all events, document all actions and process all logistics requests identified for the coalition to complete.

**2.3.1.6.1 Initial COALITION Actions**

- Establishing points of contact with jurisdictional authorities and other entities involved in the response for the particular incident

- Gathering initial information and sharing with responding COALITION members

- Establishing the operational period – The period of time scheduled for execution of a given set of operation actions as specified in the Incident Action Plan. Operational Periods can be of various lengths, although usually not over 24 hours.

- Establish the necessary incident management structure

o Who/where is the incident command

o Is there an EM EOC established

o What hospitals have established their operations centers

o Is the county or state operating theirs in response to this event

- Verify if a volunteer reception center (VRC) has been established. The VRC will be activated immediately following a disaster, typically 12-72 hours following a disaster. There will be a notification team, or phone tree, that will notify volunteers when they are needed. The location will depend on the area or areas affected by the disaster. The establishment of the VRC is the responsibility of the county.

**2.3.1.6.2 Decision-Making Criteria**

The WWIROC and all healthcare facilities in the region do not discriminate on patient placement, transportation, care, or services based on minority status, race, religion, age, or country of origin. The WWIROC team will make decisions using the following criteria:

* The first priority for all decisions will be life-saving measures.
* The primary consideration when making decisions regarding transportation and patient placement must be what is best for patients and residents, following the guidance of the medical adviser or designated medical provider
* All decisions and protective actions will support regional response operations, regardless of discipline or jurisdiction, as decided upon in coordination with affected incident commanders/EOCs or a public health liaison.

Integrating with Local, Regional, State, and/or Federal Response Efforts During a regional incident warranting the activation of the WWIROC, healthcare facilities in the region will need to work with other response agencies, potentially at all levels of government (local, regional, state, and federal). This is especially true if non-hospital owned assets are needed. The ability of the WWIROC and healthcare facilities to obtain local, state, or federal assistance is dependent on the activation of the local emergency response system and/or declaration of an emergency by Local, State, and/or Federal authorities. In accordance with NIMS, the WWIROC will coordinate all requests for additional assistance with the local jurisdiction, such as the county EOC. If the local jurisdiction cannot fulfill the request, the county will submit the request to the state. Consequently, if the state cannot fulfill the request by using its own resources or through the Emergency Mutual Aid Compact (EMAC), the state will then submit the request to the next level of authority; FEMA, CDC, etc. The WWIROC will attempt to fulfill the requests locally, if possible, first looking within the regional healthcare systems, other HERC Regions then to local municipalities such as cities and counties. Requesting resources from the State DHS and/or CDC/FEMA will usually take several days, which may be too late to meet the needs of the affected healthcare facilities. These requests will be made through local county emergency management.

**2.3.1.6.3 Communication and Coordination**

For an effective regional medical response, the WWIROC must maintain situational awareness, understand the common operational picture, and be able to provide accurate and accessible information to stakeholders in a rapid, user-friendly manner.

At the onset of an incident, the WWIROC will assess the situation, identify and prioritize requirements, establish incident objectives (in accordance with the affected EOC to support regional response efforts), and request activation of available resources and capabilities to support healthcare facilities.

Upon activation, the WWIROC will send out a request for information on the current bed status of healthcare facilities in the region. This request for information will be updated in EMResource for all healthcare facilities as soon as there is the threat or potential threat of an incident. Healthcare facilities will need to update this information on a frequent basis. The WWIROC will determine the schedule the healthcare facilities will follow to update the information based on incident requirements.

Healthcare Facility Status Information Needed by the WWIROC:

* Bed capacity
* Staffing levels
* Facility capabilities
* Epidemiological projections, if applicable
* Specialty services available or needed

**2.3.1.6.4 Communication Tools**

The WWIROC will use all available communication tools during an incident. WEB EOC & other online meeting platforms, Email, and EMResource should be used to communicate and coordinate if the Internet and connectivity are available. These systems help provide greater visibility of status and needs among all healthcare facilities, the WWIROC, and other response organizations. The tools (such as the conference call lines and the web-based disaster management system) and how to access/use them are described in the Communication section of the Western Healthcare Coalition System Plan. These systems include Western Regional Resource Coordination System Plan. These systems include, but are not limited to:

* Landline telephones
* Dedicated telephone lines,
* Fax, E-mail
* HAM radios
* Satellite phones
* Cellular phones
* WISCOM Radio
* WebEx, Zoom, Skype, Go to Meeting
* RAVE/Send Word Now

**2.3.1.6.5 Information Sharing, Information Collection and Dissemination**

During an emergency, there is a strong likelihood that communications will be degraded and various locations will have varying levels of capability. All available forms of communication should be used. The WWIROC will specify how information should be submitted back to the WWIROC when making a request for information. The WWIROC will disseminate information using as many communication methods as available to ensure receipt of information.

Information sharing/management Process for multiagency information sharing – may include virtual/physical

* Information sharing procedures
  + Communication methods, frequency, and communication systems/platforms and utilization steps refer to the WWHERC communication plan. Identify who leads information sharing efforts, what are the Essential Elements of Information (EEIs), see Annex 2 for current coalition EEI list, agreed to be shared, including information format; gain guidance from lead EOC for this
  + Information access and data protection procedures, refer to communications plan
  + Strategies to protect healthcare information systems and networks
  + Internal communications/ notifications
  + Rapidly acquire and share clinical knowledge among health care providers and among health care organizations during responses. External communications/Public information, who is the lead PIO for the event
  + Define communication methods and communication systems and platforms are detailed in the coalition communication plan
  + Overview of the existing primary and redundant communications systems and platforms capable of sending EEIs to maintain situational awareness are located within the coalition communication plan
  + System maintenance and replacement is based on manufacture specs and organization policy for maintenance and/or replacement

**2.3.1.6.6 Sharing Information with EOCs and Other First Responders**

The WWIROC will submit information and requests to EOCs using standard NIMS and ICS forms unless otherwise directed by a specific EOC to do otherwise. The WWIROC will serve as a consolidated communication and coordination center to share information bi-directionally with local emergency management offices, healthcare facilities, EMS agencies, public health, and other appropriate organizations.

**2.3.1.6.7 Resource Coordination Administration, Finance and Logistics**

The WWIROC will complete and track all time, expenses, and resources used during response to the incident in accordance with NIMS procedures and submit the request for reimbursement, as directed in the tasking. The WWIROC Regional Coordinator and the individuals supporting the WWIROC during the activation will work with the requesting jurisdiction to identify and submit the forms for reimbursement. Hospitals and supporting organizations should follow procedures for tracking resources to ensure that the necessary documentation is available should reimbursement opportunities become available. Each Hospital’s Preparedness committee will work with appropriate jurisdictional organizations such as Wisconsin Emergency Management and local Emergency Management agencies to develop a process to help facilitate reimbursement.

During an emergency incident, the availability of resources for life saving measures, medical transportation, and protection of the public and the environment are in high demand. Basic supplies (e.g., water, ice, food, fuel) may also be scarce. The WWHERC Region 4 MOU facilitates the sharing of resources, equipment, and personnel necessary to provide emergency medical care during a disaster. A copy of this mutual aid agreement is attached in Annex 1. During an emergency, the WWIROC will serve as a center for collecting and disseminating current information about healthcare resources and needs (including equipment, bed capacity, personnel, supplies, etc.), developing priority allocations, tracking disbursement of resources, and other relevant healthcare response matters. If authorized to activate, the WWIROC may be given purchasing authority, which will allow it to directly procure the resources needed to support healthcare response and recovery operations. The WWIROC will serve as a central point of contact between healthcare facilities, state and local emergency management agencies, and other governmental and nongovernmental agencies as necessary. All participating healthcare facilities will provide updated relevant information on resource requests, including available and needed resources, at the request of the WWIROC.

Requesting Resources per the MOU, only the hospital command center (COALITION) or designee of a healthcare facility needing assistance has the authority to initiate a request for resources. This request can be made through the WWIROC using the incident specific established resource request mechanism(s). In most cases, verbal telephone requests and electronic requests (submitted using WEB EOC, or email) are acceptable. All verbal requests must be followed up with a written request within 24 hours of the initial request. \*\*NOTE: Verbal requests are NOT recommended unless other methods of communication and documentation are unavailable. \*\* The WWIROC will communicate the request to the other healthcare facilities directly and to other response agencies via EOCs, and conduct the ongoing communication and coordination needed to obtain the resource. The healthcare facility requesting and receiving the resource, referred to as the recipient hospital, will assume direction and control of the resource (e.g., personnel, equipment, and supplies) during the time the resource is at the recipient hospital.

As specified in the WWHERC Hospital MOU, if the resource is obtained from another healthcare facility, the recipient hospital will reimburse the transferring hospital (the hospital that provides the resource) for all of the transferring hospital's costs as determined by the transferring hospital’s established regular rates. Reimbursable costs include salary and benefits for personnel; all use, breakage, damage, replacement and return costs of equipment and supplies; and management and administration costs. Reimbursement will be made within ninety (90) days following receipt of the invoice. When requesting resources or assistance from other Wisconsin hospitals, the WWIROC will communicate the request through the designated Regional Coordination Center.

**2.3.1.6.8 Request of Resources**

Facilities should first utilize all internal avenues to fulfill their needs prior to contacting the WWIROC. Individual facilities that are part of healthcare system should contact their hospital command center/EOC via their ICS structure, as described in their individual hospital emergency plans. The hospital command center/EOC will submit the request to the WWIROC. When a facility is requesting resources, the WWIROC will require the following information:

* Type and number of requested resources
* Estimate of how quickly the request is needed
* Location and point of contact person where the resource is to report
* Estimate of how long the resource will be needed (if applicable)
* The request for resources should be submitted in writing, preferably electronically, in the format and forms as described by the WWIROC. If available, electronic resource request forms in disaster management systems such as WEB EOC should be used

**2.3.1.6.9 Request of Personnel**

In the event the request is for personnel and the transferred personnel are required to work in a facility greater than 50 miles from their home facility, the requesting facility will be responsible for housing and feeding the transferred personnel. Documentation, credentialing, and liability will be following the guidelines stipulated in the WWHERC MOU. The use of Volunteers may be used with the utilization of WEAVER & MRC. Each hospital will maintain and be responsibility for policies and procedures for WEAVER/MRC requests. Any requests shall be shared with the WWIROC, and Western Regional Healthcare coordinator.

**2.3.1.6.10Request for Pharmaceuticals, Supplies, or Equipment**

If a facility is unable to obtain necessary resources, supplies, or equipment from its regular vendors, the WWIROC will attempt to locate needed items within the region. If no assets are found within the region, the WWIROC will reach out to DHS for assistance in locating needed items. As specified in the WWHERC MOU, the recipient hospital will reimburse the transferring hospital for any consumable supplies or pharmaceuticals at actual cost, including a fee for management and administration associated with the transfer of the supplies or pharmaceuticals. The recipient hospital will pay for all reasonable transportation fees to and from the transfer site. The recipient hospital is responsible for appropriate tracking, use, and necessary maintenance of all borrowed pharmaceuticals, supplies, and equipment during the time such items are in the custody of the recipient hospital in accordance with law as required, and shall be responsible for risk of loss and may insure or self-insure risk of loss with the right of subrogation reserved.

**2.3.1.6.11 Patient Tracking Transfer/Evacuation of Patients**

When a facility is not able to carry out its transfer/evacuation plans, the request for transfer of patients may be made via the WWIROC. In making a request to transfer through the WWIROC, a transferring hospital must specify the number of patients who need to be transferred, the general nature of their illnesses or conditions, and whether specialized services or placement is required. To the extent that is practicable in the context of the disaster, the participating hospital requesting transfer of one or more of its patients will provide copies of the patient’s pertinent medical records, registration information, and other information necessary for continued care at the receiving hospital.

Additionally, to the extent possible under the circumstances, and at the request of the receiving hospital, the transferring hospital will provide any extraordinary drugs or other special patient needs (e.g., equipment, blood products). The WWIROC will assist with coordination of the placement and transportation needs of the patients.

**2.3.1.6.12 Escalation of Response**

During a widespread catastrophic disaster, resources may need to be requested from outside the region. Resource requests for emergency supplies can be made from the healthcare facility to the WWIROC or county EM. If the WWIROC is unable to fulfill the request locally (directly or through coordination), the WWIROC will submit the request to the County EOC from which the request was made. If the County EOC is unable to fulfill the request, the County EOC may escalate the resource request to the State. The State EOC, if unable to fulfill the resource request, may seek assistance via EMAC agreements and/or escalate the request to federal agencies.

In addition, MABAS should be considered during these types of incidents. This may be coordinated through the local fire and EMS agencies. The division president, or regional coordinator for MABAS should be contacted during these types of events.

**2.3.1.6.13 Long-Term Care**

In the event of a catastrophic or impending large-scale disaster, i.e. a flood, action will need to be taken to address the potential movement of a large number of long-term care patients throughout the region. It is estimated between 300-700 patients currently reside in one county alone. Great care and planning efforts are required to be in place prior to any event happening. All memorandums of understanding/agreement should be implemented as soon as coordination can take place. At a minimum annual review of current agreements should be validated and refined as necessary.

**2.3.1.7 Demobilization**

This section describes the process the coalition will use to stand down incident response actions. This section can also address how to de-escalate from fully activated, to limited activation, to monitoring. This should address any steps needed to debrief personnel, any forms that should be completed and other administrative actions.

After Action Reports and Improvement Plans (IPs) are important parts of emergency preparedness. WEM, WWIROC, WWHERC, RTAC, Hospitals, and Emergency Services will assess the response to emergency events, and simulated events during an exercise, or real-world. AARs review the design and execution, and provide an assessment of what went well and what needs to be improved upon.

Improvement Plans (IP) outline how and when improvements will be made to address shortcomings identified by the exercise/incident evaluation and AAR.

The AAR and IP will be provided to all regional, state and federal agencies for review. The WWHERC Preparedness Coordinator will coordinate an after-action meeting with all staff, stakeholder and responders involved in the emergency or disaster. This meeting will address what went well and what needs to be improved upon. The ARR and IP will provide additionalinformation necessary to for mitigation, planning, response, and recovery for the nextemergency or disaster.

**2.3.1.8** **Recovery Phase / Return to Pre-Disaster State:**

The Recovery Phase is an important part of any emergency or disaster. WWHERC recognizes a Disaster Recovery Phase is likely to involve a significant amount of coordination and collaboration with emergency managers and services, state and federal agencies support. The priority during this phase is the safety and wellbeing of the patients, communities and other involved persons. The immediate goals during the Recovery Phase are:

1. Minimize the short- and long-term effects of the emergency or disaster.

* 1. Remove or mitigate any threat of further injury or damage.
  2. Re-establish all external services such as power, communications, water etc.
  3. Complete a Damage Assessment of all regional facilities and infrastructure.
  4. Will establish Critical Incident Stress Debriefing (CISD) for staff after an emergency or disaster WRHCP activation. Some resources will be available through the EAP. WWIROC will ensure a debriefing coordinator is established in the region as necessary.

The WWIROC will request an assessment of the follow resources, and operations from the Disaster Recovery Team.

1. Staffing
   1. Number of available hospital staff need at each hospital in 12-hour periods
   2. Staffing shortfalls by occupational specialty
   3. Number of Injuries, or deaths.
   4. Number of staff needed from outside agencies to fulfill operational needs.
   5. Request WEAVER to fulfill short falls on volunteers, or other licensed professionals.
2. Medical Equipment (Major Items)
   1. Loss of all essential medical equipment
   2. Is equipment repairable; if so, was is the estimated down time
   3. Replacement requests from within the hospital system
   4. Any projected requests for equipment from other agencies
3. Utilities
   1. Status of all utilities such as, water, sewer, electric, cable, phones, radios, intranet, and backup generator.
   2. Projected timeline line of utilities out of service.
   3. Indicators of any future loss of utilities within the next 96 hours.
   4. Determine if regional agencies are receiving any assets from utility companies.
4. Fuel, Oxygen, Gas, or Diesel Supplies
   * 1. Provide a total inventory of useable fuel and oxygen for each agency.
     2. Identify potential shortages, or quantity that will not last more than 96 hours.
     3. Identify and verify sources for resupply.
     4. Help identify any additional recourses need to maintain operations.
5. Facility Assessments
   * 1. Obtain a damage assessment reports for Regional Health Care facilities
     2. Identify potential structural issues than may affect future operations.
     3. Obtain a time line to have infrastructure repaired or replaced.
     4. Identify additional resources that will be need to ensure structural safety.
     5. Identify any potential hazards that may affect future operations.

WWIROC will review the Disaster Committee assessments and recommendations. This information will be provided to Incident Commander(s) to determine the next objectives needing to be completed during this phase of the disaster or emergency.

The recovery phase might be long or short term but either way will require coordination and funding to reach full operational capacities.

* 1. **Continuity of Operations**
* Back-up communication and coordination systems is based on regional communications plan.
* Activation of Alternate WWIROC location, see COOP Plan
* Primary and alternate personnel, to include leadership, will be identified and trained to carry out COALITION/WWIROC coordination activities to ensure the coalition can support the region for extended periods of time should the situation warrant such support.
* Continued administrative and finance management functions, including expense tracking for reimbursement will be the responsibility of the fiscal agent or coalition Treasurer for the coalition or as otherwise determined by the Executive Board and/or coalition members that are available at a given time.
* Should the region deem it necessary to evacuate, shelter-in-place, and relocate multiple facilities, it is incumbent upon the coalition to provide any support within its’ capability to ensure the safe transfer of staff, residents and any other necessary resources to ensure a continued operation of said facility.
* Devolution of Operations is based upon the ongoing situation and the need for transferring operations. Should the need arise to do so, the Executive Board will provide guidance and final approval if time warrants. Safety of all personnel assigned to the WWIROC at the time will be of the utmost importance in all considerations.

**2.5 Elements of Performance:**

An emergency or disaster WWHERC region can drastically impact the demand for services or its ability to provide services. These emergencies can either be human made, natural or a combination of both. These types of emergencies escalate in complexity, scope and durations. WWHERC shall annually conduct a hazard vulnerability assessment (HVA). The HVA provides WWHERC the first step towards mitigation of potential hazards that can directly impact WWHERC. Mitigation is done thru:

1. The WWHERC, RTAC, and WEMS and review changes in law, regulations, and the standards, and conditions; it assures that regular drills, exercises and after actions reports are conducted to assess the need to change the equipment, procedures or activity used to implement the emergency preparedness management program.

2. The Hazards Vulnerability Assessment (HVA) shall be reviewed annually by the WWHERC.

3. The HVA is reviewed by coalition partners to prioritize the potential emergencies identified in the HVA.

4. Western WWHERC communicates it needs and vulnerabilities to community emergency responders and identifies the communities’ capabilities to meet our needs.

5. The WWHERC Coordinator will work with the Western WWHERC partners to define mitigation activities. These activities are to reduce the risk of and potential damage from an emergency.

6. WWHERC shall use the HVA to determine preparedness activities that will organize and mobilize resources.

**2.6 Test, Training, and Exercise:**

The development of a comprehensive, on-going test, training, and exercise program to inform and educate decision makers, hospitals, and other response stakeholders is essential. An initial orientation and training session for all participating hospitals will be held following the adoption of this plan. Additional training sessions for senior leadership within healthcare facilities and other response agencies will be scheduled through the Coalition Exercise and Training Planning Committee. The WWIROC and all participating hospitals will conduct periodic exercises to test and validate the concept of coordination described in this plan. Following the conclusion of each exercise, the WWIROC Regional Coordinator will update and disseminate changes to this plan to reflect lessons learned and corrective actions.

**Annex 1 – Western Health Care Coalition Hospital Memorandum of Understanding**

**Western Health Care Coalition Hospital Memorandum of Understanding**

This Memorandum of Understanding (MoU) is made and entered into as of this \_4th\_\_ day of June, 2020, by and between the hospitals located within the Wisconsin area hereafter known as Western Health Care Coalition (“Western COALITION”) as identified by the State of Wisconsin ASPR Hospital Preparedness Program. This MoU also includes hospitals located in the States of Iowa and Minnesota that may wish to be included in this MoU with the Wisconsin hospitals in Western COALITION.

RECITALS

WHEREAS, this MoU is not a legally binding contract but rather this MoU signifies the belief and commitment of the undersigned hospitals that in the event of a mass casualty event or other surge event, the medical needs of the community will be best met if the undersigned hospitals cooperate with each other and coordinate their response efforts.

WHEREAS, the undersigned hospitals desire to set forth the basic tenets of a cooperative and coordinated response plan in the event of a mass casualty or other surge event.

NOW THEREFORE, in consideration of the above recitals, the undersigned hospitals agree as follows:

ARTICLE I

COMMUNICATION BETWEEN THE UNDERSIGNED HOSPITALS DURING A DISASTER EVENT

The undersigned hospitals will:

1.1 Communicate and coordinate efforts to respond to a mass casualty event via their liaison officers, public information officers and incident commanders primarily. This assumes that all participating hospitals will use some form of an Incident Command System organization.

1.2 Communicate with each other’s Incident Command Center (ICC) by phone, fax, email and will maintain radio capability to communicate.

1.3 Initialize a Joint Public Information Center (JPIC) to the extent possible during an event, to allow their public relations personnel to communicate with each other and release consistent community and media educational / advisory messages.

ARTICLE II

ONGOING COMMUNICATIONS ABSENT AN EVENT

The undersigned hospitals will:

2.1 Meet at least annually under the auspices of the Western COALITION to discuss continued emergency response issues and coordination of response efforts.

2.2 Identify primary point-of-contact and back-up individuals for ongoing communication purposes. These individuals will be responsible for determining the distribution of information within their respective healthcare organizations.

ARTICLE III

FORCED EVACUATION OF AN UNDERSIGNED HOSPITAL

3.1 If a disaster affects an undersigned hospital(s), forcing partial or complete facility evacuation, the other undersigned hospitals agree to participate in the distribution of patients from the affected hospital(s), even if this requires activating emergency response plans at the receiving hospital(s).

3.2 In the event of an anticipated evacuation, transportation arrangements will be made in accordance with the affected hospital’s usual and customary practices. Local Emergency Operations Center (EOC) resources may be used by the affected undersigned hospital to help arrange transportation resources.

ARTICLE IV

REPORTING BED CAPACITY AND CAPABILITY

4.1 The undersigned hospitals will transmit information to the local Emergency Operations Center (EOC) concerning the hospital’s bed capacity, its capabilities and its Emergency Department’s ability to receive patients when requested. The undersigned hospitals will update this information periodically and/or as capabilities change so that the EOC has current information to immediately determine regional resources during an event.

4.2 Bed capacity will include at a minimum: Medical/surgical floor, Monitored (step down), and ICU units.

4.3 Bed capability refers to the staff available to serve those available beds.

ARTICLE V

AUXILIARY HOSPITAL AND CASUALTY COLLECTION LOCATION

5.1 An auxiliary hospital and/or casualty collection location may be required if the event overwhelms the regions area hospitals’ capacity and capabilities.

5.2 The undersigned hospitals may be asked to contribute volunteer staff to an auxiliary hospital or casualty collection location on an urgent basis, subject to availability.

ARTICLE VI

STAFF, MEDICAL SUPPLIES, AND PHARMACEUTICAL SUPPLIES DURING AN EVENT

6.1 In the event of a disaster when patient care staff is available at one of the undersigned hospitals and lacking at another, an undersigned hospital with a surplus will share staff to help ensure that the available hospital beds in the region are adequately staffed during an event to the extent possible.

6.2 In the event that needed supplies are available at one of the undersigned hospitals and lacking at another, undersigned hospitals with a surplus will share supplies to help ensure that patients in the region receive necessary treatment during an event.

6.3 The above staff and supply sharing will be cooperatively managed by the incident command leadership at the involved undersigned hospitals.

ARTICLE VII

MISCELLANEOUS PROVISIONS

7.1 This MoU constitutes the entire MoU between the undersigned hospitals.

7.2 Proposed amendments to this MoU must be in writing, submitted to the Western COALITION Chairperson, voted upon and signed by the participating hospitals.

7.3 An undersigned hospital may at any time terminate its participation in this MoU by submitting written notice of termination to the Western COALITION Chairperson.

**\*\*Signed signature pages are available upon request\*\***

**Western COALITION Hospital MoU**

EXHIBIT A

DEFINITION OF TERMS

Emergency Operations Centers (EOC): A local coordination center for event response staffed by liaisons from affected response organizations.

Event: A situation in which an incident’s resource requirements exceed immediate available resources.

Hospital Emergency Incident Command Systems (HEICS): A command framework for hospitals that provides a compatible incident command format, specifies a chain of command and provides functional position definition that can enhance event communication and coordination during a mass casualty situation. The WHEPP Steering Committee for the State of Wisconsin recommends at least the first level of incident command structure be incorporated into hospital mass casualty plans.

ASPR: Office of the Assistant Secretary for Preparedness and Response.

Incident Command Center (ICC): A location within a hospital where leadership gather to coordinate in-hospital activities and communicate with the EOC during the event.

Joint Public Information Center (JPIC): A location at which information that is identified by more than one agency or group can be coordinated during an event to assure consistent messages and flow of information to the public.

**Annex 2 Region 4 Essential Elements of Information**

For a more detailed and comprehensive EEI list regarding data collection and responsible agencies refer to the EEI excel list version of this appendix.

Ref # Category Question to be answered

1 Transportation What is the status of transportation assets and routes (including air, ground, rail and accessible transportation)?

2 Command What is the scope of the incident and the response?

3 Command Where are the impacted communities?

4 Healthcare What population is impacted?

5 Healthcare What is the anticipated medical surge?

6 Communication Status of facilities comms

7 Healthcare Status of critical infrastructure (i.e., hospitals, urgent care, EMS service, long- term-care, public health department, behavioral health)

8 Finance Address regulatory requirements for reimbursements

9 Command What is duration of incident?

10 Command Loss of senior medial staff at various facilities or region leadership

11 Operational Chemical agents and how used and expected longevity

12 Healthcare Loss of facilities or anticipated loss due to event

13 Command Federal agencies moving in/out

14 Transportation Additional transports available

15 Command Other COALITION Regions affected

16 Command Follow on events that could affect operations (i.e. after shock)

17 Healthcare Loss of medical aviation assets

18 Healthcare Loss of ground transport assets

19 Command Transport route degraded (i.e. bridge collapse)

20 Healthcare Status of long-term care facilities

21 Command Status of electrical grid

22 Command Status of water supply

23 Command Status of natural gas supply

24 Command Location and operational status of sheltering facilities

25 Command Confirmed number of injuries and fatalities

26 Command Areas under current evacuation orders, and the details concerning the orders

27 Command Location, type, and operation status of PODs for distribution of food, water and other bulk commodities



**Annex 3, Western Wisconsin Healthcare Emergency Readiness Coalition Response Plan, Region 4 Pediatric Surge Annex**

1. Purpose

This pediatric surge annex has been developed for local jurisdictions, public health partners, first responders and healthcare organizations within the Western Wisconsin Healthcare Emergency Readiness Coalition to increase pediatric surge capacity. This annex applies to a mass casualty event with a number of pediatric patients that overwhelm local capacity. Actions described here are intended to support, not replace, any existing facility or agency policy or plan.

2. Overview and Background

The unique needs of children mandate specialized and appropriate planning for response to a pediatric mass casualty incident (PMCI). Children differ from adults in physiology, developing organ systems, behavior, emotional and developmental understanding of and response to traumatic events, and dependence on others for basic needs. Children’s rapid minute ventilation, large surface area relative to body mass, more permeable skin, and proximity to the ground increase their risk of adverse outcomes from exposure to environmental hazards such as particulates or droplets, whether from debris or biological or chemical threats.

Scope

For the purpose of this annex, the following age groups comprise the pediatric population.

Infants/toddlers (0 -24 months)

Toddlers/preschoolers (2 -5 years)

School aged children (6 – 13 years)

Adolescent children over 14; and children with underlying complex medical conditions.

Across the HERC region, there are local risks for pediatric-specific mass casualty events (e.g., incidents at schools, transportation accidents, events at tourist destinations) that might arise. It recognizes that facilities that treat patients will have stocks of age-appropriate medical supplies that may be requested to share resources in an emergency.

At this time, the HERC does not have a role in coordination of mental health and age-appropriate support resources, nor pediatric/neonatal intensive care unit (NICU) evacuation resources, except in its ongoing role in facilitating resource sharing requests within the region and with the state, as requested by member facilities or organizations. In the absence of a statewide pediatric plan, the HERC does not have individual coordination mechanisms with dedicated children’s hospital(s) at this time.

Concept of Operations

Activation and Notifications

Pediatric events will be notified to the HERC by individual member entities in the same way as any other incident, and as described in the HERC response plan. This will trigger the alerting and notification of members as described in the HERC response plan in order to ensure general situation awareness across the region.

Roles and Responsibilities

In the absence of a statewide pediatric plan, the role of the HERC during a pediatric surge event will be consistent with the response role during any large-scale event: predominantly information sharing amongst membership, facilitation of resource support if any is available, and as a liaison to state and federal resources, if needed. During the preparedness phase, the HERC can work to support pediatric readiness through provision of regional training, exercising around such events, and participation in statewide efforts to coordinate pediatric planning. A list of initial resources to support member readiness is included at the end of this annex.

When the HERC is notified of a pediatric event, the member organization experiencing the surge may notify the HERC of any needs or requests. The HERC will then determine if such needs should be conveyed to the membership through information sharing channels (eg, EM Resource, eICS, etc) or conveyed to state partners for a wider dissemination.

At this time, in the absence of a statewide coordinated pediatric surge plan, the HERC will work with the Wisconsin Department of Health Services and Wisconsin Emergency Management as needed to determine available local, state, and interstate resources. This includes access to subject matter experts at the local, state, and national levels.

Prioritization method for specialty patient transfers

At this time, in the absence of a statewide coordinated pediatric surge plan, the HERC could assist with patient transfers and transport decisions by ensuring bed availability in EMResource is up to date and transportation services have updated their current availability in a dispatching and ambulance tracking system that allows for real time transport visibility currently in use.

Just-in-time training

At this time, in the absence of a statewide coordinated pediatric surge plan, the HERC will not have a role in offering just-in-time training to support pediatric care.

Evaluation and exercise plan for the specialty function

At this time, the HERC will exercise its roles in information sharing and coordination of assistance upon request for pediatrics in the same way that it does for any other event of regional significance.

Deactivation and Recovery

Upon notification of the end of the incident, the HERC will cease its support operations in sharing information and resource coordination. At the request of membership or a decision of leadership, the HERC may choose to facilitate an after-action process to identify areas of strength or improvement.

**Annex 4, Western Wisconsin Healthcare Emergency Readiness Coalition Response Plan, Region 4 Burn Surge Annex**

* See separate file for this.

**Annex 5, Western Wisconsin Healthcare Emergency Readiness Coalition Response Plan, Region 4 Highly Infectious Disease Annex**

* + See separate file for this.