Alternative Medical Treatment Site Plan

(AMTS)

Florida Department of Health
Pre-Hospital Planning
Emergency Medical Response

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Table of Contents

Section 4
AMTS Establishment

Section 5
AMTS Operations

Section 6
AMTS Logistics

Section 7

AMTS Finance and Administration

Section 8

Appendices

Executive Summary

Since the events of September 11, 2001 and the “Hurricanes of 2004”, Florida has become much better prepared to deal with catastrophic disasters. This includes those resulting from terrorist incidents as well as from natural phenomenon. Even so, it is incumbent upon emergency response agencies to become even more operationally prepared and effective. This certainly extends to the field of medical care; the one “constant”” in disaster situations. This need is well stated by healthcare educator and author Dr. K. Joanne McGlown, who, in her book titled, *“Terrorism and Disaster Management – Preparing Healthcare Leaders for the New Reality,”* says, “The need for medical care is the one *constant element* in the aftermath of any disaster, whether treating the physically wounded or sick, the scared, or those suffering from the many psychological traumas that bring the “walking wounded” in for care.

Hospitals on a daily basis around Florida are very busy. The situation is exacerbated during the winter respiratory illness season which further taxes medical care facilities. As such, it would be very difficult for the system to handle the surge in patients generated by a terrorism or other large mass casualty incident. Research conducted by Dr. Bill Tynan of the Florida Department of Health indicates that in a pandemic flu scenario alone, Florida would likely require 20,000 – 65,000 beds above current capacity to handle the patient load. Additionally, while there has been progress in establishing decontamination facilities and “positive pressure” rooms at hospitals to handle contaminated patients, an incident that generates a large number of contaminated patients would quickly overwhelm these capabilities. If an influx of contaminated patients threatens the integrity of the hospital, they may not be in a position to care for remaining casualties or other non-incident medical emergencies that occur. Thus a key element in preparing for such medical emergencies is planning for the activation of *alternate medical treatment sites* (ATMS) to augment our healthcare system during times of disaster. The primary goal of such sites would be to handle non-critical patients, those patients triaged as “Green” (minor), patients that are psychological casualties with no physical injury, and other patients that self-refer to the site. This would allow hospitals to focus on patients with more serious illnesses or injuries that require “in hospital” services.
It becomes clearer each day that communities across Florida need to plan for the implementation of alternative medical treatment sites for disaster situations.

Section 1
Introduction

1.1 Background

As seen during the 2006 Governor's Annual Executive Leadership Tabletop Exercise, which focused on an Avian Influenza outbreak in Florida, one of the key issues in medical disaster situations is the need for alternative medical treatment sites. These serve as an interim treatment facility between a disaster "scene" and the hospital. The primary use of such sites is to decontaminate, triage, treat and then transport patients who are victims of a disaster. This "interim" treatment facility concept is one that is gaining support nationwide under various names. Some jurisdictions call them Alternate Treatment Sites (ATS) or Alternative Medical Treatment Sites (AMTS) while others use the terms Casualty Collection Points (CCP), Off Site Triage, Treatment and Transportation Centers (OST^3C), Secondary Assessment Centers (SAC), Temporary Alternative Healthcare Facilities (TAHCF) or Alternate Care Sites (ACS). Given the scope of the concept in Florida, the term **Alternative Medical Treatment Site** (AMTS) will be used for planning and operational purposes.

The U.S. Health and Human Services Department maintains a research arm called the Agency for Healthcare Research and Quality. In a report titled: "*Altered Standards of Care in Mass Casualty Events",* ten steps were identified for improving medical response to mass casualty events. The ten steps are:

1) Development of event specific guidance for allocating **medical resources**,
2) Creation of a process to address **non-clinical issues** of mass casualty events,
3) Development of a strategy for risk **communication**,
4) Modification of Federal, State and local **laws and regulations**,
5) Instituting a means for verifying the **credentials** of personnel,
6) Enhancing **leadership and coordination**,
7) Creation of a **training program** for mass casualty event response,
8) Development of **care standards**,
9) Development of a community based **planning guide**, and
10) The creation of mass casualty, health and medical care **response plans**.

These specific action steps served as a general guide for developing the Florida Alternative Medical Treatment Site Plan.

1.2 Purpose

The purpose of this document is to identify the process and procedures whereby local jurisdictions, with State and Federal assistance as needed, can plan for and implement alternative medical treatment sites as part of their response to terrorism or "all hazard" type incidents.

1.3 Scope

The Alternative Medical Treatment Site Plan is a component of the Catastrophic Health Incident Response Plan (CHIRP) which is currently under development by the Florida Department of Health (FDOH). The CHIRP is to be part of Florida's "All Hazards Plan" that will incorporate Emergency Support Function 8 – Health and Medical (ESF 8) and other emergency support functions (ESFs) into the State of Florida Comprehensive Emergency Management Plan (CEMP). Further, the AMTS Plan will mesh with FDOH and other agency operational plans which include but are not limited to the:

- Biological Incident Response Plan
- Bombs, Burns, Blasts (B^3) Plan
- Mass Prophylaxis Plan
- Isolation and Quarantine Plan
- Disaster Communications Plan
- Risk Communication and Public Information Plan
- Action Plan for Pandemic Influenza

1.4 Guiding Principles

The following "guiding principles" have been used in the development of this AMTS plan and many of the principles can be applied to the *operation* of an AMTS:

- All steps and actions taken during the planning and operational phases of an alternative medical treatment site (AMTS) shall **focus on patient care**. A **positive outcome for the patient** is *the* highest priority.

- This plan has not been designed as a "shelf" plan but rather an **operational guide** that will foster a rapid and effective response in the event of a catastrophic disaster. The overall plan includes a sub-plan (Appendix 9) that is operationally focused and condensed for quick field access and use.

- **Simplicity** has been a major guiding principle in the development of the plan to enhance its adoption and use.

- The plan has been designed to be **as automatic as possible** and is **aligned with everyday operations** as much as possible to insure a smooth operation during times of crisis.

- In keeping with good emergency management practices (and the national mandate calling for utilization of the National Response Plan [NRP] and the National Incident Management System [NIMS]) the plan **incorporates the latest standards of incident management** and is **aligned with the NIMS**.

- The plan has been developed through **consensus among key stakeholders and constituency groups**. This process is also critical in establishing an AMTS and in fostering an effective response, should an incident occur. All agencies need to work together and each participant needs to be clearly knowledgeable of what role they play in the establishment and operation of an AMTS.

- The plan has been designed primarily for **terrorism scenarios** but also adaptable for **"all hazards"** application.

- The plan **functions within the framework of the State Emergency Management System** with State level coordination, when needed, facilitated by ESF 8 at the State Emergency Operations Center (SEOC).

- The plan is a sub-plan of the **State's Catastrophic Health Incident Response Plan** (CHIRP) and melds with other appropriate health and medical incident response plans listed in section 1.6 - Plan Interface below.

1.5 Assumptions

1) The citizens of Florida are subject to acts of terrorism and the effects of natural and technological hazards.

2) These acts are likely to produce a significant number of casualties that may overwhelm the existing healthcare system.

3) Given that Florida hospitals are busy on a daily basis, they will not be able to handle the surge created by a significant mass casualty event that generates a large number of patients.

4) Especially in cases of terrorism, victims may be contaminated which would necessitate decontamination prior to treatment and their admission to a hospital facility. It is imperative that hospitals remain uncontaminated so they can deal with not only more seriously injured victims of the incident but also with routine medical emergencies that occur on a daily basis.

5) Hospitals can expect to receive casualties directly from the scene even if triage, treatment and transportation mechanisms are in place at the scene. Additionally, patients may also seek medical care at other types of medical facilities.

6) Patients may report to medical facilities some time after the initial incident. Additionally, some incidents, such as a chemical exposure, may result in delayed symptoms in a patient and thus cross contamination with people they come in contact with.

7) In order to decontaminate, triage, treat and transport patients, a timely and effective mass casualty management system must be implemented.

8) The local emergency medical services will, in most instances, be the first entity to deal with mass casualty victims.

9) There will, most likely, be a large number of psycho physiologic patients in such disasters.

10) One solution to deal with the large numbers of people requiring medical assistance is to establish an alternative medical treatment site to handle life saving stabilization, pre-hospital medical tasks and to deal with less serious injuries and illnesses.

11) With input from the emergency medical services and county health departments, local emergency management will be the entity to officially establish an alternative medical treatment site.

12) Local county health departments will play an integral role in the establishment and operation of alternative medical treatment sites.

13) Most patients and their families will view alternative medical treatment sites as “short term” treatment facilities and will expect treatment in a hospital as soon as possible.

14) A high level of cooperation and coordination among various agencies will be necessary to establish an AMTS and to operate it in an effective and efficient manner.

15) Hospitals, in order to have the capacity to deal with more seriously injured victims, may need to transfer patients with "minor" injuries *to* an AMTS.

16) In situations that are regional, state or national in scope, a local AMTS may need to operate somewhat independently for the first 72 hours of an incident before outside assistance can be provided. Additionally, if the scope of the disaster is large, multiple AMTSs may be needed.

17) Steps will need to be taken to not only assist and protect victims of the incident or disaster but also to protect staff personnel so they can provide continuing assistance to patients generated by the incident.

18) The standard of care may need to be temporarily altered to provide the greatest amount of care possible to the greatest number of people possible. A more appropriate term for this alteration during disaster situations might be "sufficiency of care".

19) The scope of the incident may be such that State or even Federal resources will be required to establish, enhance or replicate an AMTS.

20) A significant issue in large scale AMTS operations will be the surge in staffing needed for such sites and for the hospital receiving facilities.

21) A well organized command structure will be needed to efficiently and effectively manage an AMTS operation.

1.6 Plan Interface

A number of plans and annexes have been or are being developed to deal with medical response to terrorism and "all hazards" type of incidents in Florida. In many cases this Alternative Medical Treatment Site Plan is a part of or complements these plans. This includes, but is not limited to, the:

- State Comprehensive Emergency Management Plan
- Catastrophic Health Incident Response Plan
- National Response Plan
- National Bioterrorism Hospital Preparedness Program
- FDOH Action Plan for Pandemic Influenza
- FDOH Florida Disaster Behavioral Health Response Plan
- FDOH Emergency Operations Plan
    - Bombs, Burns and Blasts (B^3) Component
    - Biological Incident Component
    - Mass Prophylaxis Annex
    - Isolation and Quarantine Annex
    - Disaster Communication Annex
    - Credentialing Annex

1.7 Key Stakeholders

Planning for, establishing, and operating an AMTS successfully will require a cooperative effort among a wide variety of constituent groups and stakeholders. This would include:

- Emergency Medical Services and Fire Departments
- Emergency Management
- Hospitals and other healthcare facilities
- Local, State and Federal Public Health Departments
- Law Enforcement
- Various local Government agencies
- Professional Associations
- Volunteer organizations including the Medical Reserve Corps, American Red Cross, Salvation Army, etc.
- Special Teams including MMRS, DMAT, SMRT, Hazmat, etc.
- Mental Health agencies
- Faith based community

1.8 HRSA Priority Areas and Benchmarks

The Health Resources and Services Administration (HRSA) has identified "surge capacity" as one of its priority areas when evaluating funding of projects related to terrorism response. Within this priority area they have identified benchmarks for applicants that show where focus should be placed. These are applicable to AMTS planning and are as follows:

- **Hospital bed capacity** (treatment and initial stabilization of 500 adult patients per 1 million population) for acute illnesses or trauma requiring hospitalization from chemical, biological, radiological, nuclear, or explosive incidents
- **Isolation capacity**
- Deployment of **additional healthcare personnel** in support of surge capacity (identifying how personnel are recruited, received, processed, and managed through the incident)
- **Credentialing** of personnel
- Establishment of regional **pharmaceutical caches**
- **Personnel protection and decontamination** systems and equipment
- Provision of **mental health services** and **trauma/burn care services**
- Provision of **communication capability**

HRSA has also identified AMTS guidelines for those applying for grant funding in the development of their programs. These, too, are useful for communities to reference in planning for an AMTS. The guidelines are as follows:

Planning

a) **Alternate Care Sites (required of all awardees) –** Awardees must have the ability to provide surge capacity outside of the hospital setting as has been demonstrated through recent public health emergencies. Many States have undertaken very thoughtful and deliberate processes for identifying off site or alternate care sites within a certain radius of healthcare facilities. An important concept for States to keep in mind is that while selecting these sites, planning must consider that Federal assets exist that can be brought to bear but require an "environment of opportunity" for set up and operation and may not be available for 72 hours. Awardees should clearly articulate:
   - **How many sites have been identified** at the State and sub-State regional level?
   - What **types of facilities** are being considered?
   - What can the facilities accommodate in terms of **the numbers of patients and level of care**, (i.e. triage, basic care and stabilization, trauma level type care, patients transferred from hospitals, medical needs shelters, etc)?
   - What **staffing plans** have been developed for these facilities?
   - What are the **plans for supply and re-supply** of the facilities?
   - What are the **plans for the security** of the site? and
   - What are the **plans for patient movement** to the sites and from the sites to more definitive care sites either within or outside of the State?

Section 2
AMTS Organization

2.1 Surge Response Levels

The methods used to handle patient surge generated by an emergency or disaster will be dependent upon the type of scenario presented. For organizational purposes, these methods can be divided into six surge response levels:

Level	Level of Response	Scope
Level 1	Facility	"In-place" surge coverage by hospitals
Level 2	Multiple Facilities	Coordinated surge coverage by hospitals
Level 3	Community	LEOC coordinated – AMTS involvement
Level 4	Regional	LEOC coordinated – AMTS involvement
Level 5	State	SEOC coordinated – Multiple AMTSs
Level 6	Federal	Support to State response – Multiple AMTSs

Level 2 will require greater "mutual aid" type agreements between hospitals to coordinate coverage. Levels 3 through 6 necessitate the establishment of an AMTS, the involvement of Emergency Management and the implementation of an incident management system to coordinate activities. It should be noted that hospitals have been asked to prepare for 20% above their normal staffed and licensed bed number.

2.2 Guidance

National Incident Management System - Given that agencies throughout the State of Florida have adopted the National Incident Management System (NIMS) and that incidents may rise to the level whereby agencies from local, State and Federal agencies may be working together, the Florida Alternative Medical Treatment Site Plan adopts, follows, and incorporates the NIMS.

Florida Incident Field Operations Guide - The Florida Incident Field Operations Guide (FOG) has been developed to provide an "in the field" reference guide for emergency response agencies throughout Florida. Two chapters of this guide, Chapter 14 titled: "Multi-casualty" and Chapter 16 titled: Health, are directly applicable to AMTS operations and should be referenced when an AMTS is established. (A link for these sections are included in Appendix 2 of this plan.)

2.3 Emergency Management

In the State of Florida, large scale emergency and disaster response is organized under Chapter 252 of the Florida Statutes and utilizes emergency management for the coordination of resources. Thus, the activation of an AMTS will be a function of emergency management with input from key disciplines including health, fire, EMS and law enforcement. Since the local emergency operations center (LEOC) will likely be activated for the event that precipitates the need for an AMTS, the key players should already be assembled in the LEOC under their emergency support function categories and should be available to initiate and support the operation of an AMTS.

To further organize for utilizing AMTSs in a community, it is recommended that local emergency management form a task group made up of the key stakeholders and constituency groups to develop the local plan. The plan, once developed, should be exercised either as a stand-alone drill or as part of a larger disaster response exercise.

2.4 Organizational Structure

To establish and operate an AMTS, a structured approach must be used that encompasses all key components of organization. A proven system, especially during times of emergency or disaster, is the incident command system. As stated above, the system of choice, given its proven track record and acceptance nationwide, is the NIMS. This plan also encompasses the concept of "unified command" which is important when more than one discipline (usually health, fire, law enforcement) has a major stake in the incident at hand.

In following the standardized organizational structure identified in the NIMS, an AMTS would have both Command Staff and General Staff positions. Positions assigned in the "Command Staff" section would include:

- AMTS Incident Commander
- AMTS Medical Director
- AMTS Safety Officer
- AMTS Liaison Officer
- AMTS Public Information Officer

Lead positions in the "General Staff" section would include:

- AMTS Operations Chief
- AMTS Planning Chief
- AMTS Logistics Chief
- AMTS Finance / Administration Chief

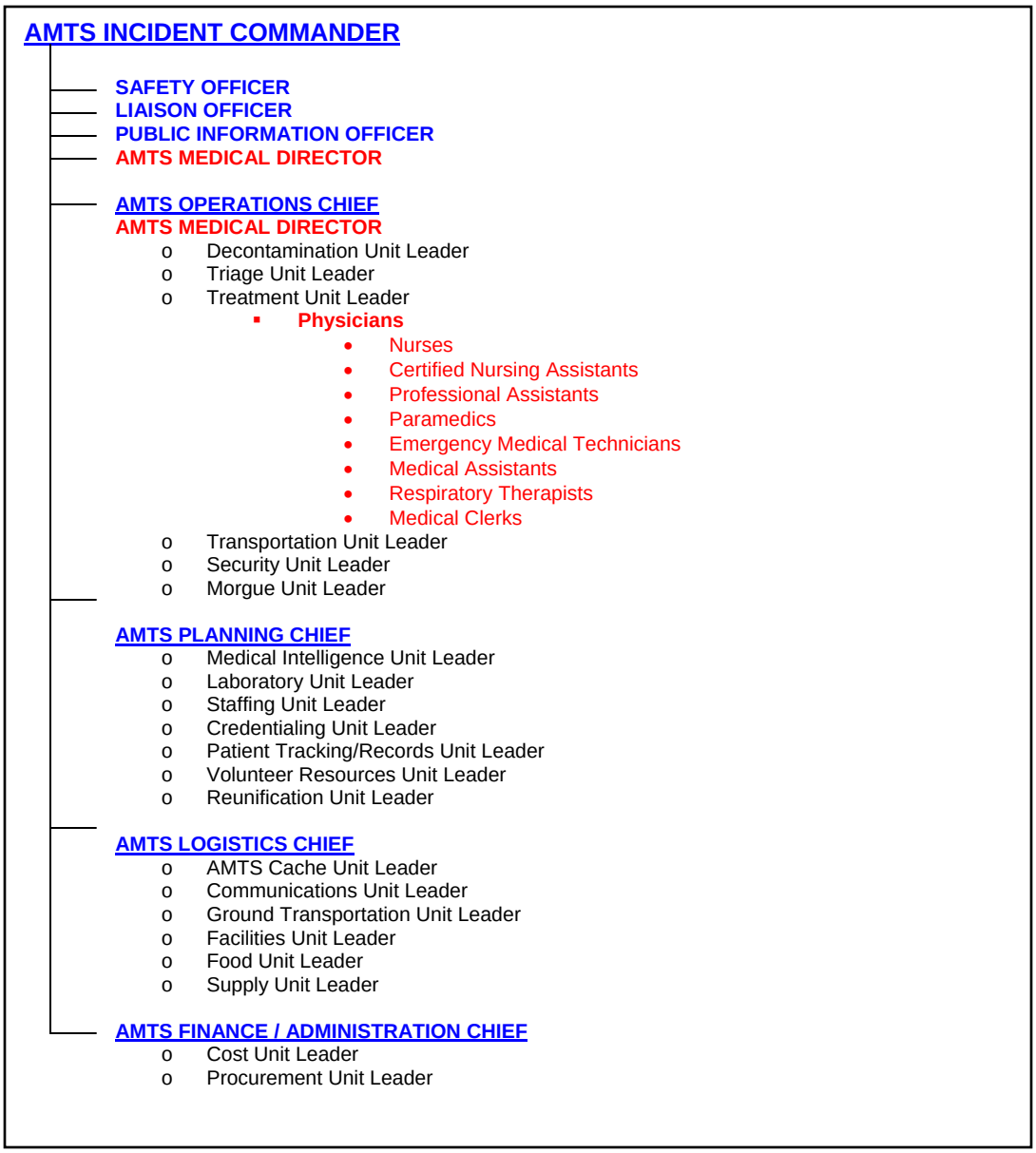
Additional positions in the “General Staff” section, depending upon the scale of the operation, would include (but not be limited to):

- Decontamination Unit Leader (Operations)
- Triage Unit Leader (Operations)
- Treatment Unit Leader (Operations)
- Transportation Unit Leader (Operations)
- Security Unit Leader (Operations)
- Morgue Unit Leader (Operations)
- Medical Intelligence Unit Leader (Planning)
- Laboratory Unit Leader (Planning)
- Patient Tracking and Records Unit Leader (Planning)
- Staffing Unit Leader (Planning)
- Credentialing Unit Leader (Planning)
- Volunteer Resources Unit Leader (Planning)
- Reunification Unit Leader (Planning)

- AMTS Cache Unit Leader (Logistics)
- Communications Unit Leader (Logistics)
- Ground Transportation Unit Leader (Logistics)
- Facilities Unit Leader (Logistics)
- Food Unit Leader (Logistics)
- Supply Unit Leader (Logistics)

- Cost Unit Leader (Finance/Administration)
- Procurement Unit Leader (Finance/Administration)

Implementation of certain positions will be dependent upon the magnitude of the incident. In less severe incidents, some positions may not be needed while major incidents may require “deputy” positions for 24/7 coverage. The AMTS Incident Commander has the latitude to expand, shrink or modify the organizational structure of the AMTS but should stay within the guidelines of the NIMS for consistency and standardization. The sample structure shown below does not include Branches or Divisions/Groups, but in a large AMTS, they may be necessary.



2.5 Position Responsibilities

Each position in the organizational structure of an AMTS will have specific responsibilities. During the planning phase, jurisdictions should pre-identify key personnel who qualify to fill each position. It is especially important that the Command Staff and General Staff Lead positions be filled with people who are decisive, can take charge of their particular area of responsibility and who will be proactive in getting the AMTS operational quickly and effectively. Specific duties for each position need to be developed so prepackaged checklists can be created and included in AMTS "command packs" in the AMTS caches.

COMMAND STAFF

AMTS Incident Commander – The AMTS Incident Commander is responsible for directing the AMTS operation. This includes top decision making duties and directing the leadership team. The Incident Commander is responsible for assigning trained personnel to fill Command Staff and General Staff positions in the command system. The Incident Commander is charged with the overall management of the AMTS.

AMTS Medical Director - The AMTS Medical Director is responsible for providing medical direction and top level medical decision making for the AMTS. The position not only works in the Command Staff to provide guidance but also plays a key role in the Operations Section through the provision of medical direction to personnel.

AMTS Safety Officer
The job of the AMTS Safety Officer is to monitor the AMTS for safety issues and to mitigate any safety deficiencies to prevent harm to patients or response personnel. Practices and procedures being used are monitored for safety compliance and additional safety personnel are deployed to assist the Safety Officer, as needed, to monitor hazard areas such as decontamination stations, triage areas, etc.

AMTS Liaison Officer
The establishment and operation of an AMTS will require cooperation and coordination among a number of different agencies. The AMTS Liaison Officer serves as the coordinator to address various participating agency needs and fosters the “linkages” that must be addressed in the operation of an AMTS.

AMTS Public Information Officer
When an AMTS is established it will be a media event. Media will be seeking information on all aspects of the AMTS service so it is crucial to have an AMTS Public Information Officer in place to address their needs. Additionally, there will be information that the Command Staff of the AMTS desires to get out to the public and it will be the job of the Public Information Officer to see that this information is properly disseminated.

GENERAL STAFF

AMTS Operations Chief - The Operations Chief is responsible for overseeing the operational aspects of an AMTS. This includes directing the decontamination, triage, treatment, and transport of patients as well as working with the Medical Director to ensure that patient care is facilitated, and addressing security issues.

AMTS Planning Chief – The Planning Chief is responsible for referencing and implementing the AMTS Plan. This position looks ahead to future operational periods to assess the staff and material needs of running the AMTS. The Planning Chief oversees medical intelligence, staffing, credentialing, and technical specialists.

AMTS Logistics Chief – The Logistics Chief is responsible for acquiring the goods and services to establish and keep an AMTS running. The position oversees such functions as the AMTS equipment cache deployment, feeding, ground transportation, supplies ordering, and facilities maintenance.

AMTS Finance / Administration Chief – The Administration / Finance Chief is responsible for the documentation and cost aspects of the AMTS. The position is responsible for accounting for personnel hours, tracking costs, facilitating the purchase of goods and services required to run the AMTS, and facilitating the state and federal reimbursement processes.

ADDITIONAL POSITIONS

Decontamination Unit Leader (Operations) – The Decontamination Unit Leader oversees the decontamination process including the establishment of decontamination stations, decontamination of patients, protection of personnel, control of runoff, and disposal of or decontamination of equipment.

Triage Unit Leader (Operations) – The Triage Unit Leader oversees the triage and re-triage of patients arriving at the AMTS, the proper tagging of patients, and the movement of patients to appropriate treatment areas or to the transportation section for transport to the hospital.

Treatment Unit Leader (Operations) – The Treatment Unit Leader oversees the treatment of patients, the separation of patients into appropriate areas, and all elements of patient care. The Treatment Officer works closely with the Medical Director in coordinating patient care.

Transportation Unit Leader (Operations) – The Transportation Unit Leader will oversee the transport of patients to hospital facilities and will maintain contact with hospitals so patient loads are properly distributed among receiving facilities.

Security Unit Leader (Operations) - The Security Unit Leader is responsible for overseeing all of the security issues associated with the operation of the AMTS. This includes coordinating the efforts of law enforcement personnel, ensuring internal security, protecting patients and staff, securing the perimeter of the AMTS, and carrying out the details identified in the Security section of the plan located in the Operations section.

Morgue Unit Leader (Operations) – The Morgue Unit Leader is responsible for the establishment and operation of a temporary morgue at the AMTS and will coordinate the efforts of additional mortuary resources summoned to the AMTS.

Medical Intelligence Unit Leader (Planning) – The Medical Intelligence Unit Leader is responsible for acquiring and processing medical information for the AMTS. This would include specifics about materials people have been exposed to, what specialized procedures need to be used, what lab testing results indicate, and what actions need to be taken once an agent is identified (if the incident involves terrorism with a resultant exposure).

Laboratory Unit Leader (Planning) – The Laboratory Unit Leader is responsible for overseeing all lab submittals and reports. While the routine AMTS patient will not normally generate a need for lab work, more involved incidents where a higher level of triaged patients are treated may require lab work and such work is coordinated by the Laboratory Unit Leader.

Patient Tracking / Records Unit Leader (Planning) - The Patient Tracking/Records Unit Leader is responsible for tracking the patient in and out of the AMTS and for creating patient records.

Staffing Unit Leader (Planning) – The Staffing Officer will be responsible for forecasting the need for AMTS staffing, identifying staffing sources, requesting personnel, and assigning personnel to specific areas.

Credentialing Unit Leader (Planning) – The Credentialing Unit leader is responsible for seeing that all personnel operating at the AMTS are properly credentialed. This includes both paid and volunteer positions.

Volunteer Resources Unit Leader (Planning) – the Volunteer Resources Unit Leader will be responsible for overseeing and coordinating the volunteer resources that are utilized in the operation of an AMTS.

Reunification Unit Leader (Planning) – The Reunification Unit Leader is responsible for establishing and operating the Reunification Center and seeing that tasks associated with releasing people from the AMTS are carried out.

AMTS Cache Unit Leader (Logistics) – The AMTS Cache Unit Leader is responsible for receiving and storing the cache(s), disseminating items, tracking inventory, and seeing that the caches are re-supplied and repackaged when the AMTS is demobilized.

Communications Unit Leader (Logistics) – The Communications Unit Leader is responsible for facilitating communications at the AMTS. This includes acquiring, distributing and tracking all communications equipment, setting up communications systems, developing a communications plan, and providing personnel with contact information and procedures.

Ground Transportation Unit Leader (Logistics) – The Ground Transportation Unit Leader is responsible for handling transportation issues for the AMTS exclusive of the medical transport that is arranged by the Transportation Officer in Operations.

Facilities Unit Leader (Logistics) - The Facilities Unit Leader is responsible for overseeing the physical set up of the AMTS, working with building/property representatives to maintain the facilities, and for seeing that the facility is returned to its original status when the AMTS is demobilized.

Food Unit Leader (Logistics) – The Food Unit Leader is responsible for securing and distributing food and beverages to patients and staff of the AMTS.

Supply Unit Leader (Logistics) – The Supply Unit Leader is responsible for acquiring and distributing all of the supplies and services necessary for AMTS operation.

Cost Unit Leader (Finance/Administration) – The Cost Unit Leader is responsible for tracking all of the expenses incurred by the AMTS and for assisting the Finance/Administration Chief in handling AMTS cost related issues.

Procurement Unit Leader (Finance/Administration) – The Procurement Unit Leader works with personnel in the Logistics Section to properly acquire and pay for all goods and services utilized by the AMTS.

2.6 Medical Personnel

The operation of an AMTS will require a cadre of medical professionals, especially if the AMTS is a Type 2 or Type 1 operation. Positions that will be needed include but are not limited to:

- Medical Director
- Physicians
- Nurses
- Nursing Assistants
- Physician Assistants
- Nurse Practitioners
- Advanced Registered Nurse Practitioners
- Paramedics
- Emergency Medical Technicians
- Medical Assistants
- Respiratory Therapists
- Clerical Staff

The number of each position will be dependent upon the type of AMTS established which relates to the scope of the incident. Staffing calculations are made by the Planning section and details can be found in Section 5 of this plan. These positions will function in the "Operations" section under the direction of the AMTS Medical Director, the Operations Chief, and the Treatment Unit Leader.

2.7 General and Volunteer Personnel

There will be a number of tasks to be completed in each of the General Staff command areas. Personnel will be needed to handle logistical tasks, administrative duties, and a multitude of general jobs associated with establishing and operating an AMTS. Staffing will come from a number of different agencies and will be coordinated by the Planning section. A good source for many of these positions will be volunteer agencies, associations/organizations, and single volunteer resources. As with all positions in the AMTS organizational structure, they will have to be registered and tracked as they carry out their work at the AMTS. Section leaders will need to identify how many people they will need in their particular section so that Planning can arrange for the necessary number of people to carry out the tasks. Florida's Emergency Health Volunteer Registry (FEHVR) will be a source of health professional volunteers.

Section 3
AMTS Planning

3.1 Pre-incident Planning

In order for an AMTS to be placed in service quickly and efficiently, certain steps in the planning process should take place well before an incident occurs. Included would be such tasks as:

1) Assigning a lead agency and/or point person in the County who will establish and maintain the local jurisdictional plan for creating and operating an AMTS.

2) Pre-arranging the necessary approval process for initiating an AMTS. This may involve action by the local political body.

3) Pre-identifying structures or locations in the community which could serve as an AMTS facility. This is an essential step to getting an AMTS quickly operational.

4) Pre-arranging Memorandums of Understanding (MOU) with facilities that may be used as an AMTS.

5) Forging agreements with health and medical service providers to supply personnel to help staff an AMTS.

6) Pre-qualifying key personnel to serve in AMTS command positions.

7) Stocking command vehicles with laminated “quick start” guides for establishing an AMTS.

8) Establishing call lists in communication centers (or pre-programming automatic dialers) for personnel/ agency notification when an AMTS is initiated.

9) Identifying the procedures to follow and contact numbers to use for requesting various specialized response teams and resources available throughout the State (see “Response Teams and Resources” in Section 5.1 of this plan for a list).

10) Training personnel in various subjects relating to the operation of an AMTS including incident command, triage, treatment, establishing an AMTS, decontamination of patients, etc.

11) Conducting drills to exercise personnel in the establishment and operation of an AMTS.

12) Pre-establishing agreements with law enforcement agencies to provide security (on short notice) for the AMTS.

13) Pre-establishing agreements with meal providers so feeding can be accomplished on short notice.

14) Pre-establishing agreements with medical and pharmaceutical vendors to provide large quantities of supplies quickly during an emergency.

15) Pre-packaging "Command Jump Packs" that would include a list of procedures and protocols, incident command worksheets, triage tags, vests, checklists, forms, etc. to utilize in quickly getting an AMTS operational.

16) Preparing, ahead of time, for quick acquisition and transport of specialized medical equipment to the AMTS.

17) Pre-identifying the layout of an AMTS for particular sites that are likely to be used.

18) Setting up an agreement with a telephone company to provide a bank of telephones for use by patients to make outgoing telephone calls.

19) Pre-identifying where the funding for various types and levels of AMTS operation will come from. This might be a several tiered approach that looks at situations falling into local, State or Federal scope.

20) Creation of "checklists" so tasks are easily identified and assigned when the decision is made to open an AMTS. This would include the development of job responsibility sheets for each position in the Command and General Staff positions.

3.2 Staffing

A key issue in the establishment and operation of an AMTS is staffing. Initial staffing for an incident will likely come from the emergency medical services, who are part of the initial "first response" contingent to an incident, or personnel from adjacent jurisdictions who can be summoned via mutual aid. Given the fact that EMS responders, either fire department or private sector ambulance companies, provide service "around the clock", they are a source of staffing for getting an AMTS operational in a short time frame. (The State Fire Marshal / Florida Fire Chiefs Association Statewide Emergency Response Plan is designed to have resources respond in an "immediate to one hour" time frame.) These people will be augmented by County Health Department personnel, specialized medical response teams, and hospital emergency department personnel. As the duration of an AMTS increases it is likely that State Medical Response Teams or Disaster

Medical Assistance Teams will be called in to provide service. If the AMTS becomes a Type 2 or Type 1 operation of longer duration, additional hospital professional staff will need to be included in the staffing plan. During incidents of extremely long duration or when multiple AMTSs are in place, non-traditional medical staffing, including a number of volunteer personnel, will be needed. One key step that jurisdictions need to take is addressing the needs of healthcare workers and their families so that personnel can concentrate on serving others in need during a disaster.

One answer to the staffing dilemma may be for a jurisdiction to have prearranged agreements with healthcare providers (all types) to commit to supply a specified number of personnel when an AMTS is activated.

It should also be noted that mutual aid can be utilized to supply staffing when a jurisdiction or region has sustained a major incident. If, however, the incident has impacted a number of areas or is a terrorism incident that causes secondary impacts to other areas, it may be difficult to obtain resources from other areas.

A key element in staffing an AMTS will be relief personnel. If an AMTS becomes an operation of extended duration, it will be necessary to find relief personnel. It may even be necessary to establish shifts at the AMTS so that personnel can rotate in and out of the facility according to a schedule.

3.3 Staffing Sources

Key groups that would provide staffing at different stages of an AMTS include:

- Fire Department and Third Service EMS personnel
- Private ambulance companies
- County Health Department personnel
- Specialized local and regional response teams
- State Medical Response Teams
- Hospital emergency department personnel
- Medical Reserve Corps
- Local nursing and allied health students
- Volunteers including CERTs

In large scale incidents that involve Federal assets:

- Disaster Medical Assistance Teams
- Public Health Commissioned Corps
- Military or Military Reserve Units

To fill general assistance positions on a voluntary basis, a number of volunteer organizations including the Salvation Army and American Red Cross could be called on to help.

3.4 Health and Medical Staffing Levels

While various types of positions in the command structure will be needed to operate an AMTS, none is more critical than the health and medical staffing that will actually triage, assess, and treat patients. Studies suggest that specific health and medical staffing for an AMTS (per 50 beds for a 12 hour shift) should include:

- One Physician
- One Physician Assistant or Advance Registered Nurse Practitioner
- Six Registered Nurses or Licensed Practical Nurses
- Six Paramedics
- Four Emergency Medical Technicians
- Four Medical Assistants
- Two Medical Clerks
- One Respiratory Therapist
- On Case Manager
- One Social Worker
- Two Housekeepers
- Two Patient Transporters

A more detailed listing of medical staffing needed is listed in Appendix 8 which references the Rocky Mountain Regional Care Model for Bioterrorism.

3.5 Credentialing

As cited in the "staffing" section of this plan, acquiring an adequate number of medical professionals to staff an AMTS in a disaster situation may be quite challenging. As such there may be a variety of standard, non-standard, and out of state personnel being utilized to cover staffing shortage. It will be necessary to ensure that these individuals are properly qualified and credentialed for the work they will be asked to do. A credentialing process must then be in place with local access capability by AMTS administrative personnel. The Florida Department of Health is in the process of fully developing this capability with an expected implementation date of June 2007. Included will be standards and guidelines recommended by the Health Resources Service Administration's Emergency System for the Advanced Registration of Volunteer Healthcare Professionals (ESAR-VHP) program (www.hrsa.gov/esarvhp/guidelines) on a state and nationwide basis. Florida has a limited system currently in place (Florida's Emergency Health Volunteer Registry) for use until the new system with enhanced capabilities can be implemented. This system, along with other credential verification procedures, should be used in the interim for any AMTS activations. At a minimum, the credentialing process should be able to verify the following information:

1) Name
2) Address and contact information
3) Agency affiliation
4) Licensure
5) Level of training
6) Level of experience
7) Any pending legal action
8) Qualification for assigned task

3.6 Patient Tracking and Charting

Patient tracking at an AMTS is not unlike the process used for a mass casualty incident. At the very least, the *triage tag system* can be used to track patients until a more detailed process is implemented once administrative resources arrive at the AMTS. Once that occurs, standardized patient tracking forms can be used for the duration of the patient's stay at the AMTS. However, since one of the challenges of a large scale incident is the excessive number of patients generated, jurisdictions may want to utilize advanced technologies to track patients. Whatever system is used, it needs to be expedient so that tracking does not delay patient care. Issues in patient tracking include:

1) Obtaining the necessary patient information
2) Utilization of a standardized method of tracking
3) Utilization of technology to simplify tracking
4) Collecting, cataloging, storing, and securing patient belongings
5) Retaining records and a tracking record if the patient is transferred to a hospital or is released from the AMTS

For patients that remain at the AMTS, medical personnel must officially document the patient's status and obtain patient information. Since an AMTS may only be open long enough to properly decontaminate, triage, treat, and transport the patient to a hospital, charting may be delayed until a patient is seen at a hospital. If, on the other hand, the patient stays at the AMTS for treatment, a chart must be kept to document the assessment and care that is provided. Administration personnel can begin the process early and then complete such charting at the out-processing point or transfer the information to the hospital with the patient when they are transported.

While documentation is an important part of AMTS administration, obtaining information should not interfere with rapid decontamination, triage, assessment, treatment or transport of patients.

3.7 Technical Information

In the incident command system, Planning (especially the Medical Intelligence Unit Leader) is responsible for fielding technical specialists in support of operations. One of the responsibilities of the technical experts is to provide caregivers with information that will enable them to carry out their responsibilities. In a terrorism incident this includes providing such information as:

1) Fact or information sheets on the particular agent used including antidote details
2) Symptoms exhibited by exposure to the agent
3) Medical conditions that are complicated by exposure to the agent
4) Treatment modalities
5) Self care guidelines to be given to the patient upon release from the AMTS
6) Any other information that will help result in a positive outcome for the patient

3.8 Out-processing

Patients may receive treatment at an AMTS and never be transported to a hospital facility. There will come a time when they will be released from the AMTS. As such, procedures need to be in place for this process when an AMTS is initiated. Included would be:

- Communications with family members
- Packaging any belongings for return to the patient
- Finalizing patient records (with a copy being provided to the patient)
- Dealing with any financial issues associated with the care
- Physically transferring the patient to a family member or caregiver
- Obtaining release signatures
- Counseling on what follow-up actions are needed

Before patients are released, Administration personnel should make sure that they have obtained (at least) the following information:

- Patient name, address, and telephone number
- Patient date of birth
- Patient medical chart or triage tag number
- An emergency contact number
- Social Security number
- Time and date of patient discharge from AMTS
- Patient signature that they are agreeing to be released from the AMTS

While these previous steps should be established for the release of a patient from an AMTS, there are portions that would also apply to those being transferred to a hospital.

3.9 Reunification

Depending upon the scope of the AMTS, ESF 6 – Mass Care, may be initiated in the LEOC or even the SEOC to assist with some of the tasks associated with reunification.

Planning personnel should provide the patient with information including:

- Details about the agent they may have been exposed to
- Signs and symptoms that would necessitate them obtaining further medical care or returning to the AMTS
- The process for re-entering the AMTS, if necessary
- Home care instructions

To handle all of these tasks, a portion of the AMTS needs to be identified for a Reunification Center. This will provide a location where:

- patients can gather before they are released
- patients can be reunited with their families
- patients can ask questions and obtain further information about their exposure to an agent and what follow-up care is necessary
- they can talk with a counselor about mental distress issues
- they can make a telephone call
- people can obtain information about a family member who was transported to the AMTS
- patients who will need transportation home from the AMTS can make the arrangements

3.10 Training

In order for an AMTS to open and operate smoothly it is essential that personnel be trained in a wide variety of subjects. Fortunately, much of the training overlaps existing training requirements associated with terrorism response preparations. HRSA's National Bioterrorism Hospital Preparedness Program can serve as a guide in this area. Training that would be beneficial to those operating an AMTS includes (but is not limited to):

- Responding to biological, chemical and radiological events
- Responding to bomb, burn, blast events
- Incident Command and the NIMS (multiple levels and classes)
- Risk Communication
- Treating special populations
- Patient Decontamination and Triage
- Personal Protective Equipment
- Hospital Staff Core Competencies for Disaster Preparedness
- Training for specific positions within the Incident Command System

Section 4
AMTS Establishment

4.1 Patient Criteria

The scope of an incident will determine what types of patients will be treated at an AMTS. While the implementation of a Type 1 AMTS (see typing matrix below) might necessitate the treatment of more serious types of illnesses and injuries, most situations will result in the following type of patients being serviced at an AMTS:

- "Green" tagged triaged patients
- People who do not have critical injuries
- Patients who are psycho physiological with no physical injuries
- People who "self admit" themselves at an AMTS for minor care
- Patients sent to an AMTS by a hospital to free-up space for more critically injured patients
- Patients who need to be decontaminated prior to transport to a hospital

Again, the exception would be patients who are in the "Red" or "Yellow" categories who cannot be immediately transported to a hospital from the scene. This type of situation would arise in an extremely overwhelming incident where hospitals are already inundated with patients. The AMTS would have to assess and treat these categories of patients until a hospital is ready to accept them.

4.2 Considerations

Factors that need to be considered by emergency management and health officials in making the decision to open up an AMTS include:

1) The size and magnitude of the incident
2) Number of expected casualties
3) Geographic distance from the scene to the hospitals
4) Duration of expected decontamination, triage, treatment and transport processes
5) Degree of patient decontamination required
6) Length of time to get an AMTS operational
7) Current status of the hospitals and the number/rate of patients that can be accepted by primary healthcare facilities
8) Need to provide decontamination and medical care to patients within a reasonable time period
9) The need for an AMTS if the hospitals are impacted by the incident, either directly or via contamination

4.3 Typing Matrix

A number of different scenarios will drive the need for an AMTS. Some considerations for the *type* of AMTS required include:

1) Term of operation (long, medium, short, MCI extension)
2) Anticipated duration (in hours) of AMTS operation
3) Nature of the disaster
4) Level of resources required
5) Facility type needed
6) Number of staff that will be required
7) Medical teams needed
8) Appropriate organizational structure needed
9) Logistics required

The following AMTS "typing" matrix has been developed to provide some general guidance on the type of AMTS that might be needed for a particular incident.

Parameter	Type 1 AMTS	Type 2 AMTS	Type 3 AMTS	Type 4 AMTS
Term	Long	Medium	Short	Extension of MCI Response
Duration	> 36 hours	16-36 hours	8-24 hours	< 8 hours
Patients	>1500	>1000 - <1500	> 500	>100 < 500
Example Natures	Pan Flu, Significant Respiratory, Major disaster	Decontamination situation, Radiological, Biological	Bomb, burn, blast, decontamination situation	Transportation accident, building collapse, industrial accident
Logistics	4+ AMTS caches and Regional, State and Federal assets	3 AMTS caches and additional Regional and State assets	2 AMTS caches and additional Regional assets	Single AMTS cache
Teams	Local, Regional, SMRT DMAT/Hospital Staff / Non-traditional medical personnel	Local, Regional, SMRT, Hospital Staff	Local, Regional, SMRT	Local/Regional

4.4 Facility Selection

The selection of a building or site for an AMTS will be dependent upon the type of AMTS needed as well as the availability of structures or sites in a given community. Key physical aspects of an AMTS should include:

1) A facility large enough to accommodate AMTS components including the operational aspects of decontamination, triage, treatment, as well as logistical aspects such as receiving, storage, and distribution
2) Parking areas to accommodate ambulances, staff personnel vehicles, law enforcement vehicles, and other logistics related vehicles
3) Good ingress and egress from the site
4) Water and sewer connections
5) Restrooms and shower facilities
6) Adequate electrical power and a backup generator
7) Air conditioning and heating including a HVAC system that can be sectored off to avoid cross contamination
8) Internal and external communication systems including a public address system, telephones, and data capabilities
9) Ability to secure the facility or site
10) Storage areas for logistical needs
11) Administrative space, preferably with chairs, tables, etc.
12) Resistance to becoming easily contaminated (floor type, etc.)
13) An area conducive to food preparation and food distribution
14) An open area that could serve as a landing zone for helicopters

Planners looking for further guidance on criteria for AMTS facility selection should reference the International Association of Assembly Manager's document titled, "*Mega Shelters – Planning and Activation"*, a link for which can be found in Appendix 2.

4.5 Facility Options

Selection of a facility will be largely dependent upon the availability of structures or areas in a given community. Possible sites for selection include:

1) Convention centers
2) Churches
3) Schools and Colleges
4) Airport hangers
5) Sports facilities or stadiums
6) Community or recreation halls
7) Medical buildings
8) Fitness centers
9) Closed hospitals or nursing homes
10) Government buildings
11) Fairgrounds

12) Skating rinks
13) Open warehouses
14) Hotels or motels
15) Military installations or National Guard Armories
16) Open area for tent setup

In some communities there may not be a wide selection of buildings available for hosting an AMTS. Some facilities, while they may be appealing because they meet various logistical criteria, may not be the best choice because of the disruption that would be caused or because of the danger of closure after an incident due to contamination. For example, a school may seem like a good choice for an AMTS but if an event becomes prolonged it would interfere with classes and there might be concerns about residual contamination. As mentioned in the planning guidelines for an AMTS, it would be prudent to pre-identify structures as potential sites so issues surrounding their use could be addressed before an incident occurs.

Care should be taken not to utilize a facility that is already under a MOU with another agency for use during a disaster situation. An example would be a facility that is pre-designated as a public shelter during times of emergency or disaster.

4.6 Additional Options for Ancillary Sites

One consideration for situations where a Type 1 AMTS is opened and medical conditions of the “Red” or “Yellow” triaged variety need to be handled outside of a hospital (due to overwhelming surge) would be to make use of such facilities as “day surgery” or “outpatient” clinics to augment the AMTS. Even veterinary hospitals have been successfully pressed into service during disaster situations. These facilities will, right from the start, be more like actual hospital facilities than other sites that might be selected.

Another option would be to make use of “mobile surge” hospitals that provide sophisticated medical capabilities in a mobile fashion through the use of specially designed and equipped 18 wheel trucks. Sources of these types of facility should be identified in pre-incident planning so they can be summoned in rapid fashion should the need arise. These intensive care type units typically have 6 beds with pre-op and post-op facilities and can serve as temporary clinics as needed.

Optional or ancillary sites would include but would not be limited to:

1) Veterinary hospitals
2) Day surgery or outpatient clinics
3) Closed or minimal population nursing homes
4) Acute care facilities
5) Mobile surge hospitals
6) Other care facilities already outfitted for medical care

7) Tents (given Florida's weather conditions, if this option is used the tents must be environmentally controlled.)

4.7 Timing

To be of greatest value, an AMTS should be able to be initiated within **1 to 3 hours** after the decision has been made to establish a site. While this may seem ambitious, the site can certainly be opened in such a time frame even if it does not have all of the components in place. In other words, an AMTS can be opened quickly and then rapidly built to assemble all of the necessary personnel, equipment, and procedures for "full mode" operation. Additionally, if possible, it would help if agencies who will be responding to an AMTS assembled their response resources at their own agency and then reported to the AMTS, This will limit confusion at the AMTS when multiple agencies are summoned for assistance.

4.8 Throughput

The number of patients generated by an incident will, of course, depend on the magnitude of the event. Research indicates that communities should prepare to implement AMTSs to manage a large number of casualties and keep hospitals from being overwhelmed with patients. As such, an AMTS should be prepared to treat from **75 to 125 patients per hour** or **900 to 1500 patients over a 12 hour period.*** If a single AMTS is inadequate to deal with this level of throughput (which may be likely if significant decontamination or lengthy treatment becomes a reality) then multiple AMTSs may have to be opened. It should be remembered that the number of patients that can be decontaminated, triaged, assessed, and treated in a given period of time is directly proportional to the number of personnel staffing the AMTS. This makes it critically important for planning and operational managers to foster an immediate response of a large number of AMTS personnel so that more than a sufficient number of people are rapidly in place to process and treat patients.

*It should be noted that non-ambulatory patients will slow down throughput thus reducing the number of "patients per hour" treated.

4.9 Activation and Notification Scheme

For maximum efficiency and effectiveness, timing is critical in making the decision of when to implement an AMTS. This decision needs to be made **well before hospitals are overwhelmed** by the surge from an incident. Key to the establishment of an AMTS will be the proper notification and activation of various agencies and stakeholders. It is helpful, therefore, to look at a sample sequence of events to see how an AMTS is implemented as part of a community's emergency response to an incident.

TYPICAL SEQUENCE OF EVENTS FOR THE ACTIVATION OF AN AMTS

(A terrorism scenario has been used for this example)

Step 1 - Incident Occurs

Step 2 - Local units respond to the scene

Step 3 - Arrival indicates multiple patients

Step 4 - Additional local units respond

Step 5 - Determination is made that a mass casualty incident is in progress and hospitals are notified of the incident

Step 6 - Additional medical, fire, and law enforcement units respond

Step 7 - Local mass casualty plan is initiated

Step 8 - Mutual aid is initiated

Step 9 - Local Emergency Management is activated and the State Warning Point is notified of the incident

Step 10 - Regional resources respond including any MMRS components

Step 11 - Regional communication centers are notified and thus make their own notifications of emergency services, health, and hospital organizations. Additionally, those utilizing such systems as “EM Systems” activate them for notification and informational purposes

Step 12 - The Florida Fire Chiefs Association Statewide Emergency Response Plan is activated to provide additional resources

Step 13 – Personnel who staff ESF 8 at the State EOC monitor the situation ahead of SEOC activation to be able to quickly facilitate requests for additional medical response resources

Step 14 - State Warning Point makes appropriate notifications of the incident in progress. Additionally, the FDOH Regional Emergency Response Advisors (RERAs) are notified

Step 15 - Local law enforcement and the Florida Department of Law Enforcement activates terrorism response plans. Their mobilization needs to include support of medical response initiatives including AMTS operations

Step 16 - Florida Incident Field Operations Guide procedures are referenced and utilized for medical response coordination

Step 17 - Communication links are established between the scene and local hospitals to facilitate the transport of patients to the appropriate hospital and to determine capacity

Step 18 - If contamination of patients is involved, fire department hazardous materials teams or specially trained fire department decon teams establish decontamination stations at the scene

Step 19 - County Health Department officials activate emergency response plans, make appropriate notifications, and staff a coordination desk at the local EOC

Step 20 – The local Emergency Manager, scene Incident Commander, local Medical Director, and the County Health Department Director, with input from the local hospitals as to capacity, make a collective decision that an alternative medical treatment site is needed (**Note:** Jurisdictions may find that this level of authorization is all that is required for a Type 4 or Type 3 operation but that a Type 2 or Type 1 may require local political body authorization.)

Step 21 - A task group is formed in the local EOC to facilitate the establishment of an AMTS

Step 22 - The task group selects an appropriate site for the AMTS, assigns an AMTS Incident Commander and assists the Incident Commander in filling command staff positions. Through the Emergency Manager, the task group places a request for the regional AMTS cache to respond

Step 23 – The AMTS plan is referenced for process guidance. Checklists are referenced to determine what tasks need to be initiated to get the AMTS operational

Step 24 - The appropriate Regional Domestic Security Task Force activates to act as a facilitator for additional resources that may be needed

Step 25 - If the situation is such that local response efforts are not sufficient and additional resources are needed, the local jurisdiction requests State involvement

Step 26 - The appropriate Emergency Support Functions (ESF 2,4,6,8,10,16 at a minimum) at the State EOC are staffed

Step 27 – The AMTS becomes operational and assigned personnel are briefed upon their arrival as to their duties and who they report to

Step 28 - State Medical Response Teams may be activated for response to the AMTS to facilitate staffing

Step 29 - Appropriate FDOH and other state resources respond to assist in the AMTS operation

Step 30 - If the incident rises to the level that would require a disaster declaration by the Governor, State Division of Emergency Management will facilitate the request and, with input from the LEOC ESF 8 desk, will highlight any medical issues that need to be identified in the declaration

Step 31 - If the incident rises to the level whereby a federal response becomes necessary, appropriate steps will be taken to request resources and if necessary, the National Disaster Medical System will be activated with a response by Disaster Medical Assistance Teams

4.10 Task List for getting an AMTS Operational

Once the decision has been made to open an AMTS a number of tasks need to be handled very quickly to achieve the goal of getting the site operational within 1 to 3 hours. It is helpful, therefore, to look at a sample *sequence of events* to see how an AMTS is assembled and put into operation.

TYPICAL SEQUENCE OF EVENTS FOR GETTING AN AMTS OPERATIONAL

1) Emergency Management, in conjunction with the scene Incident Commander, the local Medical Director, the County Health Department Director, and with input from the hospitals and other officials, makes the decision to open an AMTS

2) The “type” of AMTS to be opened, 1,2,3 or 4 is decided, an appropriate AMTS site is selected, details are worked out with the staff of the selected facility and law enforcement is requested to respond for security

3) Emergency Management , along with the task group (identified in 1 above) designates an AMTS Incident Commander and requests response of the closest AMTS cache(s)

4) AMTS Incident Commander and local Medical Director select the “Command Staff” and lead positions in the “General Staff”. All command personnel then report to the AMTS

5) AMTS Incident Commander communicates with the scene Incident Commander and advises the time that patients can be sent to the AMTS

6) AMTS Command Post is established at the selected site

7) AMTS Incident Commander and staff (especially the AMTS Logistics Chief) select areas for receipt of patients, decontamination, triage, treatment, logistics storage, and other key functional work areas

8) AMTS Safety Officer identifies and corrects any initial hazards

9) Security Officer sees that the AMTS is made secure and establishes check-in point for entrance into the AMTS

10) AMTS staff selects and assigns other AMTS organizational chart positions

11) Communications links are established with the scene, the LEOC, and the local hospital(s)

12) Fire Department Hazmat teams are requested to establish decontamination stations. Sites may be needed at the scene, the AMTS, and at the hospital(s)

13) Personnel from appropriate agencies are requested to serve as general workers in getting the AMTS set up and operational

14) Key personnel in the command structure begin arriving at the AMTS and start to organize their particular aspect of the operation. As additional personnel arrive they receive a briefing on their duties and who will be their supervisor

15) All personnel arriving at the AMTS properly “sign in” and are briefed prior to beginning their work

16) Safety Officer advises personnel what level of PPE is necessary, sees that the equipment is issued, and oversees compliance

17) Planning looks at the staffing needs for the AMTS and where they will come from. If SMRT or DMAT personnel will be used, Planning begins the process for acquiring those resources

18) Planning begins to look at the needs for operating the site for the first 12 hour period

19) Operations and Logistics Chiefs confer to refine the lay out of the physical structure of the AMTS including the traffic flow pattern in and out of the site

20) Public Information Officer begins to gather information and sets up a media location at the perimeter of the AMTS

21) All personnel consult pre-designated task checklists for tasks, duties, and responsibilities of their particular area

22) Medical Director and Triage Officer obtain the latest information from the hospital as to their capacity for accepting patients. Additionally, communication takes place with the scene medical personnel to obtain an updated status on patient numbers, injuries, etc.

23) Logistics Chief and Communications Officer establish the communications plan and distribute radios from the AMTS cache for internal communications. Additionally, a phone list of key personnel, agencies, and command positions is formulated for use by personnel

24) Finance/Administration establishes a staff check-in procedure

25) Planning establishes a patient check-in and tracking procedure

26) Logistics works to acquire food and beverage supplies for the AMTS patients and staff

27) Initial patients begin arriving at the AMTS *

28) Decontamination, triage, and treatment processes start

29) Liaison Officer, along with Logistics and other lead staff personnel, interact with and assign other agency personnel work areas within in the AMTS

30) Planning continues assessment of the need for additional personnel and works to acquire the necessary staffing for the AMTS. Additionally, a staffing schedule for future operational periods is established and disseminated to personnel

31) All urgent or critical patients are transferred to the hospital as soon as possible

32) Public Information Officer prepares a briefing on the status of the AMTS

33) Finance/Administration develops a list of staff personnel assigned to the site

34) Planning develops a list of patients being treated at the site

35) Reunification Officer establishes an area and a process to provide information to family members of people being treated in the AMTS

***** It should be noted that feedback from several exercises involving the use of alternative medical treatment sites has indicated that a "surge within a surge" of patients often occurs at Step 27. In other words, the initial surge of patients into an AMTS can be large and as overwhelming as the initial surge of patients at hospitals. As such it will be important for the local jurisdiction to plan for this and ensure that this eventuality is covered. Given the "round the clock" coverage of most emergency medical systems, it will be important that this component (including the EMS emergency response agencies) is prepared to ramp up service quickly. The particular need, with many people arriving all at once, will be expanded triaging capabilities. It may even be necessary to stand up more than one AMTS to handle the patient load. The Planning Section should monitor this closely and provide guidance to the AMTS Incident Commander on the need for additional facilities.

4.11 Public Information and Communication

Once the decision has been made to open an AMTS, public information and communication become very important issues. The AMTS Public Information Officer needs to address a number of related tasks including:

- Establishing a gathering area for the media
- The development and dissemination of a press release about the AMTS including the establishment of scheduled briefings
- Providing the media with requested information
- Compliance with HIPPA regulations when talking about patients and patient care
- Getting word out to the public on how to access care at an AMTS and what type of patients are being accepted. This may include the implementation of an AMTS "hotline"
- The process to be followed in checking on family members being treated at the AMTS
- Acquiring additional assistance for handling public information tasks
- Coordination with public information being released at the incident scene, through the LEOC or through the JIC, if one has been established
- Coordination with the AMTS Commander on information to be released and seeing that the AMTS authority figure gets face to face time with the media

Section 5
AMTS Operations

5.1 Response Teams and Resources

In an effort to respond to terrorism incidents and "all hazards" type disasters, Florida has developed (or has at its disposal) a number of emergency response teams and resources. In addition to local, regional, and mutual aid resources that respond to assist, these teams/resources may play an integral part of an AMTS operation. Included are:

1) Alternative Medical Treatment Site Caches
2) Mass Casualty Trailers
3) Urban Search and Rescue Teams
4) Hazardous Materials Response teams
5) Metropolitan Medical Response Teams
6) Disaster Medical Assistance Teams
7) Military Civilian Support Teams
8) Incident Command Teams
9) Public Information Response Teams
10) Florida Incident Dispatch Teams
11) State Medical Response Teams (under development)
12) Behavioral Health Response Teams (under development)
13) Florida Emergency Mortuary Operations Response System Teams
14) Emergency Radio Caches
15) Emergency Disaster Incident Communications Units
16) Disaster Community Health Assessment Teams
17) State Emergency Response Teams

As part of the pre-planning process, jurisdictions should identify the procedures to follow and contact numbers to use to request these resources.
Maps showing the location of some of these resources are included in Appendix 5 of this plan.

5.2 Decontamination

One of the critical steps in properly treating the victims of a terrorism incident that includes contaminated patients is the decontamination process. This, in fact, may be one of the key reasons that an AMTS is initiated in the first place since, 1) decontamination of patients is a critical first step in the treatment process and 2) it is essential that primary medical treatment facilities do not become contaminated so they are able to continue service.

Steps in the decontamination process must include:

1) Correct identification of the contaminant

2) Protection of emergency healthcare workers from becoming contaminated as they assist patients

3) Acquiring the proper equipment to conduct decontamination

4) Securing trained personnel to carry out the decontamination tasks

5) Properly decontaminating patients

6) Establishing a decontamination procedure that facilitates movement of patients from a “hot zone” through decontamination stations to triage, treatment, and transport areas

.

7) Providing privacy, including segregation of male and female decontamination areas, for the victims whenever possible and providing the patients with new garments once the process is complete

8) Keeping water temperature within acceptable limits so as not to add to medical problems of the elderly or special needs patients

9) Conducting multiple decontaminations of a patient, if necessary

10) Keeping people moving through a gross decontamination process so “bottlenecks” do not occur and a large number of patients can be decontaminated quickly

11) Control of the runoff or byproducts of the decontamination. (It should be noted that decontamination may require copious amounts of water to achieve but that, in most cases, the actual amount of contaminant in runoff water will be minimal.)

12) Protection of medical care facilities from becoming contaminated including treatment and transport areas of the incident, the AMTS, and the primary medical care facilities

13) Decontamination (or disposal) of clothing and equipment (such as PPE) including materials used in the decontamination process

14) Laboratory assessment of the suspected contaminating agent

Florida, through its domestic security funding strategy, has identified and equipped fire department hazardous materials teams throughout the State to accomplish the task of decontamination. Many fire departments are also training other personnel in this task so there will be additional units, beyond hazmat teams, that will have the capability to carry out these duties. A typing matrix for decontamination of patients (along with adopted procedures) is located in Appendix 3 of this plan. In the event of a terrorism incident these resources shall be called upon to handle the decontamination process. These tasks will need to be carried out at the:

1) Incident scene
2) AMTS, and
3) Hospitals or primary medical care facilities

Given that most decontamination processes require large amounts of water and may generate contaminated water, the Florida Department of Environmental Protection should be called upon to assist in large scale decontamination processes.

In addition to gross decontamination, hazardous materials teams or other assigned personnel also need to establish an area for fine or detailed decontamination, if necessary.

Extensive decontamination procedures can be found in the U.S. Army Soldier and Biological Chemical Command document*, "Guidelines for Mass Casualty Decontamination During a Terrorist Chemical Agent Incident"*.
http://www.au.af.mil/au/awc/awcgate/army/sbccom_decon.pdf
Recommendation diagrams from this guide for establishing "corridors" for moving patients through decontamination stations are shown in Appendix 3 of the plan.

5.3 Triage

At an emergency or disaster scene, medical personnel will conduct primary triage to determine patient treatment and transportation priorities. Likewise, when patients are transported to or report to an AMTS, there will be a need to triage or *re-triage* such patients to, again, determine treatment and transport priority. To deal with a large surge of patients and to keep the process as simple as possible, the Simple Triage Rapid Treatment (*START)* and *JUMPSTART* systems of triage are annexed to this plan. (See Appendix 4) It is recommended that response agencies utilize these triage protocols because they provide for a common recognized standard, they are easy to use, and they are supported logistically by most first response agencies and hospitals throughout the State of Florida. (Patients who have been exposed to substances involved in a terrorism incident need to be monitored closely since they may develop delayed symptoms.)

Using this system, patients will be triaged into one of the following categories:

RED (**Immediate**) – Patients in this category are the most critical and need to be transported to the hospital as soon as possible. Patients in this category are the highest priority for transport.

YELLOW (**Delayed**) – Patients in this category require medical intervention and eventually need to be transported to the hospital for treatment. Patients in this category are the second highest priority for transport.

GREEN (**Minor**) – Patients in this category require a general assessment and then can be treated at the AMTS. If necessary, they may ultimately be transported to a hospital. Patients in this category are the third highest priority for transport.

BLACK (**Expectant)** – Patients in this category arrived deceased or die at the AMTS. Patients in this category are the lowest priority for transport and should be transferred to the AMTS temporary morgue.

Note: Personnel operating at an AMTS should utilize the "color coding" scheme identified in the Florida FOG for triage equipment and personnel identification.

The Triage Section will need to:

1) Assess the triage that has been done at the incident scene prior to the patients being transported to the AMTS

2) Triage patients that have not previously been triaged and re-triage those that have

3) Utilize the START and JUMPSTART systems of triage for simplicity and standardization

4) Use these systems and available kits to properly "tag" patients

5) Using the START and JUMPSTART systems, classify the patients as RED, YELLOW, GREEN OR BLACK.

6) Maintain contact with the incident scene Triage Officer for collaboration

7) Take the necessary precautions, using PPE, so that they are not contaminated in the triage process

8) Make accommodation for triaging not only patients arriving by ambulance from the incident scene but also walk-ins and patients who are sent from hospitals to the AMTS

Given the possibility of a deteriorating medical condition due to delayed reactions from some types of terrorism causal agents, it will be incumbent upon Treatment personnel to monitor patients and *re-triage* them accordingly as needed. Additionally, triage may need to be done several times; that is, on the scene, at the AMTS, and at the hospital. Utilizing the START and JUMPSTART systems will aid in triage standardization throughout Florida and will also mesh with the "Start 2 Finish" system being utilized in most hospitals throughout the state.

5.4 Treatment

The primary mission of an AMTS is to decontaminate, triage, evaluate, and treat patients generated by a disaster. If feasible, patients in the "Red" and "Yellow" triaged categories should be transported as soon as possible to a medical facility. (In the event of a widespread or large incident, these types of patients may have to receive *some* treatment at the AMTS.) At a minimum, patients should be able to receive basic life support services at an AMTS and preferably, some level of advanced life support services, too. The treatment area should be set up so that staff and equipment resources are maximized. The AMTS Medical Director should take direct charge of the section of the treatment area designated for the more critical ("Red" and "Yellow") patients. Barring unforeseen circumstances, this area should serve only to stabilize the patients and then they should be transported to a hospital facility. If a large number of these types of patients is anticipated, Logistics should arrange for more extensive equipment to be brought to the AMTS including EKG monitors, ventilators, monitoring equipment, and medications. Given the potential large number of patients that may have to be treated, the Medical Director may need to alter the standard of care to insure that the highest level of medical care possible is delivered to the largest number of people possible. The Treatment Section will be responsible for:

- Assessing and treating patient illnesses and injuries
- Creating specific areas within the treatment section for specific classifications of patients ("Red", "Yellow", "Green", Isolation)
- Administration of antidotes
- Monitoring vital signs, symptoms, and patient condition
- Stabilizing "Red" and "Yellow" triaged patients so they can be transported to a hospital
- Evaluating medication and medical allergy issues
- Treating and if possible, releasing "minor" patients
- Assisting patients with psycho physiologic problems
- Assessing the need for and requesting specialized medical equipment for patient care
- Addressing patients that require isolation
- Treating "RED" and "YELLOW" triaged patients if transport is delayed or if the incident is of a magnitude that hospitals are unable to accept more patients

- Re-triaging patients, given the possible delayed reaction to some causal agents
- Providing BLS and in some cases, ALS levels of service
- Advising Logistics of the need for the correct number of beds or cots required for the Treatment Section
- Considering that there may be multiple agents or mechanisms of injury/illness involved. (ex. Bomb blast with a chemical agent release or injuries sustained in a hurricane and an outbreak of dysentery at a shelter)

In Type 1 operations there may also be a need for "telemedicine" to be used with distant physicians assessing patients through communications technology.

5.5 Security

For the proper operation of an AMTS, either in a field setting, temporary facility setting or outside of a hospital, a strong security response will be required. Prearranged agreements should be in place with local law enforcement to provide security at an AMTS. Because a community's law enforcement resources may be committed to the scene of a terrorism (or other) incident, it will be important to include "mutual aid" resources in planning for AMTS security so that all of the security issues can be covered. There are several key tasks that will accrue to security personnel including:

1) **Protection from Ancillary Terrorism** – In a terrorism situation the possibility exists for further terrorism at sites where victims of an initial terrorism act are being treated. Therefore, one of the key tasks for AMTS security will be to safeguard patients and emergency care workers.

2) **Perimeter Security** – This includes establishing and maintaining control of the external perimeter, sweeping for secondary devices, coordinating security requirements of a temporary morgue with investigating law enforcement agencies and the chief medical examiner, verifying staff identifications, monitoring quarantined private citizen vehicles, and controlling unauthorized access to the AMTS.

3) **Internal Security** – This includes maintaining control of unruly and disruptive patients, dealing with perpetrators posing as patients and facilitating patient flow through the AMTS. Additional responsibilities include barricading "off-limits" portions of the AMTS, and preventing unintentional cross-contamination. Additionally, a system of providing AMTS workers with ID tags might be necessary to maintain internal security goals. Security will also need to obtain full sets of keys for the host facility and will need to ensure the security of medications and antidotes.

4) **Traffic Control** – This includes establishing a flow of traffic in and around the AMTS to facilitate patient arrival, security, and patient transport. Public Works departments or response teams from local jurisdiction Traffic Engineering may be able to assist with cones and barricades to help establish AMTS traffic flow.

5) **Access Control** - In addressing the issue of access to an AMTS, security personnel should establish separate entrance/exit points for patients and staff. ID cards should be checked and an internal AMTS ID card system should be established if an incident is prolonged such as a long duration Type 1 AMTS operation. A decision will also need to be made (possibly based on whether the incident is or is not a terrorism incident) as to whether patients and/or their belongings will be subject to search prior to their entry into the AMTS. Once patients leave the AMTS, unless they are readmitted for treatment, they should not be allowed re-entry.

Incidents that occur, especially terrorism incidents, will require a significant response from law enforcement. They will not only have to respond to the scene of an incident but will also be in demand to provide protective security in a wide variety of venues. As such it will be important for planners to develop contingency plans for AMTS security that includes the use of mutual aid, private security resources, and volunteers. Additionally, when making AMTS site selection, strong consideration should be given to sites that provide “inherent” security such as facilities with controlled access, fencing, etc.

If the AMTS elevates to the level whereby State or Federal assistance is required, the Florida Department of Law Enforcement, the Florida National Guard, and the Federal Bureau of Investigation may have to be requested for assistance.

5.6 Typical AMTS Patient Sequence

To understand the steps that are necessary for patient care at an AMTS it is helpful to look at the “sequence” of events for a “typical” AMTS patient.

1) An individual becomes a victim of a terrorism or “all hazards” emergency or disaster and needs medical care

2) Patient is rescued and moved to triage area at the scene

3) After quick triage, the patient, if necessary, is moved to a gross decontamination station and goes through a decontamination process

4) Patient is moved to the scene treatment area for stabilization

5) If an antidote is needed it is administered by Treatment personnel

6) Patient is moved to the scene transport area and either transported to a hospital or to the AMTS

7) Patient arrives at the AMTS

8) Patient is logged into the AMTS and is sent to the decontamination station, if necessary, and to the triage area to be re-triaged

9) At the decontamination area the patient's belongings are bagged and either disposed of if they are contaminated or stored for return to the patient when they are released

10) Patient is sent to Treatment Section

11) Patient is assessed, stabilized, and treated

12) If medication is required, it is administered by Treatment personnel

13) Further patient information is obtained

14) If the patient is cleared, they are sent to the reunification area to be released

15) If the patient needs to be monitored or needs further treatment they are held in the treatment area and assigned a bed

16) If the patient is a special needs patient, accommodations are made to assist them in whatever way is necessary

17) If the patient is a minor, they are teamed up with their parent (if possible). If alone, attempts are made to contact immediate family. If they are to be held in Treatment, they are assigned to a mental health counselor

18) If the patient has arrived at the AMTS with a pet, the pet is turned over to animal control for decontamination, is assessed and treated by a veterinarian and is then sent to a pet holding area

19) If the patient becomes a "Red" or "Yellow" triaged category patient, they are assessed for transport priority and sent to the transportation area

20) If the patient succumbs to their injuries they are moved to the temporary morgue

21) If the patient is experiencing mental distress over the incident, they are held in the treatment area or sent to a counseling area in the AMTS

22) If the patient is in the "Green" triaged category but still needs eventual attention at a hospital, they are retained in the treatment area until the hospital load is reduced and they are able to accept the patient

23) If the patient is ready to be released at the reunification area, final information is obtained, they are provided with suitable garments, they are provided with information about the agent they were exposed to, they are given home care instructions, they are advised of AMTS readmission procedures (if it becomes necessary), and they are given guidance on any follow-up care needed

5.7 Behavioral Health

In disaster events, especially involving terrorism, people suffer mental distress. In a number of disasters post incident stress among victims has been an issue. This can be mild to severe and will make it necessary to have behavioral health counselors available at the AMTS during prolonged operations. Additionally, there may be a need for critical incident stress debriefing (CISD) for personnel assigned to an AMTS. Specialized teams have been developed for this purpose and should be utilized as part of the support for AMTS staff. ESF 8 at the SEOC can be of assistance in marshaling CISD resources throughout the state.

Behavioral health counselors will also assist with pediatric patients who have been separated from their parents.

Another aspect of mental health care that needs to be considered is pastoral care.

5.8 Transportation

One of the first tasks that will accrue to the Transportation Unit Leader is establishing a link with the hospitals. While the hospitals should be aware of the incident in progress, once the contact is made the hospitals must be advised of:

- The incident location
- The agent involved, primary injury mechanism, and chief patient complaints
- The location of the AMTS
- The purpose of the AMTS
- What PPE hospital personnel need to be using to accept patients
- Number of anticipated patients
- Anticipated duration of the event
- Types of patients the AMTS can receive back from the hospital

Most likely, patients who are transported to an AMTS will arrive via ambulance or in private vehicles. With some larger incidents, the *scene* Transportation Officer may make arrangements for a large number of patients to be transported to the AMTS by bus or other conveyance. Working with the Security Unit Leader and the Logistics Chief, Operations will need to facilitate an orderly offloading of patients and designate parking areas for private vehicles. Further, the vehicles that are used to transport patients from the scene, especially ones reused for additional trips to the AMTS may need to be decontaminated prior to being released from the AMTS.

The AMTS Transportation Unit Leader may need to arrange for various types of specialized transportation vehicles to transport patients to hospitals. Since most transports will be to a medical facility, ambulances would be the vehicle of choice but if an incident involves a large number of patients, alternative transportation methods may have to be employed.

5.9 Safety

One of the priorities in the operation of an AMTS is safety. Under direction from the Safety Officer, part of the Command Staff, safety issues that should be monitored include but are not limited to:

- Safe decontamination procedures
- Prevention of cross contamination of patients
- Proper use of equipment and personal protective equipment (PPE)
- Ensuring safe traffic flow and vehicular operation within the AMTS
- Assessing the host facility for safety issues and seeing that deficiencies are corrected
- Monitoring weather hazards
- Seeing that safe patient loading and off loading procedures are used
- Enforcing proper safety procedures with the use of oxygen
- Ensuring proper safety zones and procedures with helicopter operations

5.10 Special Needs Patients

During disaster situations special shelters are often opened for special needs patients. Likewise, special needs patients (the elderly, handicapped, blind, pregnant women, etc) may require treatment at an AMTS. Issues that may need to be addressed include:

- Designated areas of the AMTS that are handicapped accessible
- Specialized transportation capabilities
- Specialized equipment, medication, and oxygen needs
- Specialized medical personnel and additional volunteers

- Making the AMTS more handicapped accessible with portable ramps, portable showers, etc.
- Triaging some special needs patients into the “Red” or “Yellow” triage categories because of their special needs

5.11 Pediatric Patients

Pediatric patients will require special care, especially if they are unaccompanied children who have been separated from their parents by the disaster. Considerations include:

- Specialized equipment
- Care specialists that focus on pediatric care
- Custody and legal issues relating to authorization for treating / transporting a minor
- Emotional issues with children who have been separated from their parents by the disaster
- The possibility of teaming adult patients and their child according to the highest triage level that one or the other receives
- Notification of extended family members
- Utilizing behavioral health workers to manage pediatric patients

5.12 Patients with Pets

People may have pets with them when they are impacted by a disaster or may even bring pets with them when they show up at the AMTS. As such, the local Animal Control office, Humane Society, and/or local veterinarians should be included in planning efforts so they are ready to respond and assist during an incident. Issues that must be addressed include:

- How to track animal ownership
- Housing of pets in portable cages or kennels
- The possibility of having to decontaminate pets
- Veterinarian treatment of affected pets
- Housing of animals belonging to people transferred to the hospital
- Dealing with “service” animals
- Safety and sanitary concerns
- Food and water
- Return of pets to their owners when they are released from the AMT

5.13 Patient's Belongings

One issue that must be addressed is the collection, cataloging, storing, securing, and return of patient's belongings. In this plan the task accrues to the Reunification Unit Leader located in the Planning Section. Items should be bagged and marked for storage and later returned to the patients.
Such items would include:

- Keys
- Cell phones
- Electronic Devices
- Purses and wallets
- Clothing
- Shoes
- Jackets
- Other items collected during admission to the AMTS

A procedure should also be in place to identify items that had to be confiscated for evidence or destroyed / discarded in the decontamination process. If patients refuse to give up certain belongings, the Security Unit Leader should be contacted so the patient can be checked for weapons, drugs or other paraphernalia before entering the AMTS. As part of the discharge briefing process, patients should be advised how to further decontaminate items that are returned to them that did not have to be discarded in the decontamination process.

5.14 Patient Questioning by Investigative Officers

Especially in the event of a terrorism incident, law enforcement officials may find it necessary to interview or question patients about the incident. Obviously, patient care should not be jeopardized for investigations. The best solution would be for law enforcement officials to interview patients when they are out-processed. If, due to the urgency of the situation, officials need to interview patients immediately, the Security Unit Leader should work with Treatment Sector personnel to identify when and where questioning can take place. If possible, preliminary information should be gathered first to minimize the time a patient has to spend in an official interview. If a number of interviews are needed a special interview room should be established as part of the AMTS.

5.15 Weather issues

Florida is subject to a wide variety of weather conditions. Some incidents, such as hurricanes, might be the reason an AMTS had to be initiated in the first place. All sections should remain cognizant of this fact and consider steps that must be taken. Included would be such issues as:

- Protection of patients from the elements

- The impact of rain, cold, heat, high winds, and flooding on the AMTS operation
- Keeping AMTS areas heated or cooled as needed
- Consideration of water and air temperature during decontamination
- Structural soundness of the AMTS facility
- The impact of weather related power outages
- Protection of patients from severe weather events
- Specialized equipment needed to deal with weather issues

5.16 Ancillary Populations

Those operating an AMTS need to be aware of ancillary populations that may show up at their site and need to make plans to address their issues. This includes:

- Psychophsyiogenic patients that feel they need treatment even though they may or may not have been directly impacted at the disaster scene
- Patients who left the scene and are now seeking medical care
- People with non-incident related illnesses or injuries who might seek to use the AMTS as an entry point into the healthcare system
- Family and friends of people who have been transported to the AMTS who are seeking information

Previous experience in disasters shows that a rather large number of people with injuries and illnesses not related to the disaster will seek medical assistance at medical facilities opened for the emergency.

5.17 Temporary Morgue

Planning for an AMTS should include the potential of dealing with fatalities. As part of the CHIRP, one of the first steps in organizing mortuary services for an AMTS is to activate the Florida Emergency Mortuary Operations Response System (FEMORS). FEMORS' mission is to assist and support the local District Medical Examiners Office, Florida Department of Law Enforcement, and other responding agencies, in the event of a mass fatality incident as directed by the FDOH. If the scope of the incident increases to the level where federal resources are being used and the NDMS is activated, Disaster Mortuary Response Teams (DMORT) would then be part of the response assets. DMORTs are directed by the National Disaster Medical System under ESF 8 to provide victim identification and mortuary services. Teams are composed of funeral directors, medical examiners, coroners, pathologists, forensic anthropologists, medical records technicians and transcribers, finger print specialists, forensic deontologists, dental assistants, x-ray technicians, mental health specialists, computer professionals, administrative support staff, and security and investigative personnel. Considerations for operating a temporary morgue include:

- Coordination with the local medical examiners office
- Securing a refrigerated truck for body storage
- Maintaining the “chain of custody” of the bodies
- Maintaining the proper records as required by law
- Establishing procedures for the release of bodies to the local Medical Examiner or families
- Coordination with local law enforcement agencies on investigation issues

5.18 Demobilization

When an incident is over, a number of steps must be taken to properly demobilize or “shut down” an AMTS. In addition to the steps that must be taken to demobilize personnel, the following steps should be considered to “stand-down” an AMTS:

- Release of all patients
- Cleanup including disposal of trash and items that cannot be reused
- Removal of hazardous waste
- Decontamination of equipment and the site itself *
- Transfer of the temporary morgue to the local medical examiner
- Packaging and storage of AMTS cache items for future use
- Arranging testing for residual contamination before a building or site is returned to its normal use
- Return of equipment, personal property, and other items to their rightful owner following a joint inspection of the facility
- Placing the site back into the status it was in prior to the establishment of the AMTS
- Obtaining a signed “acceptance” document from the facility owner/manager

***** Given the potential scope of a site decontamination process, this work will need to be assigned to a private concern who is equipped, trained, and certified to carry out such work.

Section 6
AMTS Logistics

6.1 AMTS Caches

In order to facilitate the rapid establishment and operation of an AMTS, the FDOH has located caches of supplies and equipment throughout the state. The caches are designed to get an AMTS operational quickly and provide an initial assortment of medical equipment and supplies until additional resources can be secured. A cache (or multiple caches, if the AMTS is a Type 3, 2 or 1) should be ordered as soon as the decision is made to open an AMTS. Appendix 7 of this plan lists the locations and contents of the pre-established AMTS caches.

6.2 Specialized Equipment

While the AMTS caches have been designed to provide the necessary equipment and supplies for a quick startup, additional resources will be needed if the AMTS remains in service for any length of time. The Logistics Section will be responsible for securing the needed items and should, as part of the preplanning process, have agreements in place with private vendors to receive rapid service should an AMTS be activated.

Personal Protective Equipment

It is essential that staff personnel have adequate personal protective equipment (PPE) to keep them from being contaminated so that they can carry out their responsibilities.

Oxygen

One particularly acute item will be oxygen. Previous incidents that involved patient treatment and/or the establishment of an AMTS indicate that a large amount of oxygen is required for patient support. This would include not only the oxygen itself but also oxygen units with appropriate sized masks. While it is desirable that any patient requiring oxygen be transported to a hospital, there may be times when this is not possible. In such cases, the AMTS should have the capability of providing this level of care to its patients.

Wheelchairs / Stretchers

Another important item for the AMTS operation will be wheelchairs. These will be necessary to support the ambulation of patients to various locations within the AMTS. This would include not only special needs patients but also patients that are not able to ambulate due to their illness or injury. Additionally, stretchers may become necessary, not only for moving patients but for serving as temporary beds until a patient can be transported.

Decontamination Support Items
In order to support the decontamination process it will also be necessary to have specialized items on hand. This would include a drum for contaminated clothing, curtains for enhancing patient privacy, disposable gloves, sealable bags for contaminated item disposal, and scrubs or replacement garments for decontaminated patients.

Ambulance / Transport Unit
Logistics should also arrange for an extra ambulance or transport unit to be stationed at the AMTS. This unit should not be committed to routine transport duties but rather held in reserve in the event that an emergency occurs at the AMTS and immediate transportation of a patient or staff member is needed.

Portable Air Filtration System
To avoid cross contamination at an AMTS consideration should be given to securing portable filtration systems. Portable HEPA filter systems can be used to help with contamination issues in a number of scenarios. Additionally, AMTS Logistic Section personnel should pay close attention to the HVAC system in chosen facilities to improve contamination control throughout the site.

Sanitation
It is critical that Logistics provide for sanitation at an AMTS. This would include restroom facilities, chemical toilets to augment toilets available in the host facility, hand washing stations for staff and patients, the use of sharps containers, and the removal of waste products.

6.3 Strategic National Stockpile
If an incident rises to the level whereby Federal assets are requested, resources from the CDC's National Strategic Stockpile can be requested including pharmaceuticals, medical supplies, airway maintenance items, IV maintenance equipment, and medical surgical items.

6.4 Facilities Layout
The layout of an AMTS will, of course, be dependent upon the typing classification (See Section 4 of this plan) and the physical characteristics of the building or site chosen. In laying out an AMTS, logistics personnel should plan for the following components:

- Incident Command Post
- Perimeter security
- Security checkpoint
- Arrival area
- Parking area
- Operations Section

- Gross decontamination area
- Detailed or “fine” decontamination area
- Triage area
- Treatment area
- Food preparation and feeding area
- Staff rest / sleeping areas
- Planning Section area
- Finance and Administration Section area
- Investigation interview area
- Public Information and media area
- Logistics Section area
- Logistical storage area
- Communications area
- Reunification area

Since both patients and AMTS staff will likely be unfamiliar with the AMTS host facility, it will be important for the Logistics Section to develop extensive signage within the AMTS to provide directions and the identification of key areas.

6.5 Facilities Management

The Logistics Section is responsible for overseeing the management of AMTS facilities. Considerations include:

- Housekeeping services
- Trash collection and disposal
- Monitoring HVAC systems to ensure operability and control so that cross contamination does not occur
- Ensuring that electrical power and backup generators are available
- Ensuring that adequate lighting is available for “around the clock” operation
- Keeping the facility stocked with supplies necessary for operation
- Disinfecting rooms, apparatus, and equipment
- Addressing maintenance issues that arise
- Signage for each aspect of the AMTS operation
- Working with the Security Unit Leader to keep unused portions of the facility locked

6.6 Communications

In any disaster one of the primary challenges is communication. This includes not only verbal communications between the various agencies and responders but also with the public who needs to be well informed before, during, and after disaster situations. Considerations for optimizing communications for an AMTS include:

1) Having a predefined communications plan in place so that responders and hospitals can easily communicate during a disaster situation and exchange information about patients and hospital patient loads

2) Having communication centers set up with pre-designated page lists or preprogrammed automatic dialers so that timely and proper notifications can be made

3) Good pre-designated communications procedures between the AMTS, field incident command, and the LEOC to coordinate resources and to help in initiating an AMTS

4) Utilizing base and portable radios that are included as part of the FDOH AMTS Caches

5) Making use of the Regional radio caches, the EDICS system, and State communications vans to augment communications

6) Utilizing communications equipment that is available at the facility chosen to house the AMTS

7) Utilizing local government mobile communication centers. These units have a wide range of communications equipment including, in most cases, the ability to cross patch a variety of agencies for communications. Additionally, the State has EDICS available and a generic system of "Motobridge" (a propriety Motorola capability) available for aiding the cross patch of communications

8) Utilizing Satellite communications, especially in dealing with large scale disasters that may affect other forms of communications

9) Using Med 8 (1) Channel for State medical communications and Med 8 (2) Channel for AMTS and SMRT communications. Additionally, base stations are being installed in County Health Department offices which will further enhance communications during emergencies

10) Using "Broadband over internet" for data sharing through the use of air cards – (this technology or method is being standardized and has been endorsed by the Florida Hospital Association)

11) Use of “EM Systems” or other software applications for information sharing

12) Having the Public Information Officer linked with the Joint Information Center (JIC) that may be established for the precipitating incident

13) Establishing communication links with the hospitals

14) Communication with the public through the Public Information Officer to advise them the location of the AMTS and the details about service being provided. This will include the use of the media to disseminate key information

15) Providing patients with a phone bank for outgoing calls , thus allowing them the ability to make telephone calls

16) Ensuring that there are “backup” communications systems in place in case primary means fail

6.7 Return of Facilities in a Decontaminated Condition

One of the most controversial issues in using a particular facility as an AMTS, particularly in a biological or chemical exposure situation, is the potential for long term contamination of the building. Fortunately, in addition to current standard methods of decontaminating a building, there is new technology emerging that will enable a facility to be decontaminated easily with a thermal and/or vaporized hydrogen peroxide process. As part of the demobilization process of an AMTS, the facility owner must be assured that the facility is completely decontaminated before it is returned to its original use. It will be the responsibility of the Logistics section to see that the proper resources / services are acquired for decontaminating the host facility.

Section 7
AMTS Finance and Administration

7.1 Records

During the operation of an AMTS it will be necessary to keep a variety of records. This includes but is not limited to:

- Information on patients processed
- Credential information on assigned workers
- Name and contact information of personnel
- Costs associated with the AMTS
- Goods and services used in the operation of the AMTS
- Time sheets of all assigned personnel
- Location where patients are transported to from the AMTS
- Roster of patients released

While a number of tasks associated with staffing accrue to the Planning Section, the Finance / Administration Section will be of great assistance in managing records for the AMTS.

7.2 Finance and Costing

Funding for an AMTS is a complicated issue. Costs associated with a Type 4 and possibly a Type 3 AMTS will, most likely, be a community issue whereas a Type 2 or Type 1 AMTS will likely be, at least partially, reimbursable given the proclivity for that level of activation to be captured by a State or Federal disaster declaration. Under either scenario it will be important to track all of the associated costs of the AMTS including personnel, equipment, goods and services, and miscellaneous expenditures necessary for operation. The Costing Unit Leader will work closely with personnel in the Logistics Section to ensure that proper authorizations are received and proper payment is made for all AMTS expenditures. Tracking of orders, invoices, personnel time cards, etc. will be essential, especially when the AMTS activation is part of a declared disaster process.

Conclusion

Development of a plan for the implementation of alternative medical treatment sites is yet another important step in planning for the continued safety of Florida's citizens and visitors. To achieve the goal of having such sites operational as quickly as possible in a disaster situation, a well thought out plan must be developed and adopted by the agencies at the local level. As can be seen in the preceding information, a number of key steps will have to be taken to develop and adopt a workable solution. While the components can be readily identified, the challenge will be obtaining a consensus among all of the stakeholders and constituency groups on how to implement and operate an AMTS. Given Florida's proactive track record in disaster response planning and the "can do" attitude among the various domestic security preparedness "partner" agencies throughout the State, there is no doubt that, through the use of this "guideline" plan, excellent local AMTS plans *can* and *will* be established. By doing so, Florida can be the leader in yet another area for the homeland security of the United States of America.

Section 8
APPENDICES

Appendix 1

Acronyms and Emergency Support Function (ESF) Identification

ALS	Advanced Life Support
AMTS	Alternative Medical Treatment Site
B^3	Bomb, Burn, Blast
BIO	Biological
BLS	Basic Life Support
CCP	Casualty Collection Point
DCHAT	Disaster Community Health Assessment Team
CDC	Centers for Disease Control and prevention
CERT	Community Emergency Response Team
CHIRP	Comprehensive Health Incident Response Plan
DECON	Decontamination
DEM	Division of Emergency Management
DMAT	Disaster Medical Assistance Team
DMORT	Disaster Mortuary Response Team
DSOC	Domestic Security Oversight Council
EDICS	Emergency Disaster Incident Communications System
EMS	Emergency Medical Services
EMAC	Emergency Management Assistance Compact
EMTALA	Emergency Medical Treatment and Labor Act
EOC	Emergency Operations Center
ESAR-VHP	Emergency System for Advance Registration of Healthcare Professionals
ESF	Emergency Support Function
FDLE	Florida Department of Law Enforcement
FEHVR	Florida Emergency Health Volunteer Registry
FEMORS	Florida Emergency Mortuary Operations Response System
FOG	Florida Incident Field Operations Guide
HEPA	High Efficiency Particulate Air
HIPAA	Health Insurance Portability and
HRSA	Health Resources and Services Administration
HVAC	Heating, Ventilating and Air Conditioning
IMT	Incident Management Team
JIC	Joint Information Center
LEOC	Local Emergency Operations Center
MCI	Mass Casualty Incident
MMRS	Metropolitan Medical Response System
NDMS	National Disaster Medical System

MOU	Memorandum of Understanding
NIMS	National Incident Management System
NRP	National Response Plan
PPE	Personal Protective Equipment
RDSTF	Regional Domestic Security Task Force
RERA	Regional Emergency Response Advisor
SEOC	State Emergency Operations Center
SMRT	State Medical Response Team
START	Simple Triage and Rapid Treatment
SWG	State Working Group
SWP	State Warning Point

Emergency Support Functions

- ESF 1 – Transportation
- ESF 2 – Communications
- ESF 3 – Public Works and Engineering
- ESF 4 – Fire Fighting
- ESF 5 - Information and Planning
- ESF 6 – Mass Care
- ESF 7 – Resource Support
- ESF 8 – Health and Medical
- ESF 9 – Search and Rescue
- ESF 10 – Hazard Materials/Environmental Protection
- ESF 11 – Food and Water
- ESF 12 – Energy/Utilities
- ESF 13 – Military Support
- ESF 14 – Public Information
- ESF 15 – Volunteers and Donations
- ESF 16 – Law Enforcement
- ESF 17 – Animal Protection.

Appendix 2

Internet Links to Specialized Information for AMTS Operation

Capabilities Chart of Florida Emergency Rooms
http://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/Hospital_Outpatient/forms/hosp_er_svcs_inventory_011006.pdf

Florida Comprehensive Emergency Management Plan – ESF 8 – Health / Medical Section
http://www.floridadisaster.org/documents/CEMP/Appendices/ESF%208.pdf

Emergency Medical Treatment and Labor Act (EMTALA)
http://www.cms.hhs.gov/EMTALA/

Florida Incident Field Operations Guide (FOG)
http://floridadisaster.org/internet_library.htm

Guidelines for Mass Casualty Decontamination During a Terrorist Chemical Agent Incident
http://www.au.af.mil/au/awc/awcgate/army/sbccom_decon.pdf

Medical Telecommunications and Transportation Florida Statute
http://www.leg.state.fl.us/Statutes/index.cfm?App_mode=Display_Statute&URL=Ch0401/titl0401.htm

Mega Shelters – Planning and Activation –
http://www.iaam.org/members/Sec_pages/Mega-ShelterPlanning&Activation.pdf

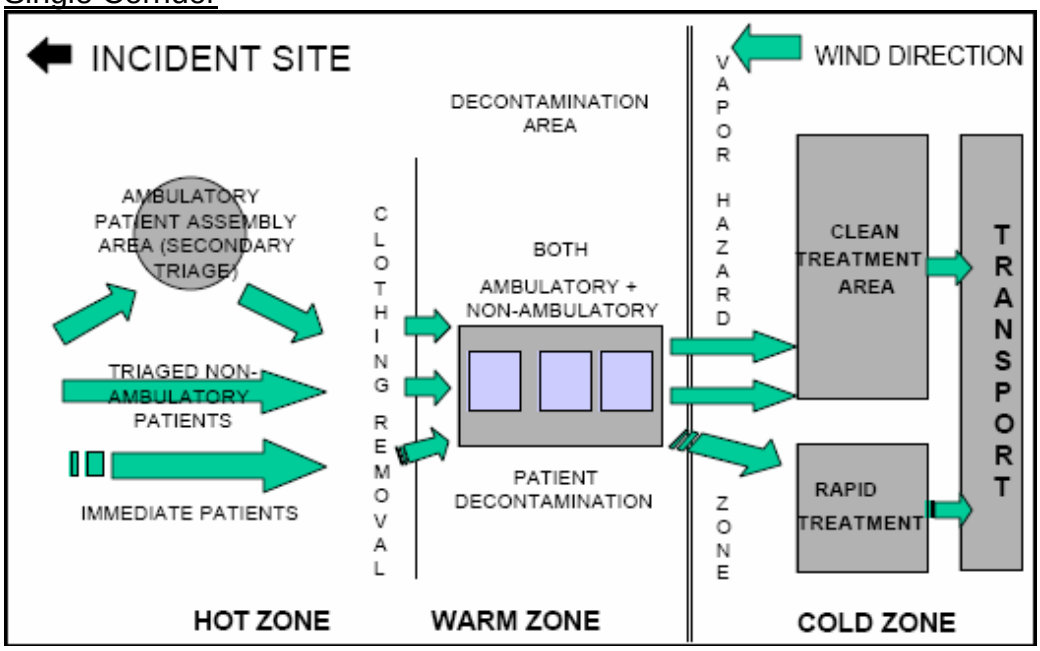
National Bioterrorism Hospital Preparedness Program
http://www.hospitalconnect.com/aha/key_issues/disaster_readiness/content/BioTHospFINAL1.pdf

Rocky Mountain Regional Care Model for Bioterrorist Events
http://www.ahrq.gov/research/altsites.htm

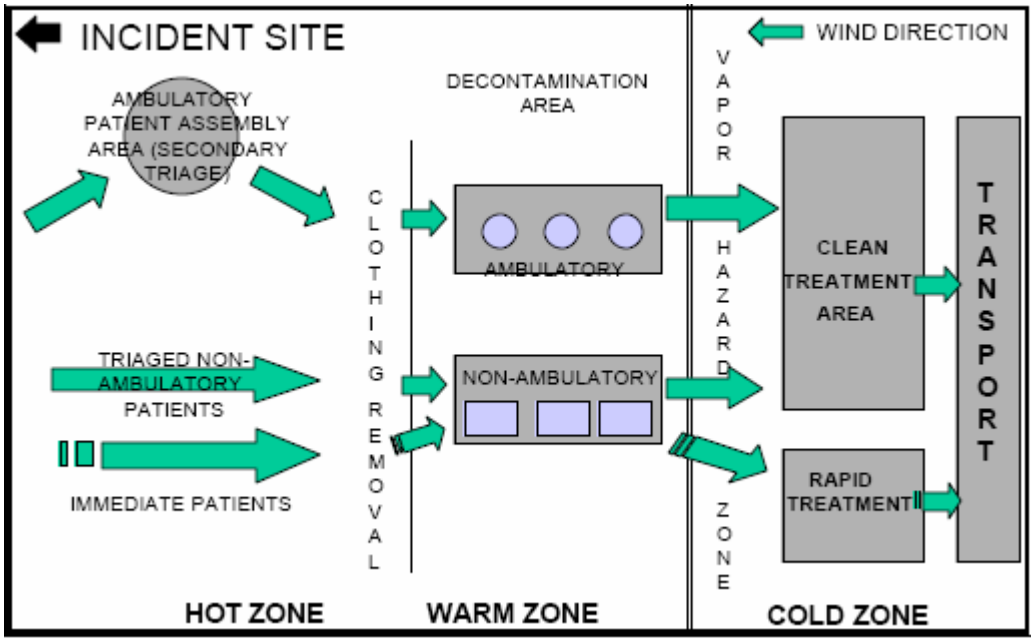
Appendix 3

Decontamination Process Diagrams – Typing Matrix – Decon Procedures

Single Corridor



Double Corridor



Decontamination Resource Typing

On the following pages the Mass Casualty Decontamination Resource Typing is listed. This typing allows for particular levels of decontamination expertise to be requested for AMTS operations.

RESOURCE: MASS CASUALTY DECONTAMINATION RESOURCE TYPING				
CATEGORY:	HazMat (ESF #10)		**KIND:**	Team
MINIMUM CAPABILITIES:		TYPE I MCI DECONTAMINATION RESOURCE (MCI OPERATIONAL TEAM)	TYPE II MCI DECONTAMINATION RESOURCE (PRE-STAGING EQUIPMENT FOR EVENTS)	TYPE III DECONTAMINATION ASSET (PERSONNEL ASSET ONLY)
Component	Metric			
Personnel	Staffing	There shall be a minimum of 2 hazardous materials technicians and 12 operations level personnel. The positions shall include: • Decontamination Team Leader (1) • Safety Officer (1) • Logistics Officer (1) • Non-ambulatory Decon Group (6) • Post Decon monitoring (2) • Ambulatory Decon Group (3) 7 personnel responding immediately and 7 personnel responding within 1 hour of dispatch.	There shall be a minimum of 2 operations level personnel. Should this team be deployed to a mission, additional manning would be required to meet Type I Resource requirements.	There shall be a minimum of 2 hazardous materials technicians and 12 operations level personnel to fulfill positions of a Type I team. 7 personnel responding immediately and 7 personnel responding within 1 hour of dispatch.
Team	Safe and Effective Response Operation Incidents	This operational team is capable of managing ambulatory and non-ambulatory victims. All run of is capable of being contained, victim redressing, and tagging of personal belongings.	This team is used to pre-stage decontamination equipment at large events.	Manning asset. Used to enhance or support Type I or II teams.
Team	Areas of Specialization	This resource is equipped to decontaminate 500 victims of a WMD/ Hazmat Incident.	Not an operational team.	Not an operational team
Personnel	Training	All personnel must be trained to the minimum response standards in accordance with the most current editions of NFPA Standard # 471, "Recommended Practice for Responding to Hazardous Materials Incidents" and NFPA Standard # 472, "Standard for Professional Competence of Responders to Hazardous Materials Incidents" as is appropriate for the specific personnel position. All personnel must be trained to the specific operations of deployment of the decontamination system and victim decontamination.	All personnel must be trained to the minimum response standards in accordance with the most current editions of NFPA Standard # 471, "Recommended Practice for Responding to Hazardous Materials Incidents" and NFPA Standard # 472, "Standard for Professional Competence of Responders to Hazardous Materials Incidents" as is appropriate for the specific personnel position. All personnel must be trained to the specific operations of deployment of the decontamination system and victim decontamination.	All personnel must be trained to the minimum response standards in accordance with the most current editions of NFPA Standard # 471, "Recommended Practice for Responding to Hazardous Materials Incidents" and NFPA Standard # 472, "Standard for Professional Competence of Responders to Hazardous Materials Incidents" as is appropriate for the specific personnel position. All personnel must be trained to the specific operations of deployment of the decontamination system and victim decontamination.
Team	Sustainability	Capable of operating for an 8-hour Period. Teams are to be 72 hour self-sustainable.	Capable of operating for an 8-hour Period. Teams are to be 72 hour self-sustainable.	Capable of operating for an 8-hour Period. Teams are to be 72 hour self-sustainable.
	Field Testing	(Post Decontamination Testing for Known Chemicals or Weapons of Mass Destruction Chemicals) Post Decontamination Testing to verify efficiency of decontamination procedures. Testing equipment may consist of field testing kits, specific chemical testing kits, chemical testing strips, and air-monitoring equipment.	(Post Decontamination Testing for Known Chemicals or Weapons of Mass Destruction Chemicals) Post Decontamination Testing to verify efficiency of decontamination procedures. Testing equipment may consist of field testing kits, specific chemical testing kits, chemical testing strips, and air-monitoring equipment.	Not applicable

	Air Monitoring	(Basic Monitoring Equipment for Specific Known Chemical or WMD Chem/Bio Aerosols or Vapors) The use of four gas monitors with Photo-ionization detection capability. Monitors shall be used to monitor victims post-decontamination and to monitor the area of the decontamination process. Sensors may include oxygen percentage, flammable atmosphere Lower Explosive Limit [LEL], carbon monoxide, and hydrogen sulfide). Advanced detection equipment may be used from Hazmat Teams if warranted.	(Basic Monitoring Equipment for Specific Known Chemical or WMD Chem/Bio Aerosols or Vapors) The use of four gas monitors with Photo-ionization detection capability. Monitors shall be used to monitor victims post-decontamination and to monitor the area of the decontamination process. Sensors may include oxygen percentage, flammable atmosphere Lower Explosive Limit [LEL], carbon monoxide, and hydrogen sulfide). Advanced detection equipment may be used from Hazmat Teams if warranted.	Not applicable
	Radiation Monitoring/ Detection	(Alpha Detection; Beta Detection; Gamma Detection) The ability to accurately interpret readings from the radiation-detection devices of a suspected radiological victim. Ability to conduct environmental and personnel survey. Basic criteria include detection and survey capabilities for alpha, beta, and gamma. Ensure all members of survey teams are equipped with accumulative self-reading instruments (dosimeters)	(Alpha Detection; Beta Detection; Gamma Detection) The ability to accurately interpret readings from the radiation-detection devices of a suspected radiological victim. Ability to conduct environmental and personnel survey. Basic criteria include detection and survey capabilities for alpha, beta, and gamma. Ensure all members of survey teams are equipped with accumulative self-reading instruments (dosimeters)	Not applicable
	Protective Clothing: Ensembles	(Liquid Splash-Protective CPC; WMD Liquid Splash-Protective CPC) Chemical protective clothing (CPC), which includes complete ensembles (suit, boots, gloves) and positive air purifying respirators to protect personnel during decontamination. Level of CPC liquid protection is: Liquid Splash-Protective, which must be compliant with NFPA Standard # 1994, “Standard on Liquid Splash Protective Ensembles and Clothing for Hazardous Materials Emergencies", current edition.	(Liquid Splash-Protective CPC; WMD Liquid Splash-Protective CPC) Chemical protective clothing (CPC), which includes complete ensembles (suit, boots, gloves) and positive air purifying respirators to protect personnel during decontamination. Level of CPC liquid protection is: Liquid Splash-Protective, which must be compliant with NFPA Standard # 1994, “Standard on Liquid Splash Protective Ensembles and Clothing for Hazardous Materials Emergencies", current edition.	(Liquid Splash-Protective CPC; WMD Liquid Splash-Protective CPC) Chemical protective clothing (CPC), which includes complete ensembles (suit, boots, gloves) and positive air purifying respirators to protect personnel during decontamination. Level of CPC liquid protection is: Liquid Splash-Protective, which must be compliant with NFPA Standard # 1994, “Standard on Liquid Splash Protective Ensembles and Clothing for Hazardous Materials Emergencies", current edition.
	Technical Reference	(Printed Decontamination Manuals of Toxic Industrial and WMD Chem/Bio) Manuals to determine appropriate decontamination practices for based on information provided by Hazmat Teams.	(Printed Decontamination Manuals of Toxic Industrial and WMD Chem/Bio) Manuals to determine appropriate decontamination practices for based on information provided by Hazmat Teams.	Not applicable

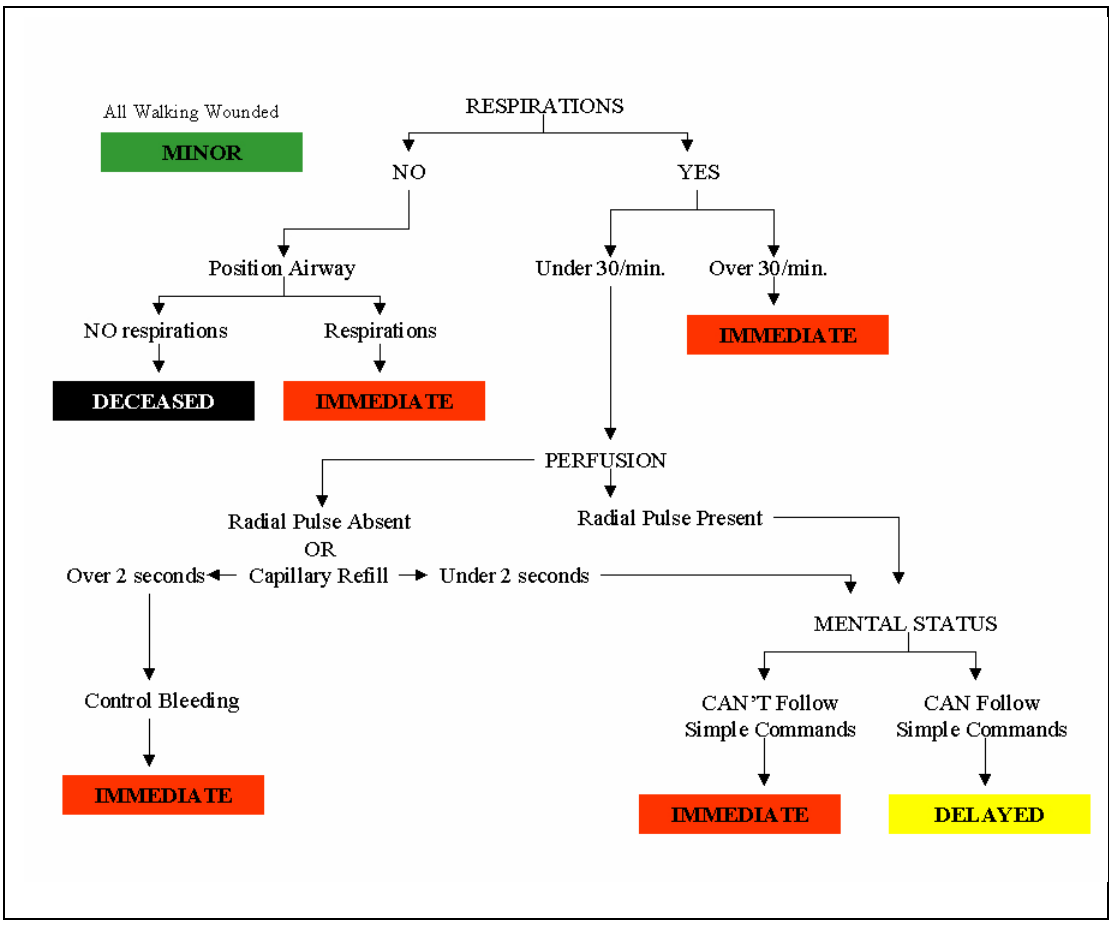
	Decontamination Equipment	(Mass Casualty Decontamination Equipment; Runoff Containment Capabilities; Victim Belongings Identification Kits; Redress Clothing for Victims; Various Decontamination Solutions; 110 volt source for portable lighting) Mass Casualty Decontamination Equipment, e.g. Nor-E Decon System, shall be used for decontamination of ambulatory and non-ambulatory victims. The system should have a capability of 60 victims per hour. Transfer pumps from containment areas should be connected to a bladder system for containment. Victims clothing and belongings should be labeled utilizing a serial number/ bar-coded bagging system, e.g. IDecon. At least 500 ID kits should be available. Teams should be equipped with various sized, disposable redress overalls. Decontamination solutions shall be insufficient quantities for 500 victims.	(Mass Casualty Decontamination Equipment; Runoff Containment Capabilities; Victim Belongings Identification Kits; Redress Clothing for Victims; Various Decontamination Solutions; 110 volt source for portable lighting) Mass Casualty Decontamination Equipment, e.g. Nor-E Decon System, shall be used for decontamination of ambulatory and non-ambulatory victims. The system should have a capability of 60 victims per hour. Transfer pumps from containment areas should be connected to a bladder system for containment. Victims clothing and belongings should be labeled utilizing a serial number/ bar-coded bagging system, e.g. IDecon. At least 500 ID kits should be available. Teams should be equipped with various sized, disposable redress overalls. Decontamination solutions shall be insufficient quantities for 500 victims.	Not applicable
	Communications	(Wireless Voice) Personnel utilizing CPC shall be able to communicate appropriately and safely with one another and their team leaders	(Wireless Voice) Personnel utilizing CPC shall be able to communicate appropriately and safely with one another and their team leaders	Not applicable
Comments	FEMA Team Typing Ref#	Not defined in FEMA Typing	Not defined in FEMA Typing	Not defined in FEMA Typing
COMMENTS				

Appendix 4

START and JUMPSTART Triage Procedures

Four S.T.A.R.T. Categories

S.T.A.R.T. Category	Decon Priority	Classic Observations	Chemical Agent Observations
IMMEDIATE Red Tag	1	Respiration is present only after repositioning the airway. Applies to victims with respiratory rate >30. Capillary refill delayed more than 2 seconds. Significantly altered level of consciousness.	• Serious signs/symptoms • Known liquid agent contamination
DELAYED Yellow Tag	2	Victim displaying injuries that can be controlled/treated for a limited time in the field.	• Moderate to minimal signs/symptoms • Known or suspected liquid agent contamination • Known aerosol contamination • Close to point of release
MINOR Green Tag	3	Ambulatory, with or without minor traumatic injuries that do not require immediate or significant treatment.	• Minimal signs/symptoms • No known or suspected exposure to liquid, aerosol, or vapor
DECEASED/ EXPECTANT Black Tag	4	No spontaneous effective respiration present after an attempt to reposition the airway.	• Very serious signs/symptoms • Grossly contaminated with liquid nerve agent • Unresponsive to autoinjections



Generic Triage Tag Sample

I HAVE CHECKED THIS DOCUMENT. BY SIGNING I REALIZE THAT I AM TAKING FULL RESPONSIBILITY FOR ALL TYPE, SPELLING, PUNCTUATION ERRORS AND OMISSIONS.

Signed _____ Date _____

☐ O.K. ☐ Please Make The Corrections Indicated.

Fax (909) 594-8894
Phone (909) 594-9596

July 12, 2006
Florida Proof

To: Susan Bulecza
Florida Dept. of Health

Dear Susan Bulecza,

We've just received a P.O. for a reprint of the Florida Tag. Please sign, date and fax back your approval or any corrections you may have to 909 594-8894.

Best regards,

Rob Mudd
Disaster Management Systems
909 534-8315 cell
909 594-9596 office

CONTAMINATED

Personal Property Receipt/ Evidence Tag *1234567*

Destination _____ *1234567*

Via _____

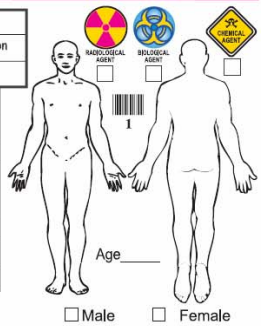
All Risk™ TRIAGE TAG *1234567*

☐S Salivation ☐L Lacrimation ☐U Urination ☐D Defecation ☐G G.I. Distress ☐E Emesis ☐M Miosis

AUTO INJECTOR TYPE ☐1 ☐2 ☐3
AUTO INJECTOR TYPE ☐1 ☐2 ☐3

Yes	No	Primary Decon
Yes	No	Secondary Decon
Solution		

- Blunt Trauma
- Burn
- C-Spine
- Cardiac
- Crushing
- Fracture
- Laceration
- Penetrating Injury



Age____

☐Male ☐ Female

Other: _____

VITAL SIGNS

Time	B/P	Pulse	Respiration

Time	Drug Solution 2	Dose

1234567

EVIDENCE

EXPECTANT

IMMEDIATE *1234567*	IMMEDIATE *1234567*
DELAYED *1234567*	DELAYED *1234567*
MINOR *1234567*	MINOR *1234567*

Comments/Information

Patient's Name

DMS-FLA Rev 10/6/05

START TRIAGE UTILIZATION

INITIAL RIBBON TRIAGE COLOR

RED YELLOW GREEN

- OR -

Move the Walking Wounded ▶ MINOR

No Respirations After Head Tilt ▶ EXPECTANT

R Respirations - Over 30 3 ▶ IMMEDIATE

P Perfusion - Capillary Refill Over 2 Seconds/No Radial Pulse ▶ IMMEDIATE

M Mental Status - Unable to Follow Simple Commands ▶ IMMEDIATE

Otherwise ▶ DELAYED

TREATMENT ADMINISTRATION • COMMENTS

Rescuer Name _____ ID# _____

Agency _____ Unit # _____

PERSONAL INFORMATION		
NAME		
ADDRESS		
CITY	ST 4	ZIP
PHONE		

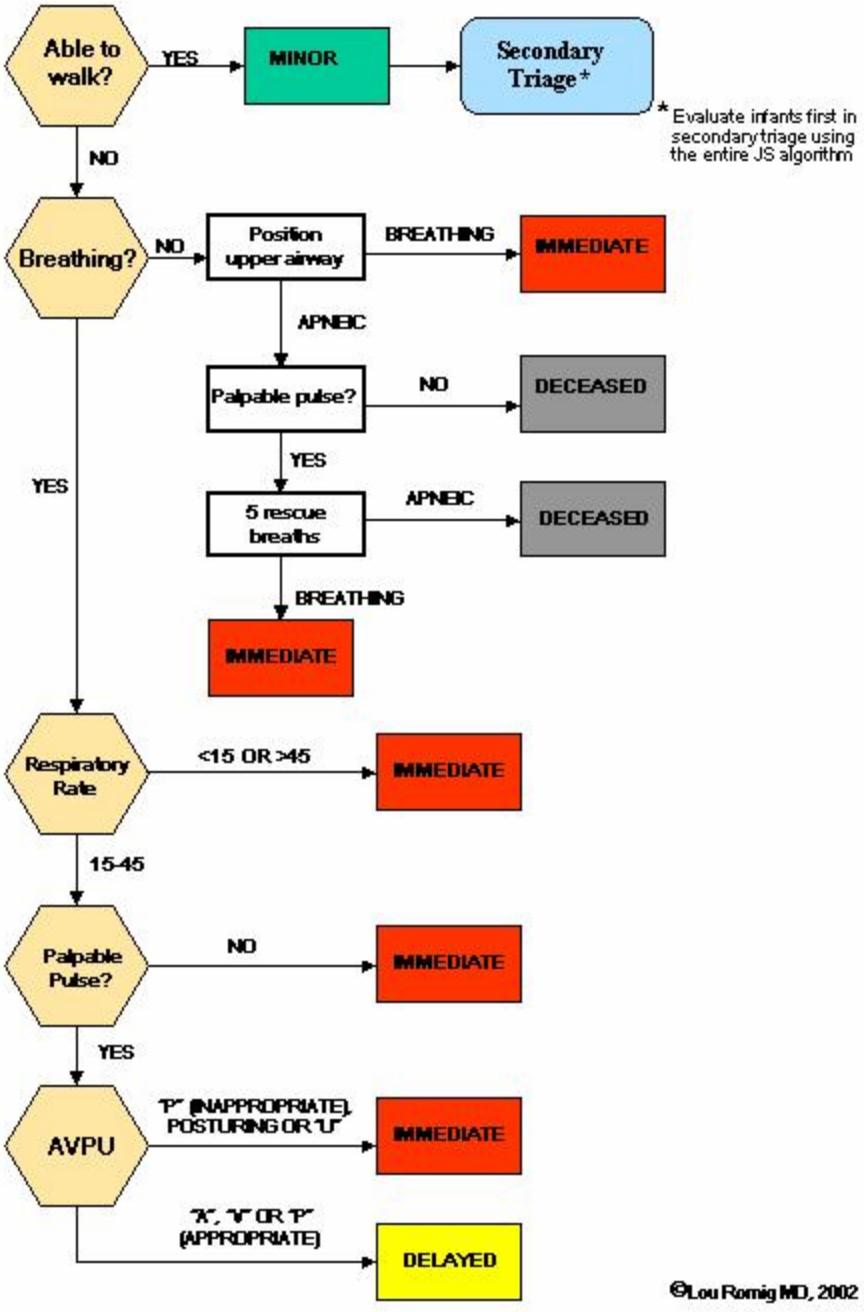
EXPECTANT
Pulseless/Non-Breathing

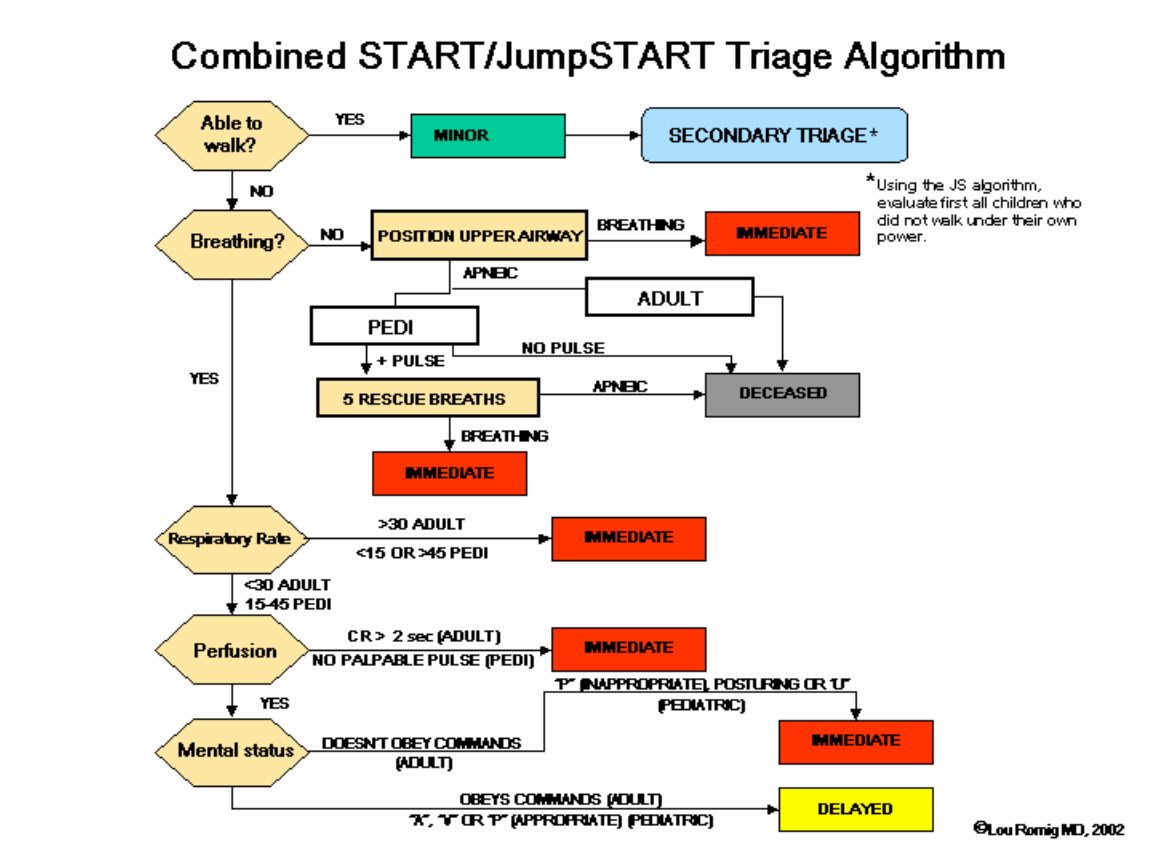
IMMEDIATE Life Threatening Injury	IMMEDIATE Life Threatening Injury
DELAYED Serious Non Life Threatening	DELAYED Serious Non Life Threatening
MINOR Walking Wounded	MINOR Walking Wounded

CONTAMINATED

EVIDENCE

JumpSTART Pediatric MCI Triage©

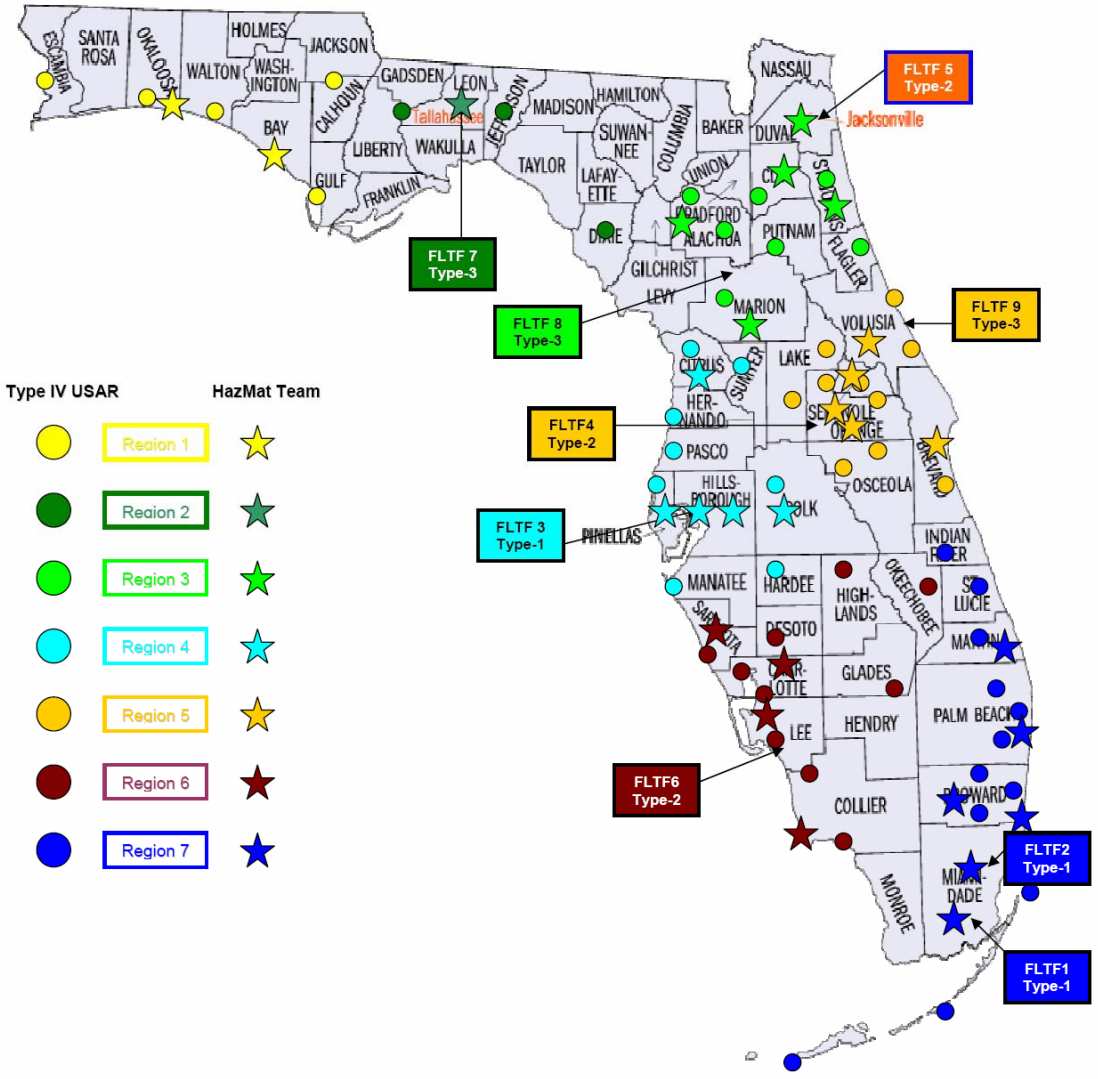



Combined START/JumpSTART Triage Algorithm
Able to walk?
YES
MINOR
SECONDARY TRIAGE*
*Using the JS algorithm, evaluate first all children who did not walk under their own power.
NO
Breathing?
NO
POSITION UPPER AIRWAY
BREATHING
IMMEDIATE
APNEIC
ADULT
PEDI
+ PULSE
NO PULSE
YES
5 RESCUE BREATHS
APNEIC
DECEASED
BREATHING
IMMEDIATE
Respiratory Rate
>30 ADULT
<15 OR >45 PEDI
IMMEDIATE
<30 ADULT
15-45 PEDI
Perfusion
CR > 2 sec (ADULT)
NO PALPABLE PULSE (PEDI)
IMMEDIATE
"P" (INAPPROPRIATE), POSTURING OR "U"
(PEDIATRIC)
YES
Mental status
DOESN'T OBEY COMMANDS
(ADULT)
IMMEDIATE
OBEYS COMMANDS (ADULT)
"A", "V" OR "P" (APPROPRIATE) (PEDIATRIC)
DELAYED
©Lou Romig MD, 2002

Appendix 5

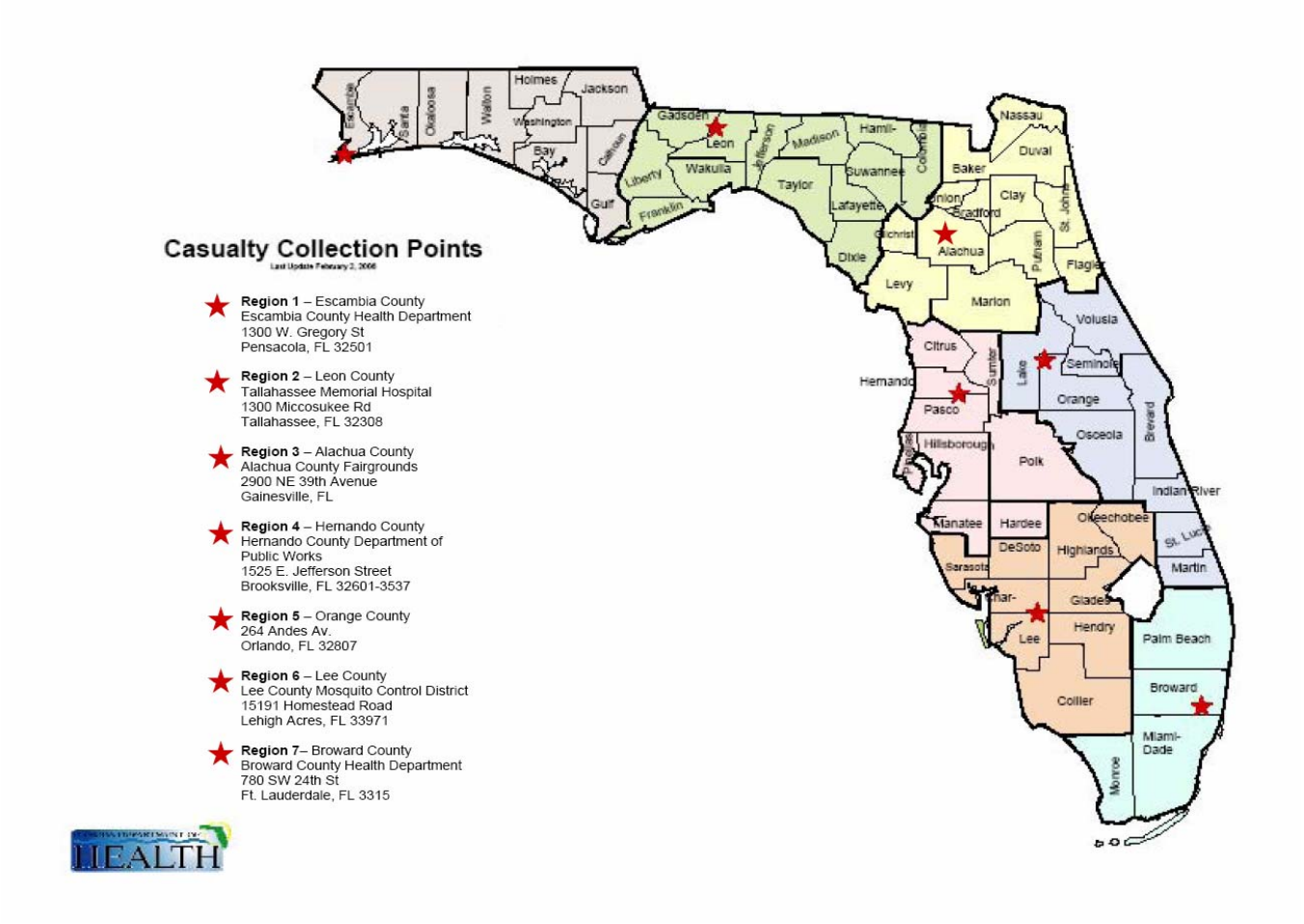
Response Teams / Resource Locations

Florida Urban Search and Rescue and Hazardous Materials Team Locations

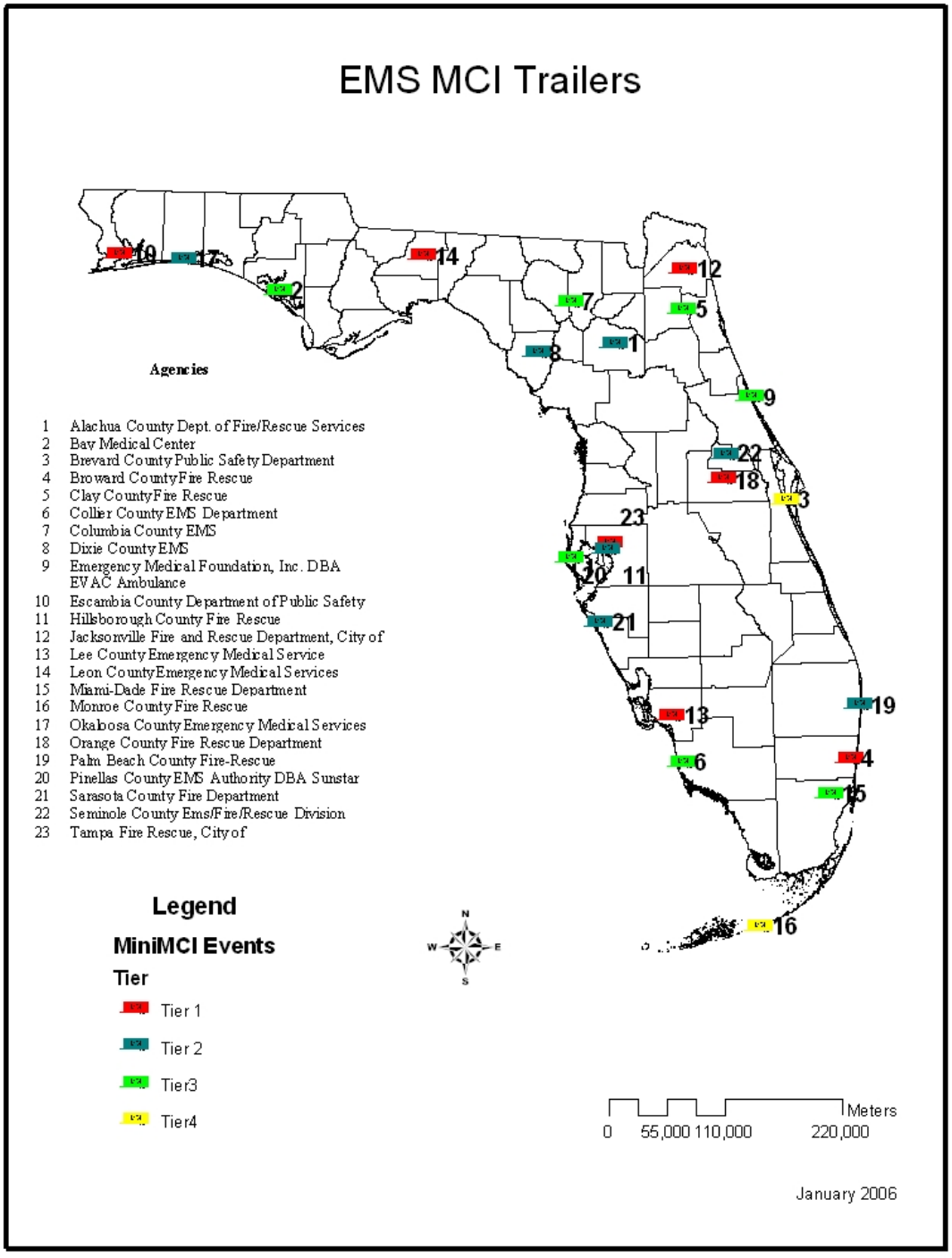


Florida Urban Search and Rescue Task Force and HazMat Team Locations Map

FLORIDA AMTS CACHE LOCATIONS



Florida Mass Casualty Incident Trailer Locations



Appendix 6
Number of Hospital Beds by RDSTF Region (2004 data)

Hospital Beds by DSTF Region

Source: AHCA FUHRS Data, FY2004

*These hospitals/hospital systems file one report with AHCA for multiple campuses.

Hospital	County	DSTF Region	# Hospitals Reporting For*	Beds	
				Licensed	Staffed
Bay Medical Center	Bay	1	1	403	403
Gulf Coast Medical Center	Bay	1	1	176	176
Select Specialty Hospital - Panama	Bay	1	1	30	30
Calhoun-Liberty Hospital, Inc.	Calhoun	1	1	25	25
Baptist Hospital - Pensacola	Escambia	1	2	552	552
Sacred Heart Hospital of Pensacola	Escambia	1	1	449	449
West Florida Hospital	Escambia	1	1	531	531
Doctors' Memorial Hospital	Holmes	1	1	25	25
Campbellton-Graceville Hospital	Jackson	1	1	25	25
Jackson Hospital	Jackson	1	1	100	100
Ft. Walton Beach Medical Center	Okaloosa	1	1	247	247
North Okaloosa Medical Center	Okaloosa	1	1	110	110
Twin Cities Hospital	Okaloosa	1	1	65	65
Jay Hospital	Santa Rosa	1	1	55	55
Santa Rosa Medical Center	Santa Rosa	1	1	129	129
Healthmark Regional Medical Center	Walton	1	1	50	50
Sacred Heart Hospital on the Emerald Coast	Walton	1	1	50	50
Northwest Florida Community Hospital	Washington	1	1	59	59
Lake City Medical Center	Columbia	2	1	67	67
Shands at Lake Shore	Columbia	2	1	99	82
George E. Weems Hospital	Franklin	2	1	25	25
Trinity Community Hospital	Hamilton	2	1	42	42
Capital Regional Medical Center	Leon	2	1	180	180
Tallahassee Memorial Hospital	Leon	2	1	770	630
Madison County Memorial Hospital	Madison	2	1	42	42
Shands at Live Oak	Suwannee	2	1	15	15
Doctors Memorial Hospital	Taylor	2	1	48	48
North Florida Regional Medical Center	Alachua	3	1	278	278
Shands at The University of Florida	Alachua	3	2	1,082	925
Baker Community Hospital and Health Center	Baker	3	1	25	25
Shands at Starke	Bradford	3	1	49	30
Kindred Hospital North Florida	Clay	3	1	60	60
Orange Park Medical Center	Clay	3	1	230	230
Baptist Medical Center	Duval	3	1	583	543
Baptist Medical Center Beaches	Duval	3	1	98	98
Memorial Hospital Jacksonville	Duval	3	1	353	353
Shands Jacksonville Medical Center	Duval	3	1	696	526
Specialty Hospital of Jacksonville	Duval	3	1	107	107
St. Luke's Hospital	Duval	3	1	289	289
St. Vincent's Medical Center	Duval	3	1	528	455
Florida Hospital - Flagler	Flagler	3	1	81	81
Nature Coast Regional Health Network	Levy	3	1	40	40
Munroe Regional Medical Center	Marion	3	1	421	408
Ocala Regional Medical Center	Marion	3	2	270	270
Baptist Medical Center Nassau	Nassau	3	1	54	54
Putnam Medical Center	Putnam	3	1	141	141
Flagler Hospital	St. Johns	3	1	290	290

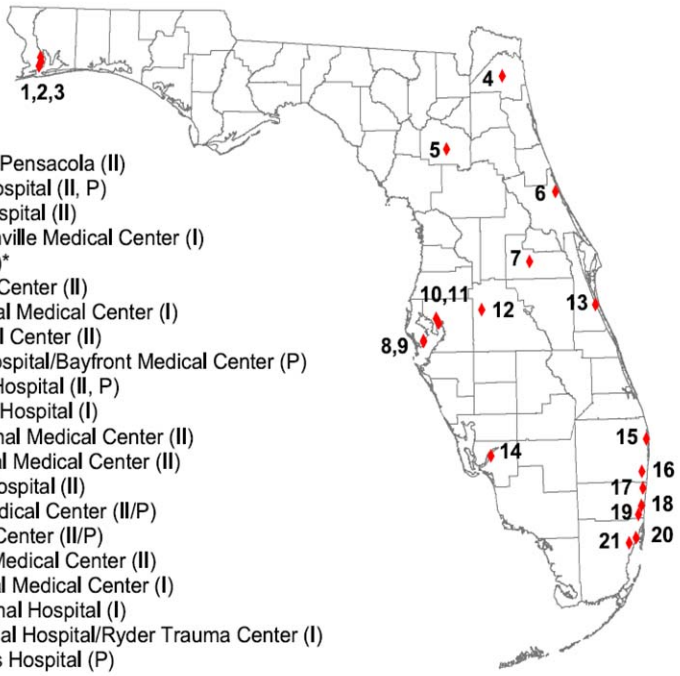
Lake Butler Hospital/Hand Surgery Center	Union	3	1	25	25
Citrus Memorial Hospital	Citrus	4	1	171	171
Seven Rivers Community Hospital	Citrus	4	1	128	128
Florida Hospital Wauchula	Hardee	4	1	25	25
Brooksville Regional Hospital	Hernando	4	2	186	186
Oak Hill Hospital	Hernando	4	1	204	204
Brandon Regional Medical Center	Hillsborough	4	1	277	277
H. Lee Moffitt Cancer Ctr/Rsrch Inst	Hillsborough	4	1	162	162
Kindred Hospital Central Tampa	Hillsborough	4	1	102	102
Kindred Hospital Tampa	Hillsborough	4	1	73	73
Memorial Hospital of Tampa	Hillsborough	4	1	180	149
South Bay Hospital	Hillsborough	4	1	112	112
South Florida Baptist Hospital	Hillsborough	4	1	147	147
St. Joseph's Hospital, Inc.	Hillsborough	4	1	883	883
Tampa General Hospital	Hillsborough	4	1	877	826
Town & Country Hospital	Hillsborough	4	1	201	201
University Community Hospital	Hillsborough	4	1	431	431
University Community Hospital at Carrollwood	Hillsborough	4	1	120	93
Blake Medical Center	Manatee	4	1	383	383
Lakewood Ranch Medical Center	Manatee	4	1	120	120
Manatee Memorial Hospital	Manatee	4	1	491	491
Community Hospital of New Port Richey	Pasco	4	1	392	392
East Pasco Medical Center	Pasco	4	1	154	154
Morton Plant North Bay Medical Center	Pasco	4	1	302	122
Pasco Regional Medical Center	Pasco	4	1	120	120
Regional Medical Center Bayonet Point	Pasco	4	1	290	268
All Children's Hospital	Pinellas	4	1	216	216
Bayfront Medical Center	Pinellas	4	1	502	404
Edward White Hospital	Pinellas	4	1	167	167
Helen Ellis Memorial Hospital	Pinellas	4	1	168	168
Kindred Hospital Bay Area/St. Petersburg	Pinellas	4	1	82	82
Largo Medical Center	Pinellas	4	1	256	256
Mease Hospitals	Pinellas	4	2	378	378
Morton Plant Hospital	Pinellas	4	1	687	574
Northside Hospital & Heart Institute	Pinellas	4	1	288	214
Palms of Pasadena Hospital	Pinellas	4	1	307	307
St. Anthony's Hospital, Inc.	Pinellas	4	1	405	405
St. Petersburg General Hospital	Pinellas	4	1	219	219
Sun Coast Healthcare	Pinellas	4	1	300	205
Bartow Regional Medical Center	Polk	4	1	56	56
Heart of Florida Regional Medical Center	Polk	4	1	127	127
Lake Wales Medical Centers, Inc.	Polk	4	1	154	154
Lakeland Regional Medical Center	Polk	4	1	851	735
Winter Haven Hospital	Polk	4	2	527	499
The Villages Regional Hospital	Sumter	4	1	60	60
Cape Canaveral Hospital	Brevard	5	1	150	150
Holmes Regional Medical Center	Brevard	5	2	574	574
Parrish Medical Center	Brevard	5	1	210	210
Wuesthoff Health Systems, Inc.	Brevard	5	1	245	245
Wuesthoff Medical Center-Melbourne	Brevard	5	1	65	65
Indian River Memorial Hospital	Indian River	5	1	335	335
Sebastian River Medical Center	Indian River	5	1	129	117
Florida Hospital Waterman	Lake	5	1	195	195
Leesburg Regional Medical Center	Lake	5	1	294	294
South Lake Hospital	Lake	5	1	68	68
Martin Memorial Medical Center	Martin	5	2	336	308
Florida Hospital Orlando	Orange	5	7	1,776	1,729

Health Central	Orange	5	1	171	171
Orlando Regional Healthcare System	Orange	5	6	1,572	1,354
Select Specialty Hospital - Orlando	Orange	5	1	35	35
Osceola Regional Medical Center	Osceola	5	1	231	231
Central Florida Regional Hospital	Seminole	5	1	226	226
Lawnwood Regional Medical Center	St. Lucie	5	1	353	353
St. Lucie Medical Center	St. Lucie	5	1	194	194
Bert Fish Medical Center	Volusia	5	1	116	116
Florida Hospital - Oceanside	Volusia	5	2	324	324
Florida Hospital Deland	Volusia	5	1	156	156
Florida Hospital Fish Memorial	Volusia	5	1	139	139
Halifax Community Health System	Volusia	5	1	764	548
Charlotte Regional Medical Center	Charlotte	6	1	208	208
Fawcett Memorial Hospital	Charlotte	6	1	238	164
Peace River Regional Medical Center	Charlotte	6	1	212	212
Cleveland Clinic	Collier	6	1	83	83
Naples Community Hospital, Inc.	Collier	6	2	548	548
Desoto Memorial Hospital, Inc	Desoto	6	1	49	49
Hendry Regional Medical Center	Hendry	6	1	66	40
Florida Hospital Heartland Medical Center	Highlands	6	2	161	161
Highlands Regional Medical Center	Highlands	6	1	126	126
Cape Coral Hospital	Lee	6	1	281	281
Gulf Coast Hospital	Lee	6	1	120	120
Lee Memorial Health System	Lee	6	2	667	667
Lehigh Regional Medical Center	Lee	6	1	88	88
Southwest Florida Regional Medical Center	Lee	6	1	400	400
Raulerson Hospital	Okeechobee	6	1	101	101
Doctors Hospital of Sarasota	Sarasota	6	1	168	168
Englewood Community Hospital	Sarasota	6	1	100	100
Sarasota Memorial Hospital	Sarasota	6	1	828	828
Venice Regional Medical Center	Sarasota	6	1	312	312
Broward General Medical Center	Broward	7	1	716	567
Cleveland Clinic Hospital	Broward	7	1	150	150
Coral Springs Medical Center	Broward	7	1	200	182
Florida Medical Center	Broward	7	1	459	459
Hollywood Medical Center	Broward	7	1	324	324
Holy Cross Hospital	Broward	7	1	577	577
Imperial Point Medical Center	Broward	7	1	204	180
Kindred Hospital Ft. Lauderdale	Broward	7	1	70	70
Kindred Hospital Hollywood	Broward	7	1	124	124
Memorial Hospital Pembroke	Broward	7	1	301	301
Memorial Hospital West	Broward	7	1	236	236
Memorial Regional Hospital	Broward	7	1	684	684
North Broward Medical Center	Broward	7	1	409	337
North Ridge Medical Center	Broward	7	1	332	332
Northwest Medical Center	Broward	7	1	175	175
Plantation General Hospital	Broward	7	1	264	264
University Hospital & Medical Center	Broward	7	1	317	317
Westside Regional Medical Center	Broward	7	1	224	224
Aventura Hospital & Medical Center	Miami-Dade	7	1	407	407
Baptist Hospital of Miami, Inc.	Miami-Dade	7	1	577	570
Bascom Palmer Eye Institute	Miami-Dade	7	1	100	54
Cedars Medical Center	Miami-Dade	7	1	560	560
Coral Gables Hospital	Miami-Dade	7	1	256	154
Doctors Hospital	Miami-Dade	7	1	281	148
Hialeah Hospital	Miami-Dade	7	1	378	378
Homestead Hospital	Miami-Dade	7	1	120	116

Jackson Memorial Hospital	Miami-Dade	7	3	1,757	1,444
Kendall Medical Center	Miami-Dade	7	1	412	412
Kindred Hospital South Florida/Coral Gables	Miami-Dade	7	1	53	53
Larkin Community Hospital	Miami-Dade	7	1	130	130
Mercy Hospital	Miami-Dade	7	1	483	367
Miami Children's Hospital	Miami-Dade	7	1	268	250
Mount Sinai Medical Center	Miami-Dade	7	2	935	935
North Shore Medical Center	Miami-Dade	7	1	357	357
Palm Springs General Hospital	Miami-Dade	7	1	247	247
Palmetto General Hospital	Miami-Dade	7	1	360	360
Pan American Hospital	Miami-Dade	7	1	146	146
Parkway Regional Medical Center	Miami-Dade	7	1	382	382
Select Specialty Hospital-Miami	Miami-Dade	7	1	40	40
Sister Emmanuel Hospital	Miami-Dade	7	1	29	29
South Miami Hospital	Miami-Dade	7	1	445	346
University of Miami Hospital/Clinics	Miami-Dade	7	1	40	40
Westchester General Hospital	Miami-Dade	7	1	172	172
Fishermen's Hospital	Monroe	7	1	58	58
Lower Keys Medical Center - DePoo	Monroe	7	2	167	167
Mariners Hospital	Monroe	7	1	42	42
Bethesda Memorial Hospital	Palm Beach	7	1	362	344
Boca Raton Community Hospital	Palm Beach	7	1	394	354
Columbia Hospital	Palm Beach	7	1	250	250
Delray Medical Center	Palm Beach	7	1	372	372
Glades General Hospital1	Palm Beach	7	1	73	73
Good Samaritan Medical Center	Palm Beach	7	1	333	333
JFK Medical Center	Palm Beach	7	1	424	424
Jupiter Medical Center	Palm Beach	7	1	156	156
Palm Beach Gardens Medical Ctr.	Palm Beach	7	1	204	204
Palms West Hospital	Palm Beach	7	1	140	140
St. Mary's Medical Center	Palm Beach	7	1	460	460
Wellington Regional Medical Center	Palm Beach	7	1	121	121
West Boca Medical Center	Palm Beach	7	1	185	185
Total				54,206	50,962

Trauma Center Locations

FLORIDA TRAUMA CENTERS



1. Baptist Hospital Pensacola (II)
2. Sacred Heart Hospital (II, P)
3. West Florida Hospital (II)
4. Shands Jacksonville Medical Center (I)
5. Shands at UF (I)*
6. Halifax Medical Center (II)
7. Orlando Regional Medical Center (I)
8. Bayfront Medical Center (II)
9. All Children's Hospital/Bayfront Medical Center (P)
10. Saint Joseph's Hospital (II, P)
11. Tampa General Hospital (I)
12. Lakeland Regional Medical Center (II)
13. Holmes Regional Medical Center (II)
14. Lee Memorial Hospital (II)
15. Saint Mary's Medical Center (II/P)
16. Delray Medical Center (II/P)
17. North Broward Medical Center (II)
18. Broward General Medical Center (I)
19. Memorial Regional Hospital (I)
20. Jackson Memorial Hospital/Ryder Trauma Center (I)
21. Miami Children's Hospital (P)

I - Level One
II - Level Two
P - Pediatric

*Received provisional level I status in Oct. '04

P - Pediatric

*Received provisional level I status in Oct. '04

Appendix 7

Alternative Medical Treatment Site Cache Contents

Category	Count /Container	Short Description	Additional Description
Storage	2 Ordered 12 Out on Bid	Containerized Storage System 2 Ordered, 12 out for bid	20 foot 14 gauge steel shipping container with cargo door and outside dimension of 20' x 8.5' x 8'. Container frames made of minimal 6-8 gauge steel. Containers are approximately 1" treated hard wood floors. Unit is refrigerated using 220V - 3Phase.
Linen	10	Bags, laundry, commercial mesh, 24" x 36"	Heavy duty mesh fabric bag with drawstring top
Linen	240	Blankets	non-woven 70% wool 30%synthetic flame retardant blanket, whipped stitched or otherwise bound on all four sides, 62" x 80" , grey
Linen	100	Gowns	55% cotton 45% polyester midweight fabric, stain guard finished sweep of 66" One size fits all. Case of 12.
Linen	100	Pillow Cases	20" x 40". 50% Cotton/50% Polyester, 2 per pkg
Linen	130	Pillows - Disposable	200-thread count cotton cover, 100% Polyester fiberfill. 100% Cotton cover. Machine washable. 20" x 28"
Linen	300	Sheets - Disposable	180-thread count 50% Cotton/50% Polyester sheets. White. Flat. Machine washable.Twin set - flat 66" x 96"
Med Kits	50	ALS Kit Bag, Ferno, red	Comes with the addition of 4 Mini-Kits: 1-Medication Mini-Kit, 1-Intubation Mini-Kit, 2-Intravenous Mini-Kits
Med Kits	50	BLS Kit Bag, Ferno, blue	
Med Kits	2	Kits, Mass Casualty	Model EM36, 4 ea. 15' x 20' treatment tarps to immediately establish and identify treatment areas 6 ea. Key position vests for rapid deployment - Triage Unit Leader - Treatment Unit Leader - Minor Treatment Manager - Delayed Treatment Manager - Immediate Treatment manager - Morgue Manager 50 ea. All new triage tags. Developed to aid in the treatment of contaminated patients. A must for incidents involving industrial accidents, chemical or biological contamination. Water-proof and durable. May be decontaminated with patient.
Med Kits	10	Pediatric Trauma Kit (Broselow-Luden Bag)(Broselow-Hinkle bag)	Each system bag contains seven delivery modules with twenty-eight size-specific procedural kits in seven pouches, flying carpet, and Broselow tape. Each module includes the following sized kits sized in accordance with the Broselow Pediatric Emergency Tape: I.V. Delivery Kit: safety I.V. catheters, 1 - I.V. prep kit, and 1 - I.V. extension set; Intraosseous Kit: 1 - Sternal/Iliac needle and 1 - I.V. extension set; Intubation Kit: Bauman Disposable® laryngoscope blade(s), 2 - endotracheal tubes, 1 - ETT stylet, suction catheter(s), NG tube(s), lube jelly, a gauze pad, ETT tape, and 10cc syringe (syringe included in Orange and Green Modules only).
Med/Surg	2	Airway, nasopharyngeal, Rusch, non latex, 20 Fr(4.5)	

Med/Surg	2	Airway, nasopharyngeal, Rusch, non latex, 22 Fr(5.0)	
Med/Surg	2	Airway, nasopharyngeal, Rusch, non latex, 24 Fr(5.5)	
Med/Surg	2	Airway, nasopharyngeal, Rusch, non latex, 26 Fr(6.0)	
Med/Surg	2	Airway, nasopharyngeal, Rusch, non latex, 28 Fr(6.5)	
Med/Surg	3	Airway, nasopharyngeal, Rusch, non latex, 30 Fr(7.0)	
Med/Surg	3	Airway, nasopharyngeal, Rusch, non latex, 32 Fr(7.5)	
Med/Surg	2	Airway, nasopharyngeal, Rusch, non latex, 34 Fr(8.0)	
Med/Surg	2	Airway, nasopharyngeal, Rusch, non latex, 36 Fr(8.5)	
Med/Surg	5	Alcohol Preps	Pad, Prep, alcohol on rayon pad, individually wrapped, box of 200 pads
Med/Surg	4	Angiocatheter, 1.25", 16 gauge	Angiocatheters, 16 gauge, 1.16", box of 50
Med/Surg	4	Angiocatheter, 1.25", 18 gauge	Angiocatheters, 18 gauge, 1.16", box of 50
Med/Surg	4	Angiocatheter, 1.25", 20 gauge	Angiocatheters, 20 gauge, 1", box of 50
Med/Surg	10	Arm Sling, Envelope, large, 43 cm	polyester and cotton with 1" envelope-style sling with 1" wide shoulder strap and hook and loop closure. Washable
Med/Surg	5	Arm Sling, Envelope, medium, 36cm	polyester and cotton with 1" envelope-style sling with 1" wide shoulder strap and hook and loop closure. Washable
Med/Surg	10	Arm Sling, Envelope, x-large, 51cm	polyester and cotton with 1" envelope-style sling with 1" wide shoulder strap and hook and loop closure. Washable
Med/Surg	5	Arm Sling, Envelope, small, 28 cm	polyester and cotton with 1" envelope-style sling with 1" wide shoulder strap and hook and loop closure. Washable
Med/Surg	100	Backboards, adult, decon ready	Plastic latex free, no pins, approximate size 72”L x16"W x 2.5”D, weight approx.11 lbs, load capacity 350 lbs.
Med/Surg	30	Backboards, pediatric, decon ready	One-piece, seamless pediatric backboard rotomolded from high-density polyethylene (HDPE). Includes board, shoulder restraint, chest strap, four body straps, two wrist restraints, two head blocks, two head block straps, and carry case. 48"L x 12"W x 1.75"H
Med/Surg	10	Bags, Body	External bag made of 15 Ounce, 1000 denier or greater opaque poly reinforced vinyl (PRV) with a 12,000 pound or better PSA burst strength rating for rip and tear resistance. Inner bag will be a clear layer of vinyl material equivalent to 18 Mil or greater thickness that will allow for contents viewing without opening. Both the inner and outer bags will be sealable with #8 envelope style, double pull YKK zipper. All seams will be sealed and certified vapor and fluid leak proof. The bag will have heavy duty web handles located at each corner and the two midpoints of the long sides of the bag for a total of six (6) handles. The bags will be certified with an 800 pound or greater weight rating for the contents.
Med/Surg	15	Bags, sand	Vinyl covered bag with 8 lbs. with fine sand and handles.
Med/Surg	5	Bags, trash, contaminated, red	Bag infectious waste w/biohazard logo, 40" x55" , low density 2.5mil, red, case of 150
Med/Surg	5	Bags, trash, regular	2-Ply Trash Can Liners, 55-60 Gallons, .90 Mil Thick, 38" x 58", Box Of 100
Med/Surg	10	Bandage, Ace, 3	Ace-type rubber elastic bandage, individually wrapped with 2 metal clips, box of 10 each

Med/Surg	10	Bandage, Ace, 4	Ace-type rubber elastic bandage, individually wrapped with 2 metal clips, box of 10 each
Med/Surg	10	Bandage, Ace, 6	Ace-type rubber elastic bandage, individually wrapped with 2 metal clips, box of 10 each
Med/Surg	8	Bandage, roller, 4.5"	Gauze, Keri type, non-sterile, 6 ply, 4.5" x 6 yes./roll, case of 10 cartons of 10 rolls
Med/Surg	1	Bandage, Triangular, 36"x36"x51"	case of 144
Med/Surg	1	Bandage, Triangular, 40"x40"x56"	case of 240
Med/Surg	5	Band net, size 6	Tubular poly covered nylon and rubber stretch net, 50yards/roll
Med/Surg	5	Bedpans, disposable	Plastic, Pontoon-type, saddle shaped, carton of 10 each
Med/Surg	5	Beta dine Preps	Pad, Prep, 10% PVP-I on rayon pad, individually wrapped, box of 100 pads
Med/Surg	50	Blankets, Emergency	disposable,air-tight,fluid barrier, mildew resistant, heavy duty, yellow
Med/Surg	100	Blankets, Emergency, foam-backed	Single use fabric, with soft insulating lining and windproof and waterproof outer layer, 47" x 79", case of 50.
Med/Surg	100	Blocks, Head	Plastic
Med/Surg	60	Blood Pressure Cuff	Child, Adult, and Large Adult Cuffs, certified accurate to ±3mmHg and vinyl zipper case
Med/Surg	50	Board, KED	Kendrick Extraction Device, made of a flexible material reinforced with wooden slats to prevent deformation once applied. Head piece which, in combination with a hard cervical collar, eliminates movement of the cervical spine. 3 torso straps and buckles, 2 groin straps and head and chin straps. Has carrying/lifting handles on both sides. 500 lb load capacity.
Med/Surg	150	Body Bag	External bag made of 15 Ounce, 1000 denier or greater opaque poly reinforced vinyl (PRV) with a 12,000 pound or better PSA burst strength rating for rip and tear resistance. Inner bag will be a clear layer of vinyl material equivalent to 18 Mil or greater thickness that will allow for contents viewing without opening. Both the inner and outer bags will be sealable with #8 envelope style, double pull YKK zipper. All seams will be sealed and certified vapor and fluid leak proof. The bag will have heavy duty web handles located at each corner and the two midpoints of the long sides of the bag for a total of six (6) handles. The bags will be certified with an 800 pound or greater weight rating for the contents.
Med/Surg	16	Burn Sheet	Sheets, Sterile, Burn, LSP, 58" x 84", (LSP #830-052), case of 6
Med/Surg	6	Burn Towel, 20"x30"	Towels, Sterile, Burn, , LSP, 20" x 30", (LSP #830-058), box of 6
Med/Surg	6	Catheter, urinary, straight, 10fr, 11"	Catheter with polished eyelets, tapered tip, clear non-latex PVC material, color-coded, size specific funnels.
Med/Surg	6	Catheter, urinary, straight, 12fr, 11"	Catheter with polished eyelets, tapered tip, clear non-latex PVC material, color-coded, size specific funnels.
Med/Surg	6	Catheter, urinary, straight, 6fr, 11"	Catheter with polished eyelets, tapered tip, clear non-latex PVC material, color-coded, size specific funnels.
Med/Surg	6	Catheter, urinary, straight, 8fr, 11"	Catheter with polished eyelets, tapered tip, clear non-latex PVC material, color-coded, size specific funnels.
Med/Surg	10	C-Collars, Infant	Adjustable, radiolucent, latex free, foam padded, Velcro closures, size color coded
Med/Surg	10	C-Collars, Neckless	Adjustable, radiolucent, latex free, foam padded, Velcro closures, size color coded
Med/Surg	1	C-Collars, Pediatric	Adjustable, radiolucent, latex free, foam padded, Velcro closures, size color coded, case of 30
Med/Surg	1	C-Collars, Regular	Adjustable, radiolucent, latex free, foam padded, Velcro closures, size color coded, case of 30

Med/Surg	20	C-Collars, Short	Adjustable, radiolucent, latex free, foam padded, Velcro closures, size color coded
Med/Surg	10	C-Collars, Tall	Adjustable, radiolucent, latex free, foam padded, Velcro closures, size color coded
Med/Surg	100	Cervical Collars, adjustable	Polyethylene shell material. 16 settings from Neckless (size 3 to Tall (size 6). Measures approx. 56 x 18 x 1.5 cm
Med/Surg	200	Cervical Immobilization Devices, disposable	Accommodates head sizes from 19.7" to 28" circumference, plastic, radiolucent
Med/Surg	40	Combination Dressing	Dressing ABD combine, 5"x9", case of 16 boxes of 25 (400)
Med/Surg	1	Container, Sharps	2 gallon, red, locking for final disposal, case of 20
Med/Surg	5	Decontamination Solution, Detergent Disinfectant	Wet or dry reconstitutes to 1 gallon. 3 year or greater shelf life and 7 days reconstituted. Safe for general use, non-irritating. Recommended by CDC for general and viral disinfecting.
Med/Surg	2	Defibrillator, Medtronic Physio-Control LifePak CR Plus, fully automated	includes power supply, two (2) sets of defibrillation electrode pads, Ambu® rescue kit, carry case, user manual, quick-use card.
Med/Surg	1	Disinfectant Solution, Wexcide	Case of 4 1 gallon containers
Med/Surg	2	Dressing, non-occlusive 4"x4"	1 wrap 12 ply sterile gauze pad, case of 1200
Med/Surg	1	Dressings, 2' x 2"	Non-sterile surgical gauze dressings of U.S.P. Type VII gauze, 20" x 12" mesh, case of 8000
Med/Surg	2	Dressings, 3" x 3"	Non-sterile surgical gauze dressings of U.S.P. Type VII gauze, 20" x 12" mesh, case of 8000
Med/Surg	2	Dressings, 4" x 4"	Non-sterile surgical gauze dressings of U.S.P. Type VII gauze, 20" x 12" mesh, case of 8000
Med/Surg	6	Drip Sets, Macro, 15gtt/cc	Drip Sets, Macro, 10 gtt/cc, case of 48
Med/Surg	1	Emesis Basin, disposable	Plastic 9", 500cc, kidney shaped, carton of 50 each
Med/Surg	1	Facial Tissue, Kleenex-type, case of 30 boxes	2-ply facial tissue, 100 tissues per box
Med/Surg	4	Flex-o-Blade	polyethylene; individually packaged, multi-purpose tongue blades; 50 Individually Wrapped Blades/Box
Med/Surg	4	Gauze Dressing, Non-sterile, 4"x4"	Sponge, gauze, sterile, 8 ply, 4"x4" Dynarex, case of 20 boxes of 200
Med/Surg	8	Gauze Dressing, Sterile, 4"x4"	Sponge, gauze, sterile, 8 ply, 4"x4" Curity, case of 24 boxes of 50
Med/Surg	1	Gloves, nitrile exam, extra large	Gloves, Extra Large, Non-latex, Non-sterile, Exam, case of 1000
Med/Surg	1	Gloves, nitrile exam, large	Gloves, Large, Non-latex, Non-sterile, Exam, case of 1000
Med/Surg	1	Gloves, nitrile exam, medium	Gloves, Medium, Non-latex, Non-sterile, Exam, case of 1000
Med/Surg	1	Gloves, nitrile exam, small	Gloves, Small, Non-latex, Non-sterile, Exam, case of 1000
Med/Surg	10	Half Sheet, sterile	Steri-Drape, 45X30, sterile, 40/CS
Med/Surg	3	Hand Disinfectant, CalStat	Isopropyl alcohol with emollients. Meets the criteria of the FDA as a healthcare personnel handwash. 4 oz. flip cap bottle. Case of 72 bottles.
Med/Surg	4	Ice Pack, Chemical	Contains solid Urea ($CO(NH_2)_2$) and Ammonium Chloride (NH_4Cl). Holds at less than 32 degrees F for 25 minutes after activation. 6" x 9"pack, Case of 24 packs
Med/Surg	4	Intraosseous Needles, Cook, 16 gauge	disposable, 18G x 3cm
Med/Surg	50	IV Pole, standing or litter	21" diameter, 4 leg, gray powder-coated steel base, chrome hooded casters, chrome steel pole, a twist lock adjusting mechanism and a 2 hook top. Height is adjustable from 45 inches to 83 inches.
Med/Surg	4	Kits, Intubation (scopes and blades)	Laryngoscope Kit, lighted, with at least the following: stainless steel #1, #2, #3 and #4 Mac Blades and stainless steel laryngoscope body.

Med/Surg	4	Kits, Intubation (scopes and blades)	Laryngoscope Kit, lighted, with at least the following: stainless steel #1, #2, #3 and #4 Miller Blades and stainless steel laryngoscope body.
Med/Surg	50	Litter Stands, set of 2	Lightweight aluminum folding litters stands that locks into place to provide a stable platform for a patient on the litters abovet. Litter stirrups fit into the slots of the stands. Folded:: 34" x 2.5" x 25" Open: 33" Height, Base: 23.5" . Weight: 10 lbs. Unit of Issue: Pair .
Med/Surg	10	Litter Tenders, All-Terrain	Stretcher Carrier with 16" x 2" non-pneumatic tires, steel frame, to fit portable litter below
Med/Surg	100	Litter, field, folding	Heavy duty aluminum frame & hinges, polypropylene mesh cover, two attached plypropylene restraints. Follows US Mil Spec MIL-L-49511B Open: 92" L x 23" W x 6" H Folded:46.5" L x 8" W x 7" H
Med/Surg	40	Litter, portable	Lightweight aluminum frame, heavy-duty, vinyl-coated nylon cover, trigger-release folding 4" wheels and posts
Med/Surg	10	Mask, bag valve, adult	AMBU Medibag Adult -450-111-010 -- Version - W/ 1 Medium Adult Mask,40" Open Reservoir Tube 6/pcs
Med/Surg	10	Mask, bag valve, adult	AMBU Medibag Adult -450-111-010 -- Version - W/ 1 Large Adult Mask, 40" Open Reservoir Tube 6/pcs
Med/Surg	8	Mask, bag valve, pediatric	Medibag Pediatric-460-111 W/ Neonate Mask, Closed Reservoir, each
Med/Surg	4	Mask, pocket	mask, Laerdal, 1-way valve and filter w/O2, case of 10
Med/Surg	5	Masks, procedure, box/50	Procedure face mask, 0.1 micron filter, passes all industry standard tests for fluid resistance, hypoallergenic, latex-free, ultrasonic weld construction
Med/Surg	4	Occlusive Dressing, 3"x9"	U.S.P. White Petrolatum impregnated Occlusive Dressings, 3"X 9", box of 12
Med/Surg	2	Oropharyngeal airways, Rusch #0	
Med/Surg	3	Oropharyngeal airways, Rusch #1	
Med/Surg	5	Oropharyngeal airways, Rusch #2	
Med/Surg	5	Oropharyngeal airways, Rusch #3	
Med/Surg	3	Oropharyngeal airways, Rusch #4	
Med/Surg	2	Oropharyngeal airways, Rusch #5	
Med/Surg	5	Oxygen Manifolds, multipatient	8 or more patient regulators with one high pressure hose for connection to cylinder;·20 masks with tubing; ·Two O2 regulators (CGA 870 for "D" and "E" tanks and CGA 540 for "H" and "M" tanks); ·One 20 ft. pressure hose with Ohmeda male quick connect (if needed) for attachment to the "inside" vehicle O2 source; ·One O2 tank key; ·Extra manifold hose barbs; ·Kelly green hard case 18L x 16W x 10 in.H (46 x 41 x 25.4cm); Weight: 5 lb. (2.3kg); dimensions: 91/2L x 6W x 23/4 in.H (24.1 x 15.2 x 7cm) O2 Manifold Specifications:·Eight valve hookups per manifold; each flow control valve hookup has a flow range of 0, 0.5, 1, 2, 2.5, 3, 4, 6, 8, 10, 12, and 15L/min. (govt. flows supplied); two male DISS ports for connection to O2 sources/s/Oxylator
Med/Surg	20	Pressure Infusers	Armstrong Pressure Infuser with gauge, 500ml
Med/Surg	10	Saline, Sterile, irrigation	Sterile, 0.9% Sodium Chloride, 500ml, case of 18 500ml bottles
Med/Surg	20	Scissors, trauma	EMT/Paramedic Scissors, hardened surgical stainless steel blades, contoured handles, 5 1/4" with safety bandage tip, autoclavable to 143 C
Med/Surg	1	Splints, SAM, 10cm finger splint, box of 10	
Med/Surg	1	Splints, SAM, 46cm Junior or equivalent	Case of 75, flat, marked "Florida DOH MCI Trailer"

Med/Surg	2	Splints, SAM, 91cm Multifit, or equivalent	Case of 75, flat, marked “Florida DOH MCI Trailer”
Med/Surg	20	Stethoscope	Aluminum chest piece, adjustable chrome plated brass binaurals with PVC eartips, 22” PVC tubing, spare eartips.
Med/Surg	200	Strap, litter	7 foot two inch wide nylon webbing with metal clasp
Med/Surg	400	Straps, stretcher	5 foot x 2 inch wide nylon webbing with metal clasp
Med/Surg	100	Straps, stretcher	9 foot x 2" inch wide nylon webbing with metal clasp
Med/Surg	10	Stylet, Intubation, adult	Intubation Stylettes, vinyl coated wire,14 fr.
Med/Surg	10	Stylet, Intubation, adult	Intubation Stylettes, vinyl coated wire,12 fr.
Med/Surg	10	Stylet, Intubation, child	Intubation Stylettes, vinyl coated wire,10 fr
Med/Surg	10	Stylet, Intubation, neonatal	Intubation Stylettes, vinyl coated wire,06 fr.
Med/Surg	10	Suction Apparatus	Portable suction unit with disposable cannister, battery and built-in charger. Capable of 30 LPM at 500mmhg
Med/Surg	2	Syringe, armed, 10cc, 20 gauge, carton/10	
Med/Surg	2	Syringe, armed, 1cc, 26 gauge, carton/10	
Med/Surg	2	Syringe, armed, 5cc, 21 gauge, carton/10	
Med/Surg	2	Tape, surgical transport, 1"	Transpore,3M 1527, transparent, 2", box of 12
Med/Surg	1	Tape, surgical transport, 1/2"	Transpore, 3M 1527, transparent, box of 24
Med/Surg	60	Tape, surgical transport, 2"	Transpore, 3M 1527, transparent, 2", box of 6
Med/Surg	2	Tape, surgical transport, 3"	Transpore,3M 1527, transparent, 2", box of 4
Med/Surg	1	Thermometer Probe Covers, IVAC	disposable plastic probe covers for IVAC thermometer above. 200/Carton
Med/Surg	5	Thermometer, IVAC	Portable dual probe electronic thermometer equipped with a 60-second pulse/respiration rate timer. Firm, disposable plastic probe covers. Memory mode displays the last measurement with the touch of a button. Back-lit, easy-to-read LCD display. Gives oral temperatures in approximately 7 seconds. It offers oral, axillary and rectal site measurement. Error codes minimize the possibility of cross contamination due to accidental mixup of oral and rectal probes and/or wells. Includes oral/axillary and rectal probes and wells, three (3) AA batteries, a security base and a one-year limited warranty.
Med/Surg	2	Tournequets, Latex	Tourniquet, 1" x 18" x .025", latex, flat, bag of 100
Med/Surg	1	Tournequets, Latex	Tourniquet, 1" x 18" x .025", latex, flat, bag of 100
Med/Surg	2	Towels, Bath, approximately 24" x 48", 24/case	100% combed cotton, weight 9lbs per dozen
Med/Surg	1	Tray, Suture Laceration, SPD, case/20	Ready-to-use sterile suturing supply tray containing 1 Drape, fenestrated;2 Towels, blue-blotting;2 O.R. cloth towels;1 ShieldmateÆ facemask w/shield & ties;1 Needleholder, Webster;1 Scissors, Iris, straight;1 Forceps, Adson Tissue, 1" x 2";1 Forceps, AdsonThumb;1 Hemostat, Mosquito, curved;5 Sponges, 2" x 2", 12-Sponges, 4" x 4", 12-ply;1 Syringe, 10cc L/L;1 Needle, 18G x 1 1/2";1 Needle, 27G x 1/2";1 Needle, 25G x 5/8";2 Medicine cups, 2 oz;1 Tray, two compartment;1 CSR wrap, 20" x 20";1 CSR wrap, 24" x 24";1 Envelope-style pouch
Med/Surg	1	Tray, Suture, SPD, case/50	Sterile Suture Removal Tray with Littauer wire scissors, plastic forceps, 3" x 3" gauze
Med/Surg	2	Tube, Endotracheal , 4mm	Endotracheal Tubes, 4mm, pediatric, uncuffed, box of 10
Med/Surg	2	Tube, Endotracheal, 2.5mm	Endotracheal Tubes, 2.5mm, pediatric, uncuffed, box of 10
Med/Surg	2	Tube, Endotracheal, 7.5mm	Endotracheal Tubes, 7.5mm, adult, cuffed, box of 10

Med/Surg	2	Tube, Endotracheal, 7mm	Endotracheal Tubes, 7mm, adult, cuffed, box of 10
Med/Surg	4	Tube, Endotracheal, 8.5mm	Endotracheal Tubes, 8.5mm, adult, cuffed, box of 10
Med/Surg	4	Tube, Endotracheal, 8mm	Endotracheal Tubes, 8mm, adult, cuffed, box of 10
Med/Surg	1	Urinals, disposable	Plastic, male, 2 quart with cover, case of 50
Med/Surg	24	Water, Sterile, irrigation	Sterile, 500ml, case of 18 500ml bottles
Med/Surg	4	Wheelchairs	18" seat with rugged cross-brace construction. Up to 250 lbs. capacity. Cushioned arm pads, embossed upholstery with a heavy-duty inner liner, stainless steel clothing guards, and fixed, non-elevating foot rests. Foot rests can be removed
PPE	1	Boot Covers, tyvek, XL, cs/200pr	
PPE	1	Boot Covers, tyvek, XXL, cs/200pr	
PPE	1	Coveralls, ProShield, adult casualty redress	Coveralls, Proshield, Disposable, Adult, Small, with elastic wrists, collar, front zipper closure, case of 25.
PPE	1	Coveralls, ProShield, adult casualty redress	Coveralls, Proshield, Disposable, Adult, Medium, with elastic wrists, collar, front zipper closure, case of 25.
PPE	1	Coveralls, ProShield, adult casualty redress	Coveralls, Proshield, Disposable, Adult, Large, with elastic wrists, collar, front zipper closure, case of 25.
PPE	2	Coveralls, ProShield, adult casualty redress	Coveralls, Proshield, Disposable, Adult, XL, with elastic wrists, collar, front zipper closure, case of 25.
PPE	2	Coveralls, ProShield, adult casualty redress	Coveralls, Proshield, Disposable, Adult, XXL, with elastic wrists, collar, front zipper closure, case of 25.
PPE	1	Coveralls, ProShield, adult casualty redress	Coveralls, Proshield, Disposable, Adult, XXXL, with elastic wrists, collar, front zipper closure, case of 25.
PPE	4	Coveralls, ProShield, child casualty redress	Coveralls, Proshield, Disposable, Pediatric with elastic wrists, collar, front zipper closure, case of 25.
PPE	4	Masks, N95 TB, regular, bx/20	NIOSH approved as a Type N95 respirator to meet OSHA requirements and CDC guide lines for TB exposure control. 99% BFE. Does not contain either natural rubber latex or dry natural rubber as components in the product or its packaging
PPE	1	Masks, N95 TB, small, bx/20	NIOSH approved as a Type N95 respirator to meet OSHA requirements and CDC guide lines for TB exposure control. 99% BFE. Does not contain either natural rubber latex or dry natural rubber as components in the product or its packaging
PPE	50	Overalls, Tyvek, hooded	Hooded TYVEK 3X large YLW 6/CS; Vendor No.:QC526BYL3X000600
PPE	1	Tape, duct	3M Scotch Multipurpose duct tape or equivalent, 2" x 50yds
PPE	1	Tyvek QC, large, 25/case	With zipper, attached hood, boots and elastic wrists
PPE	1	Tyvek QC, medium, 25/ case	With zipper, attached hood, boots and elastic wrists
PPE	1	Tyvek QC, x-large, 25/case	With zipper, attached hood, boots and elastic wrists
PPE	1	Tyvek QC, xx-large, 25/case	With zipper, attached hood, boots and elastic wrists
Radios	5	Battery Charger Bank	Rapid Charger Banks for 4 handheld battery units
Radios	1	Duplexer	VHF/UHF dual band duplexer
Radios	1	Mounting Hardware	Dual Band Mobile Antenna, UHF Connector, and NMO Mounts
Radios	1	Radio Transmitter/Receiver VHF/UHF	Dual VHF high band (100W) - UHF (100W) (Florida EMS specification) with control head, power cables, mike and mounting hardware.
Radios	20	Radio Transmitter/Receiver VHF/UHF	Handheld, Midland Allen series, UHF with antenna, carrying case and 2 nickel metal hydride batteries.
Radios	20	Remote Speaker	Remote speaker / microphone for Allen series radio
Set Up	2	Cart, Oxygen cylinder	Cylinder truck, for M sized cylinders, steel tube construction, 2 wheels, holding chain
Set Up	40	Chair, folding	Steel construction in "Y" frame design, triple welded rear leg braces, powder coated finish, polyethylene leg caps, W18 1/2" x D19 3/4" x H29 1/2"

Set Up	50	Clipboard	Hardboard, letter size, 9" x 12 1/2", brown
Set Up	20	Cones, Traffic, 28-30"	Cone 28-30", 7 lb., 1-6"Reflective Band
Set Up	5	Containers, water	HDPE covering with UV stabilizers, insulated core, white FDA Grade inner liner, wide mouth lid, reinforced handles,"Drinking Water" imprint meets OSHA requirements, 5 year warranty, all parts are replaceable.
Set Up	1	Cups, Hot/Cold,styrofoam, 12 oz., pk of 1000	
Set Up	50	Delineator Posts, 42"	Delineator Posts, 42", 15lb base, 1 reflective band, stackable ( )
Set Up	10	Extension Cords, 100 feet	Extension Cords, Power, outdoor rated, 12-3, 120V, 15 A, 100'
Set Up	10	Extension Cords, 25 feet	Extension Cords, Power, outdoor rated, 12-3, 120V, 15A, 25'
Set Up	10	Extension Cords, 50 feet	Extension Cords, Power, outdoor rated, 12-3, 120V, 15A, 50'
Set Up	4	Generator, >6KW, portable	contractor grade, diesel, electric start
Set Up	4	Hand Carts, all-terrain	Convertible hand truck with 5 in. casters and a 1-1/4 in. frame, 1 in. strip and 2 cross member bars for strength. 5/8 in. axle, 10 in. pneumatic wheels with steel hubs, brass stem valves. 51 in. high, adjustable to 56 in. for taller loads. Wheel guards protect your load. 8 x 14 in. toe plate. 600 lbs capacity.
Set Up	2	Lighting Unit with all-terrain wheels	Lighting Unit, Utility, 500W, 2 bulb, quartz halogen, tripod with GFI
Set Up	2	Markers	Sanford Super Sharpie or equivalent, fine tip, pack of 6
Set Up	8	Misting Systems, portable	!0 Gallon capacity, 18" fan, 5750 CFM, 18' cord, GFCI Protected
Set Up	5	Pads, Stenographer	Steno Notebook, spiral bound at top, Gregg ruled, green tint, 6" x 9", 70shts, pack of 12
Set Up	10	Pencil	Wood, box of 12
Set Up	10	Pens	Ballpoint stick, medium (1.0mm) point, black, box of 12
Set Up	2	Portable/Disposable Toilets	Tubular steel legs with a durable plastic seat and a removable plastic ring that secures toilet bags. Includes 6 toilet bags.
Set Up	2	Public Address Systems Battery Kit	(AC adapter/charger & 8 rechargeable batteries
Set Up	2	Public Address Systems,30W, portable	Rated power output: 30 watts; Max SPL @ rated power: 117 dB @ 1 meter; Range: 1,000 yards (900 meters); Speaker type: reentrant horn; Battery type: eight C-size 1.5 volt alkaline; Average operation time: 10-14 hours (alkaline batteries); Dimensions: 9” dia x 14.5", 23 dia x 37 cm; Weight: 3.3 pounds, 1.5 Kg.
Set Up	48	Saw Horse, folding	Lightweight, rust-resistant galvanized steel sawhorses . Load Capacity 1000 lbs. per pair. 29-1/4 in. high x 32-1/2 long open; 6 x 8 in. x 32-1/2 in. closed.
Set Up	12	Shelves, adjustable, Stainless Steel, 48" x 24" x 72"	Tubular steel corner posts with 4 stainless steel wire shelves adjustable in 1 inch increments. 800 lbs capacity.
Set Up	6	Shelves, adjustable, Stainless Steel, 60" x 24" x 72"	Tubular steel corner posts with 4 stainless steel wire shelves adjustable in 1 inch increments. 650 lbs capacity.
Set Up	18	Shelving Casters, lockable, 5"	Lockable polyurethane swivel casters, set of four, for adjustable shelves above
Set Up	4	Strobe Lights, landing zone	Kit contains 5 Strobes, Hi Intensity, Xenon (white), 5 Weightwashers, with 4 each clear, blue, amber and red acryllic lens covers, 10 AA Batteries, carring bag, ID tag and guide. Strobe lights have high efficiency circuitry and reflective design to provide maximum light visibility for over two miles with a 180 degree spread. Strobes can operate on 2 AA battery power for up to 8 hours continuous or 20 hours intermittent usage without battery changes. Approximately 3.5 inches long by 3.5 inches wide and 1.5 inches high.

Set Up	10	Table, Folding	lightweight folding table with smooth surface steel-reinforced resinite top and powder-coated steel oval legs, 1,000 lb load capacity, resistant to hot and cold temperatures. L96" x W30" x H29"
Set Up	6	Tape, perimeter, "Do Not Enter"	Perimeter Tape, 3", 3 mil, 1000' roll
Set Up	6	Tape, perimeter, black	Perimeter Tape, 3", 3 mil, 1000' roll, black
Set Up	6	Tape, perimeter, green	Perimeter Tape, 3", 3 mil, 1000' roll, green
Set Up	6	Tape, perimeter, red	Perimeter Tape, 3", 3 mil, 1000' roll, red
Set Up	6	Tape, perimeter, yellow	Perimeter Tape, 3", 3 mil, 1000' roll, yellow
Set Up	1	Tool Box, general utility	40 pc. Home Owner Set or equivalent
Set Up	10	Trash Can, large, heavy-duty, 55 gal	
Special	2	Boards, Command	Briefcase command board . Center panel with one large map pouch attached with a metal “o” rings. The briefcase section flaps to keep out rain, dirt and other elements. Four clipboard panels and special elastic straps to accommodate light sticks The Deluxe Board measures 30 inches x 68 inches open and 16 inches x 24 inches closed. Black
Tags	500	Triage Tags, Florida Approved	All risk decontamination, water repellent, synthetic paper tags, 50 per package.
Tents	4	TVI Outdoor Negative Pressure Isolation System,	Portable isolation chamber with airlock Standard windows on each side and double end viewing portals. Sized for eight gurneys. Filtration system removes chemical and biological agents and harmful airborne particulates and vapors. Delivers up to approximately 1500 CFM, max air flow provides minimum 12 air changes per hour for rooms 7500 cubic feet*. Triple element filter design. Control system auto-adjusts required blower speed in response to chamber air pressure fluctuations. Upper and Lower Alarm and Warning set points for each of the pressures monitored. Audible and visual indicators alert the user when the system is in an alarm or warning state with digital display of the system status. Can be used in conjunction with TVI's infection control shelters or as a stand alone unit for rooms. Unit includes wheels, handles and or other devises for safe loading, unloading and transport in outdoor or indoor environments.
Tents	1	TVI Quick Erect Command and Control Sys., 9' x 13'	Shelter with transport bag, repair kit, and anchor kit. End doors with quick connect strip Two curtains creating three stalls with water booms and nozzles. Chemical Resistant Fabric. Ground cloth or floor. Wind resistent design. Able to be deployed by minimally trained staff within 15 minutes.
Tents	2	TVI Quick Erect, 3 Line Decontamination Shelter, 10'x12'	Shelter with transport bag, repair kit, and anchor kit. End doors with quick connect strip Two curtains creating three stalls with water booms and nozzles. Chemical Resistant Fabric. Ground cloth or floor. Wind resistent design. Able to be deployed by minimally trained staff within 15 minutes.
Tents	1	TVI Quick ErectPortable Air Conditioner	Cooling capacity of 14,000btu and 26,000btu. Able to reduce temperatures in the listed shelters to 70°F with an outside temperature of up to 115°F. Standard 100v. 12 month warranty on entire unit 36 month warranty on compressor. UL listed with compressor overload relay, compressor short cycle protection, automatic restart, return air thermostat, and fan motor protection.
XMed/Surg	4	Cart, Disaster, A&D	

XMed/Surg	2	Cart, Pharmacy (for Disaster Plus)	All aluminum medication cart package with lockable cassette, 20 patient bins, 40bin dividers, 1000 bin labels, key locking ar, plastic top, bumper, handles, and casters. Approximate dimensions: 45 1/2"H x 25"D x 32 3/4"W (includes bumper, handles, and casters).
XMed/Surg	2	Cart, CPR Crash	Metal emergency carts with side shelf, plastic top, 2 push handles, 2 accessory panels, 4 swivel casters with 2 locking, locking bar, stabilizing frame with bumper, and aluminum mounting tracks. Overall approximate dimensions: 39" H x 25" D x 32 3/4" W (includes bumper/handles/casters). Approximate drawer size: 17 1/16"D x 22 1/4"W. Approximate drawer heights: 3"H (3), 6"H, 9"H. Assembled.
XMed/Surg	10	Gurney, rolling	Heavy duty fully welded steel construction, 4 IV pole sockets, full perimeter bumper, 8 inch all-surface casters, 2" pad, Fowler back rest, chrome frame and rails.
XMed/Surg	10	Kit, Irrigation, sterile	
XMed/Surg	4	Respirator with O2	
XSet Up	10	Signage	
XSet Up	10	Stands, signs	

Appendix 8
Staffing Guidelines

Staffing Considerations for Alternative Medical Treatment Sites: Suggested Minimum per 12-Hour Shift for 50 Bed Units

Class	Infectious	Non-infectious	Quarantine
Physician	1	1	0
Physician extender (PA/NP)	1	1	0
RNs or RNs/LPNs	6	6	2
Health technicians	4	6	1
Unit secretaries	2	2	1
Respiratory Therapist	1	1	0
Case Manager	1	1	0
Social Worker	1	1	1
Housekeepers	2	2	1
Lab Personnel	1	1	0
Medical Asst/Phlebotomy	1	1	0
Food Service	2	2	2
Chaplain/Pastoral	1	1	1
Day care/Pet care	0	0	1
Volunteers	4	4	4
Engineering/Maintenance	0.25	0.25	0
Biomed-to set up equipment	0.25	0.25	0
Security	2	2	2
Patient transporters	2	2	0

Source: Adapted from *The Concept of Operations for the Acute Care Center, the U.S. Army Soldier and Biological Chemical Command (SBCCOM), 2003,* in press. Used by permission.

Alternative Medical Treatment Site Plan

Concise Field Operational "Quick Start" Guide

Appendix 9

"Quick Start" GUIDE FOR THE ALTERNATIVE MEDICAL TREATMENT SITE PLAN

ESTABLISHMENT CRITERIA – QUESTIONS

- What is the **type of situation**?
- What is the **anticipated duration** of AMTS operation?
- What is the current available **capacity at the hospitals**?
- What is the **number of patients** expected?
- What type and **size of facility** is needed?
- What is the **number of staff** that will be required?
- What is the appropriate **organizational structure** needed for operating the AMTS?
- What **logistical support** is required?

FACILITY SELECTION CRITERIA – QUESTIONS

- What **size of facility** is needed?
- What is the **distance** between the scene and the hospitals and what is a **good location** for the AMTS?
- Is **decontamination** of patients required?
- Have the **hospitals** been **directly impacted** by the incident?
- Is the **facility slated for use** by other agencies involved in the incident?
- Does the proposed facility meet the **layout requirements** listed in Section 4.4 of the Plan?

FACILITY ATTRIBUTES

- Good ingress /egress
- Water / sewer
- Restrooms and showers
- Power and generator backup
- Air conditioning and heating
- Internal and external communications
- Ability to secure site
- Storage areas
- Administrative space and gear
- Contamination resistance
- Food prep and distribution areas
- LZ for helicopters

AMTS TYPING MATRIX

Parameter	Type 1 AMTS	Type 2 AMST	Type 3 AMTS	Type 4 AMTS
Term	**Long**	**Medium**	**Short**	**Extension of MCI**
Duration	> 36 hours	16-36 hours	8-24 hours	< 8 hours
Patients	>1500	>1000 <1500	> 500	>100 < 500
Example Natures	Pan Flu, Significant Respiratory	Decontamination situation, Radiological	Bomb, burn, blast, decontamination situation	Transport accident, building collapse, industrial
Logistics	4+ AMTS caches and Federal assets	3 AMTS caches	2 AMTS caches	Single AMTS cache
Teams	DMAT/Hospital Staff / Non-traditional medical personnel	SMRT	Regional, SMRT	Local/Regional

COMMAND DECISION POINTS WORKSHEET

1) Justification criteria met to open AMTS? _____NO _____YES

2) **Initial type of AMTS** _____1 _____2 _____3 _____4

3) **Size of facility needed**._____

4) **Location of facility**._____

5) **Command positions needed**._____
_____

6) **Decontamination needed?** _____NO _____YES

7) **How many AMTS caches needed?** _____1 _____2 _____3 _____4

8) **What initial level of triaged patients will be received?**
_____Deceased _____Minor _____Delayed_____Immediate

9) **Are any specialized response teams needed?** _____NO_____YES If YES, what special teams?
_____

10) **Are any specialized resources needed?** _____NO _____YES If YES, what special resources?_____

11) **What level of staff PPE is needed?**_____

12) **Who will be the AMTS "authority" figure for the news media?**_____

13) **Is there a need for patient isolation or quarantining?** _____NO _____YES

14) **Are there any major safety issues?** _____NO _____YES If YES what are they?_____

ORGANIZATION ASSIGNMENT LIST
(modified for AMTS operation**)**

1. Incident Name	
2. Operational Period Date and Time	
Position	**Name**
3. Incident Commander and Staff	
AMTS Incident Commander	
AMTS Medical Director	
AMTS Safety Officer	
AMTS Liaison Officer	
AMTS Public Information Officer	
4. Agency Representative	
Agency	**Name**
5. Planning Section	
AMTS Planning Chief	
Medical Intelligence Unit Leader	
Laboratory Unit Leader	
Staffing Unit Leader	
Credentialing Unit Leader	
Patient tracking/Records Unit Leader	
Volunteer Resources Unit Leader	
Reunification Unit Leader	
6. Logistics Section	
AMTS Logistics Chief	
AMTS Cache Unit Leader	
Communications Unit Leader	
Ground Transportation Unit Leader	
Facilities Unit Leader	
Food Unit Leader	
Supply Unit Leader	

7. Operations Section	
AMTS Operations Chief	
AMTS Medical Director	
Decontamination Unit Leader	
Triage Unit Leader	
Treatment Unit Leader	
Transportation Unit Leader	
Security Unit Leader	
Morgue Unit Leader	
Medical Personnel	**Name**
Medical Personnel	**Name**
8. Administration / Finance Section	
Administration/Finance Chief	
Cost Unit Leader	
Procurement Unit Leader	
9. Prepared by:	**Date and Time:**

DECONTAMINATION PROCEDURES

- **Identify the contaminant** if possible
- **Protect emergency healthcare workers** from becoming contaminated as they assist patients
- Assemble **proper equipment** for decontamination
- **Assign trained personnel** to handle the decontamination process
- **Set up decontamination "stations"** similar to diagram below
- Properly **decontaminate patients**
- **Provide privacy** for patients
- Keep decontamination water within **acceptable temperature**
- Conduct **multiple decontamination** processes as necessary
- **Control the runoff** or byproducts of decontamination for future disposal
- Take steps to insure equipment and medical care **facilities do not become contaminated**
- **Decontaminate or dispose** of equipment including PPE and decontamination equipment
- Follow-up with a **lab assessment** of the contaminant

PATIENT TREATMENT

- **Assess and treat** patient illnesses and injuries
- Create specific areas within the treatment section for **specific classifications of patients** (minor, delayed, immediate, isolation)
- **Administer antidotes**
- **Monitor vital signs**, symptoms, and patient condition
- **Stabilize** "immediate" and "delayed" patients so they can be transported to a hospital
- **Evaluate** medication and medical allergy issues
- **Treat and if possible, release** "minor" patients
- **Assist patients** with psycho-physiologic problems
- Assess the need for and request **specialized medical equipment** for patient care
- Address patients that require **isolation**
- **Treat "immediate" and "delayed" patients** if transport is delayed or if the incident is of a magnitude that hospitals are unable to accept more patients
- **Re-triage patients**, given the possible delayed reaction to some causal agents
- Provide **BLS** and in some cases, **ALS** levels of service
- Consider that there may be **multiple agents** or mechanisms of injury/illness involved.

TRIAGE - FOUR S.T.A.R.T. CATEGORIES

CATEGORY	DECON PRIORITY	CLASSIC OBSERVATION	CHEMICAL AGENT OBSERVATIONS
RED (Immediate)	**1**	Respiration is present only after repositioning airway. Applies to victims with respiration rate >30. Capillary refill delayed more than 2 seconds. Significantly altered level of consciousness.	Serious signs and symptoms. Known liquid agent contamination
YELLOW (Delayed)	**2**	Victim displaying injuries that can be controlled/ treated for limited time in the field.	Moderate to minimal signs/symptoms Known or suspected liquid agent contamination Known aerosol contamination
GREEN (Minor)	**3**	Ambulatory, with or without minor traumatic Injuries that do not require immediate or significant treatment	Minimal signs/symptoms No known or suspected exposure to liquid, aerosol or vapor
BLACK (Expectant)	**4**	No spontaneous effective respiration present after an attempt to reposition the airway.	Very serious signs/symptoms Grossly contaminated with liquid nerve agent Unresponsive to auto injections

COMMAND POSITION TASK LISTS

AMTS Incident Commander

- Work with the County Emergency Manager, Medical Director, and Health Department Director to make key decisions concerning AMTS establishment and operation
- Establish a Command Post and take command over the entire AMTS operation
- Assign Command and General Staff positions
- Hold staff and briefing meetings to keep AMTS on track
- Establish an Incident Command and communicate regularly with staff personnel
- Ensure that the AMTS functions at a high level of efficiency and effectiveness

AMTS Medical Director

- Oversee all medical aspects of the AMTS
- Provide guidance to the AMTS Incident Commander on medical triage and treatment issues
- Work with the Operations Chief to oversee the medical operations of the AMTS, especially the areas of triage and treatment
- Make contact with key hospital officials to coordinate efforts
- Determine the need for altering the standard of care and moving to the *sufficiency of care* (and back) as needed

AMTS Safety Officer

- Develop and enforce a safety plan for the AMTS
- Conduct an initial survey of the AMTS and eliminate any safety hazards
- Monitor the AMTS operation for safety issues and correct deficiencies
- Assign additional safety staff personnel to assist in monitoring decontamination and other key AMTS processes
- Ensure that the AMTS is operating within safety standards and ensure compliance with safety rules / regulations
- With guidance from the Operations Chief, determine the proper level of PPE and ensure compliance
- Assess the need for additional safety equipment and advise Logistics of needed items
- Prepare appropriate safety messages for the operational plan
- Pay special attention to safety measures that will serve to eliminate “cross contamination” of patients

AMTS Liaison Officer

- Serve as the coordinator of all agencies taking part in the operation of the AMTS
- Establish and oversee agreements and memorandums of understanding with outside agencies supporting the AMTS
- Serve as a facilitator for the Incident Commander
- Serve as a negotiator/facilitator between external agencies and the various sections within the AMTS operation

AMTS Public Information Officer

- Coordinate public information releases with the scene PIO and/or JIC, if one has been established
- Establish a gathering/briefing location at the AMTS for the media
- Prepare press releases on AMTS activities, status, etc.
- Stay in close communications with the AMTS Incident Commander in order to disseminate key information that needs to be transmitted to the public
- Ensure that HIPAA rules are followed to protect patient privacy
- Get word out to the public on what type of patients are being accepted at the AMTS, how to access care, and other important information. Establish "hotlines" to disseminate information and to answer questions
- Schedule media briefings and include the person selected to be the "key authority figure" so they get "face time" with the news media
- Remain available to answer questions the media may have about the AMTS.

AMTS Planning Chief

- Address the staffing needs of the AMTS and ensure that the appropriate type and number of personnel are being acquired and assigned to the AMTS
- Forecast the future needs of the AMTS and ensure that adequate steps are being taken to have the proper personnel and equipment in place
- Work with emergency medical providers, hospitals, and Health Department officials to ensure that the proper level of medical expertise is being provided for patient care at the AMTS
- Ensure that all personnel operating at the AMTS are properly credentialed for the work they are assigned to do
- Implement a patient tracking and charting system
- Establish a system for the "out-processing" of patients including the initiation of a reunification area in the AMTS

AMTS Operations Chief

- Oversee all operational aspects of the AMTS
- Ensure that the appropriate response teams and resources (listed in Section 5.1 of the Plan) needed for the AMTS are being activated
- Work closely with the Medical Director to ensure that maximum patient care is taking place at the decontamination, triage, treatment, and transport areas
- Monitor activities and support operations at the decontamination, triage, treatment, and transport areas
- Work with the Safety Officer to ensure that proper PPE is being utilized and that all operations are functioning in a safe manner
- Monitor and support the care being provided to special patients including those with special needs and pediatric patients
- Work with the Logistics Chief to ensure security for the AMTS and to ensure that all of the proper equipment and supplies needed for the AMTS operation are being acquired
- Ensure that the transportation aspect of the AMTS operation is functioning effectively

AMTS Logistics Chief

- Oversee the logistical operations of the AMTS
- Work with the Security Unit Leader and Operations Chief to establish the layout of the AMTS
- Ensure that the AMTS Cache(s) have been ordered and are enroute to the AMTS. Assign a Cache Coordinator to oversee cache distribution
- Procure all equipment and supplies needed to operate the AMTS including medical supplies, pharmaceuticals, cots, equipment, and vehicles
- Address specialized equipment needs including PPE, oxygen, beds, wheelchairs, decontamination support items, portable air filtration systems, sanitation equipment, etc.
- Become aware of the logistical supplies available including those that can be provided from the Strategic National Stockpile, should the AMTS become a large scale operation
- Work closely with the management and maintenance personnel of the host facility to gain knowledge about the facility and its equipment
- Address sanitation issues and keep in mind that the facility will need to be turned back over to the owner in as good or better condition than when it was turned over for use as an AMTS
- Facilitate all communications needs for the AMTS and work with the Communications Unit Leader to acquire the necessary equipment and to establish a communications plan
- Ensure that all proper steps are taken to demobilize the AMTS including extensive cleanup and decontamination of the host facility

AMTS Finance/Administration Chief

- Oversee all financial aspects of the AMTS operation
- Account for all of the costs of operating the AMTS and facilitate the rapid acquisition of needed supplies and equipment
- Track hours worked for all assigned AMTS personnel
- Track information for and initiate state and federal reimbursement processes
- File all records associated with the AMTS operation

MASTER "QUICK START" CHECKLIST

- ☐ AMTS Incident Commander assigned
- ☐ AMTS Command Staff positions assigned
- ☐ AMTS General Staff positions assigned
- ☐ AMTS Plan referenced for detailed guidance
- ☐ AMTS Facility selected
- ☐ AMTS Command Post established
- ☐ Communication links established with the scene Incident Command, the LEOC, and the hospitals
- ☐ Security established
- ☐ AMTS Organizational Chart positions assigned
- ☐ Fire Department Hazardous Materials Teams notified for decontamination duties
- ☐ General workers for the AMTS requested
- ☐ Command and General Staff formulate AMTS layout with designated areas for each activity
- ☐ Staff check-in station and procedures are developed
- ☐ All staff positions reference plan for tasks and responsibilities
- ☐ AMTS Cache(s) requested
- ☐ Regional communication centers notified
- ☐ Brief command personnel
- ☐ Public Information Officer gathers initial information and sets up a media gathering location
- ☐ Level of required AMTS PPE established
- ☐ Medical Director provides direction on the standard or sufficiency of care
- ☐ Medical Director and Triage Unit Leader obtain latest information on hospital capacity
- ☐ Scene Incident Command notified that the AMTS can accept patients
- ☐ Logistics Chief and the Communications Unit Leader complete communication plan and distribute radios
- ☐ Additional logistical resources are requested to facilitate operations for the first 12 hour period

MASTER "QUICK START" CHECKLIST (CONTINUED)

- ☐ Special teams including State Medical Response Teams, requested
- ☐ Safety Officer identifies and corrects any initial safety hazards
- ☐ A check-in procedure developed for those being admitted to the AMTS
- ☐ Logistics arranges for food and water for meals during the first 12 hour operational period
- ☐ AMTS Incident Commander briefed by Planning Chief on the status of personnel resources
- ☐ Assessment is made on what type of patients (according to triage categories) will be treated at the AMTS
- ☐ Medical staff assignments are made

NOTIFICATION CHECKLIST

- ☐ Scene Incident Command
- ☐ Medical Director
- ☐ County Health Department
- ☐ LEOC
- ☐ Law Enforcement
- ☐ Special Teams and Resources
- ☐ Area Communication Centers
- ☐ State Department of Health
- ☐ State EOC
- ☐ ESF 8
- ☐ RERAs
- ☐ Hospitals
- ☐ Fire Departments
- ☐ Private ambulance transport services
- ☐ RDSTF
- ☐ FFCA SERP
- ☐ AMTS Cache responders
- ☐ Volunteer service agencies

CONTACT NUMBERS

Emergency Manager	( ) _____
Medical Director	( ) _____
County Health Department Director	( ) _____
Law Enforcement contact	( ) _____
Fire Department contact	( ) _____
State Warning Point	( ) _____
RDSTF Chair	( ) _____
Local EOC	( ) _____
State EOC	( ) _____
ESF 8 Desk at the State EOC	( ) _____
FFCA SERP Contact	( ) _____
Local Hospital 1	( ) _____
Local Hospital 2	( ) _____
Local Hospital 3	( ) _____
Communication Center	( ) _____
Private ambulance service	( ) _____
Contact for nearest AMTS Cache	( ) _____
State Department of Health	( ) _____
Volunteer Service Agency 1	( ) _____
Volunteer Service Agency 2	( ) _____

LOGISTICS CHECKLIST

- Acquire and set up the AMTS cache(s)
- Lay out the AMTS and allocate space to the individual task areas
- Arrange for appropriate PPE for staff personnel
- Acquire any needed garments or supplies to support the decontamination process
- Get oxygen supply delivery established if respiratory patients are being treated at the AMTS
- Arrange for cleaning service and waste disposal for the AMTS
- Acquire an additional ambulance unit for standby at the AMTS
- Arrange for portable air filtration systems to help control cross contamination
- Establish strong security measures for the AMTS
- Create signage around the site for easy recognition of specialized areas
- Establish a strong communications plan and use the “Communications Checklist” to see that key areas are covered
- Ensure that the power supply is adequate and that backup generators are in place
- Order any additional key supplies early to ensure that the supply chain is uninterrupted
- Order food and beverages for the first operational period
- Establish a records system to track patients at the AMTS
- Track all costs associated with the establishment and operation of the AMTS
- Keep track of all costs and information necessary for later reimbursement processes
- Keep time sheets on all personnel assigned to the AMTS
- Facilitate the purchase of goods and services and coordinate with the Logistics section on financial issues

COMMUNICATIONS CHECKLIST

- Establish a communications plan for the AMTS
- Set up and distribute base and portable radios from the AMTS cache
- Assess and make use of the host facility communication systems
- Publish and distribute an AMTS internal / external phone extension list
- Set up fax machines and internet service for use in the AMTS
- Make use of Regional radio caches or EDICS to facilitate communications
- In larger operations, establish a radio network with the Med 8 channels
- Utilize “broadband over Internet” for data sharing
- Acquire phone banks from private providers to facilitate patient phone needs
- Ensure that backup communications systems are operational in case primary ones fail

SECURITY CHECKLIST

- Establish a secure perimeter around the AMTS
- Safeguard AMTS staff and workers from ancillary terrorism
- With Planning and Administration personnel, establish a staff check-in point
- Establish an ID system for AMTS staff and check upon entry
- Create a traffic flow pattern for the AMTS
- Control any unruly or disruptive patients
- Obtain facility keys and keep unused areas locked
- If necessary, search victims and their belongings prior to their entry into the AMTS
- Assist in securing “controlled” pharmaceuticals
- Acquire the necessary security staffing to accomplish the security mission.

PLANNING CHECKLIST

- ☐ Establish a staffing plan
- ☐ Order necessary staff personnel
- ☐ Establish a Planning area
- ☐ Set up a patient tracking and records system
- ☐ Establish a staff check-in station
- ☐ Insure staff personnel are credentialed
- ☐ Establish a lab / testing procedure
- ☐ Establish an out-processing procedure
- ☐ Set up a reunification area
- ☐ Implement a volunteer resources process

OPERATIONS CHECKLIST

- ☐ Establish decontamination station
- ☐ Establish triage area
- ☐ Establish treatment and transportation areas
- ☐ Implement security plan for the AMTS
- ☐ Order any specialized teams needed
- ☐ Order any specialized resources needed
- ☐ Establish a helicopter landing zone
- ☐ Set up an antidote administration process
- ☐ Establish a receiving process for patients coming from hospitals
- ☐ Work with Safety Officer to develop a safety plan

ADMINISTRATION / FINANCE CHECKLIST

- ☐ Establish a records system to track patients at the AMTS
- ☐ Track all costs associated with the establishment and operation of the AMTS
- ☐ Keep track of all costs and information necessary for later reimbursement processes
- ☐ Keep time sheets on all personnel assigned to the AMTS
- ☐ Facilitate the purchase of goods and services and coordinate with the Logistics section on financial issues

FLORIDA AMTS CACHE INFORMATION

Region: 1
Escambia County
Location: Escambia County Health Department
Address: 1300 W. Gregory St.
Pensacola, FL 32501

Region: 2
Leon County
Location: Tallahassee Memorial Hospital
Address: 1300 Miccosukee Rd.
Tallahassee, FL 32309

Region: 3
Alachua County
Location: Alachua County Fairgrounds
Address: 2900 NE 39th Ave.
Gainesville, FL 32609

Region: 4
Hernando County
Location: Hernando County Department of Public Works
Address: 1526 E. Jefferson St.
Brooksville, FL 32601

Region: 5
Orange County
Location: Orange County Health Department
Address: 264 Andes Ave.
Orlando, FL 32807

Region: 6
Lee County
Location: Lee County Mosquito Control District
Address: 15191 Homestead Rd.
Lehigh Acres, FL 33971

Region: 7
Broward County
Location: Broward County Health Department
Address: 780 SW 24th St.
Ft. Lauderdale, FL 33315

Appendix 10
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