



ALTERNATE CARE SITE STANDARD OPERATING PROCEDURE

**SUPPLEMENT TO THE
EMERGENCY SUPPORT FUNCTION 8 APPENDIX TO THE
STATE COMPREHENSIVE EMERGENCY MANAGEMENT PLAN**

Florida Department of Health
Bureau of Preparedness and Response

April 2013

TABLE OF CONTENTS

1. Purpose	2
2. Situation	4
A. Surge Response Levels	4
B. Types of Incidents Necessitating an Alternate Care Site	4
C. Alternate Care Site Typing	5
D. Types of Possible Alternate Care Site Assistance	6
3. Assumptions	7
4. Concept of Operations	9
A. Overview	9
B. Operations	9
1) Alternate Care Site Facilities	9
2) State Medical Response Team Role in ACS Operations	12
3) Alternate Care Site Staffing	12
4) Alternate Care Site Credentialing	14
5) Alternate Care Site Equipment and Supplies	15
6) Alternate Care Site Patient Tracking and Documentation	16
7) Alternate Care Site Activation and Support Sequence	16
8) Alternate Care Site Logistical Support	19
9) Alternate Care Site Transportation	20
10) Alternate Care Site State Support Organization	20
11) FL Department of Health Operated Alternate Care Sites	20
12) Alternate Care Site Demobilization	20
5. Authorities and References	21
A. Core Missions	21
B. Florida Statutes	21
C. Local Alternate Care Site Plans	22
D. Emergency Medical Treatment and Labor Act	22
6. Attachments	22
A. Alternate Care Site Support Worksheet	22
B. Federal Medical Station Deployment Criteria	25
C. Recommend Supplies and Equipment for an Alternate Care Site	32
D. Acronyms	36
E. References	37
F. Alternate Care Site Training Plan	38
G. Record of Review and Approval	39

1. Purpose

The Alternate Care Site (ACS) Standard Operating Procedure (SOP) establishes an emergency framework to prepare for and respond to local requests for assistance in helping to establish, operate, and demobilize alternate care sites initiated for medical surge.

The SOP, and its supporting documentation:

- Describes the roles and responsibilities in supporting local ACS activations.
- Establishes a concept of operations that covers the response of assets to a local (or regional) ACS activation, operation, and demobilization.
- Describes how the ACS SOP aligns with the other public health and medical plans to support the core missions of Emergency Support Function (ESF) 8, public health and medical.
- Describes key actions that must be taken by the State in the event that a local jurisdiction is not able to implement a needed ACS.

The following are overarching goals and supporting objectives for this ACS SOP:

Goal 1: Assist with statewide response to medical surge.

- Objective A: Provide and coordinate state resources to help minimize the impact of medical surge.
- Objective B: Assist in a services coordination role for multiple ACSs established across the State, utilizing appropriate Department plans and annexes.

Goal 2: Provide support for local ACS activations.

- Objective C: Assist with ACS staffing support to, potentially, include State Medical Response System (SMRS) response.
- Objective D: Assist with logistical support to include supplies, equipment, and pharmaceuticals.
- Objective E: Provide assistance with ACS facility identification, selection, and operational support.
- Objective F: Coordinate Emergency Management Assistance Compact (EMAC) and/or federal assistance that is activated for local ACS support.

Goal 3: Establish an ACS when local communities are unable to do so.

- Objective G: Utilize Department pre-identified (or other) facilities for housing a State-operated ACS.
- Objective H: Operate a local or regional ACS to deal with medical surge or other emergency/disaster situations that impact critical medical/healthcare operations.

This SOP does *not* contain detailed guidance on the establishment or operation of a local ACS. Such guidance is provided in the FDOH document titled: *“Alternate Care Site Operational Guidance”* which is available on the Department’s website. A web link to this document can be found in Attachment E, the “References” section of this document.

This SOP does *not* contain detailed guidance on local jurisdiction ACS plan development. An additional document has been created to assist communities in the development of their own local ACS plan. The document is titled: *“Alternate Care Sites: Local Plan Development Guide.”* A web link to this document can be found in Attachment E, the “References” section of this document.

2. Situation

A. Surge Response Levels

Surge capacity in a local community will be dependent upon the number of hospital beds available at any given time. A list of total hospital beds and services available throughout Florida is available on the Agency for Healthcare Administration’s website. A web link, titled: *Florida Hospital Beds and Services List* is included in Attachment E, the “References” section of this document.

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 shown in Table 1 below:

Table 1 – Surge Response Levels

LEVEL	RESPONSE	SCOPE
1	Facility	“In-place” surge coverage by hospital
2	Multiple Facilities	Coordinated surge coverage by multiple hospitals
3	Community	Local EOC Coordinated, Alternate Care Site use
4	Regional	Local EOC Coordinated, Alternate Care Site use
5	State	State EOC Coordinated, Multiple Alternate Care Sites
6	Federal	Support to State response, Multiple Alternate Care Sites

Table 1 Notes

- *Level 2* will require “mutual aid” type agreements between hospitals to coordinate coverage.
- *Level 3* through *Level 6* will necessitate the establishment of an ACS, the involvement of local 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.
- Department involvement would, most likely, commence when surge reaches *Level 3* and a “community” ACS is established. At *Level 5* the State may be in a posture of coordinating the support and supply operations for multiple ACSs. At *Level 6*, the State will serve in coordination mode between federal assets and the locally established ACSs.

B. Types of Incidents Necessitating an Alternate Care Site

There are a number of incidents that could result in one or more ACSs being established across the State. Activation may be in response to:

Medical Surge: A large number of people seeking medical care, which overloads hospital emergency departments,

Damaged Medical Facilities: A hospital or other medical facility that has been damaged or destroyed, or

A Combination of 1 and 2 above: A hospital or medical facility has been damaged or destroyed in which the incipient incident has also caused a medical surge situation.

Incident types that could necessitate ACS establishment include, but are not limited to, the following:

- Hurricane or other severe weather event
- Bioterrorism event
- Bomb or blast event
- Pandemic situation
- Large scale terrorist strike
- Radiation incident
- Inadvertent evacuation or closing of a hospital
- Chemical release
- Mass prophylaxis event
- Other types of natural or man-made hazards necessitating a medical response

C. Alternate Care Site Typing

In assessing the assistance to be provided to a locally activated ACS, it will be important to know the “scale” of the operation. This, of course, will be dependent upon such factors as the type of incident, number of patients, expected duration of the event, and the level of resources needed. Table 2, below, shows an ACS “typing” matrix that will aid in forecasting needs. The matrix addresses such issues as term of activation, duration of event, number of patients, example incident types, logistical needs (caches of supplies and equipment), and the types of teams needed to carry out ACS operations.

Table 2 – ACS Typing Matrix

Parameter	Type 1 ACS	Type 2 ACS	Type 3 ACS	Type 4 ACS
Activation 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
Scenarios	Pan Flu, Significant Respiratory, Major disaster	Decontamination situation, Radiological, Biological	Bomb, burn, blast, decontamination situation	Transportation accident, building collapse, industrial accident
Logistics	Regional, State, and Federal assets	Local, Regional, and State assets	Local ACS cache and/or SMRT resources, Regional assets	Local ACS cache and/or SMRT resources
Teams	Local, Regional, SMRS DMAT/Hospital Staff / Non-traditional medical personnel	Local, Regional, SMRS, Hospital Staff	Local, Regional, SMRS	Local/Regional

D. Types of Possible State Alternate Care Site Assistance

In the event that a county or region establishes an ACS, the State may be called upon to support the establishment, operation, and demobilization of the site. As such, various services and support may be requested. This may include (but is not limited to) the following types of assistance:

- Planning
- Supplies and pharmaceuticals
- Equipment
- Food and water (through the emergency management system)
- State Medical Response Team (SMRT) response
- Incident Management Team (IMT) response
- Additional staffing
- Patient tracking
- Patient movement
- Decontamination
- Laboratory services
- Assistance in locating appropriate ACS facilities
- Communications
- Transportation vehicles
- Florida Mortuary Response Team response
- Credentialing
- Security
- Hospital status information
- Legal opinions
- Department 50 bed mobile treatment units (Western Shelter Gatekeeper System) with positive/negative pressure capability
- Behavioral Health Team response
- Mass Prophylaxis
- Coordination of Federal Resources requested by the State including:
 - Federal Medical Station
 - Disaster Medical Assistance Team
 - Strategic National Stockpile
 - Disaster Mortuary Response Team
 - Other federal assistance or assets
 - Other assistance, as needed, in line with the ESF 8 mission

3. Assumptions

- A. The citizens of Florida are subject to acts of terrorism and the effects of natural and technological hazards. These acts and effects are likely to produce a significant number of casualties that may overwhelm the existing healthcare system.
- B. Given that Florida hospitals are near or at capacity on a daily basis, they may not be able to handle the surge created by a significant mass casualty or other type event that generates a large number of patients.
- C. Especially in cases of terrorism, victims may be contaminated which would necessitate decontamination prior to treatment and their admission to a hospital facility.
- D. Hospitals can expect to receive “self transport” casualties directly from the scene even if triage, treatment, and transportation mechanisms are in place at the scene.
- E. Patients may seek medical care at other types of medical facilities.
- F. In order to decontaminate, triage, treat, and transport patients, a timely and effective mass casualty management system must be implemented.
- G. Patients may report to medical facilities some time after the initial incident.
- H. Some incidents, such as a chemical exposure, may result in delayed symptoms in a patient who may cross contaminate people with whom they come in contact.
- I. The local emergency medical services will, in most instances, be the first entity to deal with mass casualty victims.
- J. There will, most likely, be a large number of psycho-physiologic patients, which will increase the number of “worried well” patients that will need to be treated.
- K. The surge situation will necessitate the establishment of an ACS to handle pre-hospital medical tasks and to deal with less serious injuries and illnesses.
- L. With input from the Emergency Medical Services (EMS) and County Health Departments (CHD), local Emergency Management (EM) will be the entity to coordinate the establishment of a “community” ACS as the operation of an ACS is a local responsibility.

- M. Hospitals and local County Health Departments will play an integral role in the establishment and operation of alternate care sites.
- N. Many patients and their families will view ACSs as “short term” treatment facilities and will expect treatment in a hospital as soon as possible.
- O. A high level of cooperation and coordination among various agencies will be necessary to establish an ACS and to operate it in an effective and efficient manner.
- P. In situations that are regional, state, or national in scope, a local ACS may need to operate somewhat independently for the first 72 hours of an incident before outside assistance can be provided.
- Q. Steps will need to be taken not only to 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.
- R. The scope of the incident may be such that state or even federal resources will be required to establish, enhance, or replicate an ACS.
- S. A significant issue in large-scale ACS operations will be the surge in staffing needed for such sites and for the hospital receiving facilities.
- T. An incident command structure will be needed to efficiently and effectively manage an ACS operation.
- U. Community initiated ACSs will rely on Department assistance for logistical and other operational support.

4. Concept of Operations

A. Overview

Alternate care site establishment and operation is the responsibility of local jurisdictions. When an incident creates medical surge that exceeds the ability of a hospital, of several hospitals, or a community to handle it, the State has an obligation to assist. This extends to the operation of an ACS being used to decompress emergency department surge. While ACS planning in Florida has focused mainly on “short fused/short duration” incidents, there are a variety of situations that might necessitate the operation of an ACS or multiple ACSs. This SOP uses, as a guide for ACS need, seven possible scenarios identified by the Agency for Healthcare Quality and Research:

- *Bed capacity and surge relief by offering non-acute (ward) inpatient services to allow for decompression of existing hospitals or to augment in-patient ward care capacity.*
- *Primary medical care and behavioral/mental health services for persons and residents with pre-existing chronic diseases who, as a result of the event, are unable to access their routine sources of health care, including supportive care for family members and pets.*
- *Primary medical care and behavioral/mental health services for displaced or sheltered special needs persons with chronic diseases, limited mobility, or other impairments making them unqualified for general population shelters, including supportive care for family members and pets.*
- *Pre-hospital evaluation and triage services to determine the need for hospital care.*
- *Evaluation and support for isolation and quarantine operations.*
- *Provide a site for mass immunization and prophylaxis, and point of dispensing services for mass medication distribution.*
- *Community outreach to, and assessment of, affected populations.*

B. Operation

There are a number of ACS operational components in which the Department may be called upon to support.

1) Alternate Care Site Facilities: When the decision is made to establish an ACS, an appropriate location and facility (fixed or mobile) must be selected. If at all possible, communities should have pre-identified facilities so the establishment of these as an ACS can be expedited in times of emergency.

The Joint Commission, in their report, “*Surge Hospitals: Providing Safe Care In Emergencies*,” identifies three types of surge facilities:

- **Facilities of opportunity**, which are defined as nonmedical buildings which, because of their size or proximity to a medical center, can be adapted into surge hospitals.
- **Mobile medical facilities**, which are mobile surge hospitals based on tractor-trailer platforms with surgical and intensive care capabilities.
- **Portable facilities**, which are mobile medical facilities that can be set up quickly and are fully equipped, self-contained, turnkey systems usually stored in a container system and based on military medical contingency planning.

The size, type, and location of an ACS will be dependent upon the size, type, and location of the incident itself. An ACS may operate out of a tent, a state mobile treatment unit, on the grounds of a hospital, in a community facility normally used for other purposes, or in any appropriate facility that will support ACS operations. Most long-term ACS operations will utilize a large fixed structure with the necessary support infrastructure such as bathrooms, heating/cooling units, a sufficient power supply, kitchen facilities, etc. There will also be licensure and reimbursement issues to consider when implementing a “long-term” ACS facility.

In conjunction with the local hospitals, it is the responsibility of local communities to identify the facility or location for an ACS. Selection of a facility will be largely dependent upon the availability of structures or areas in a given community. The Department needs to be prepared to support ACSs set up in a variety of settings. Possible sites for selection include:

- Convention centers
- Churches
- Schools, colleges, and universities
- Airport hangars
- Sports facilities or stadiums
- Community or recreation halls
- Medical buildings
- Fitness centers
- Closed hospitals or nursing homes
- Government buildings
- Fairgrounds
- Skating rinks

- Open warehouses
- Hotels or motels
- Military installations or National Guard Armories
- Open areas large enough for tent setup
- Other facility types that meet criteria for ACS use

In order for a community to establish an ACS, a viable facility must be identified to accommodate the operations. While this is a local responsibility that falls under the local ACS planning initiatives, the State has identified a minimum of two facilities in each of the seven Regional Domestic Security Task Force (RDSTF) regions that can serve as an ACS. These facilities have been properly assessed for viability with the assessments being kept on file at the Department. A complete assessment for each facility is available on a “need to know basis” (given the sensitive nature of the facility information) from the Department’s Logistics Section. These assessments contain the following information about each facility:

- Facility name
- RDSTF region
- Location and address
- Contact person, with telephone number and email address
- GPS and map coordinates
- Nearest hospitals, including mileage and location
- General description
- Electrical service
- HVAC
- Building access
- Parking
- Food service capability
- Showers and restrooms
- Security
- Responder staging areas
- Facility layout
- Photos
- Area map and satellite map
- Floor-plan / layout
- Additional information including (but not limited to) door sizes for gurneys, floor type, loading docks, roof structure, walls, additional rooms, storage areas, water access, communication capabilities, Internet access, laundry services, oxygen capability, etc.
- Facility ranking according to *Rocky Mountain Bioterrorism ACS Facility Selection Matrix Tool*

In a large-scale emergency, disaster, or pandemic, it may be necessary to establish multiple ACSs. As such, a variety of facilities may have to be pressed into service to function as an ACS. An assessment tool, titled the *Alternate Care Site Selection Matrix Tool*, for determining the feasibility of a particular facility for use as an ACS has been developed by the *Agency for Healthcare Research and Quality* and can be accessed at the link found in Attachment E, the “References” section of this SOP. This tool identifies important criteria that a facility must meet to serve as an ACS and assists the user with assessing a facility for its viability as an ACS.

In the event that an ACS must be expanded to the extent that federal assistance is needed, the FDOH may request a Federal Medical Station (FMS) response from the *United States Department of Health and Human Services – Centers for Disease Control and Prevention, Division of Strategic National Stockpile*. The FMS is a federal, deployable all-hazards medical asset designed to provide surge capacity support for a State, tribal, or local healthcare agency in response to a catastrophic event. The FMS can provide medical special needs sheltering, inpatient non-acute treatment, and support to quarantine missions. The FMSs have minimum space and other criteria that must be met for deployment. Host criteria, planning layouts, and other details for a FMS setup can be found in Attachment B of this SOP.

2) State Medical Response System (SMRS) Role in ACS Operations:

One of the components of the Department’s response to support the implementation and operation of local alternate care sites is the State Medical Response System. The SMRS provides medical surge care to the survivors of and responders to a Florida disaster, and supports ESF 8 infrastructure and operations for regional and local jurisdictions where the public health and medical infrastructure is compromised due to a disaster. If assistance is needed for the initiation and/or operation of an ACS, activation of the SMRS can be requested. The SMRS teams possess a complement of equipment and supplies that can be used to get an ACS established. Further, the initial arriving State Medical Response Team (SMRT) members can make an assessment on what additional resources will be needed for the operation of the ACS and forward that information back to the appropriate resource coordination personnel. Supplies and equipment appropriate to ACS operations are available for response through SMRS activation.

If an ACS requires the use of a “tent” type of facility, one of the three Department mobile field treatment units can be requested. These 50-bed “Western Shelter Gate Keeper System” units are climate controlled, are positive/negative pressure capable and contain the necessary equipment to establish a tent-based treatment unit in the field. The mobile field

treatment units are activated through the SMRS. These units are located in South, Central, and North Florida.

SMRT Locations

Region 1 – Okaloosa County

Region 2 – Leon County (cache but no personnel)

Region 3 – Duval County

Region 4 – Pinellas County

Region 5 – Orange County

Region 6 – Charlotte County

Region 7 – Broward County

Florida Advanced Surgical and Transport Team (FAST) – Broward County

Requests for SMRS assets are processed through local emergency management. Requests are then forwarded to the State Division of Emergency Management in accordance with procedures established in the *State of Florida Comprehensive Emergency Management Plan* (CEMP). This includes the development of an approved “mission” with an associated mission number in the Division of Emergency Management’s (DEM) *EM Constellation System*. Details on SMRS operations, including the roles and responsibilities of the SMRTs, can be found in the *State Medical Response System Standard Operating Guide*.

3) Alternate Care Site Staffing: One of the greatest challenges local communities will face in the establishment and operation of an ACS is staffing. If assistance from the State is requested, there is a good possibility that additional staffing resources will be part of the request. Sources of staffing for an ACS include, but are not limited to:

- Hospital personnel
- County Health Department personnel
- EMS personnel
- Fire Department personnel
- Private physicians and nurses
- Skilled Nursing Facility (SNF) and Assisted Living Facility (ALF) personnel
- Nursing and allied healthcare students
- State Medical Response Teams (SMRT)
- Private ambulance companies
- Community Emergency Response Teams (CERT)
- Medical school staff and students
- Medical Reserve Corps (MRC)
- Community healthcare workers
- Specialized local and regional response teams
- Volunteer service agencies

In large-scale emergencies or disasters that involve a federal response, additional staffing (or staffing support resources) may be available from:

- USPHS Commissioned Corps
- National Disaster Medical System (NDMS)
- Strategic National Stockpile (SNS)
- Federal Medical Stations (FMS)
- Department of Veterans Affairs (VA), the Department of Defense (DoD), and other federal agencies
- Medical Reserve Corps (MRC)

Suggested Medical Staffing

Table 3, below, shows a sample ACS medical staffing configuration for a 50-bed unit, based on a 12-hour shift. Recommended staffing is listed for infectious, non-infectious, and quarantine scenarios. It should be noted that this is *medical* staffing and that *organizational* staffing, including command personnel, will be in addition to the numbers listed in Table 3.

Table 3 – Recommended ACS Medical Staffing – 50-bed – 12-hour shift

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

Table 3 is from the *Rocky Mountain Regional Care Report for Bioterrorism Events* published by the Agency for Healthcare Research and Quality.

4) Alternate Care Site Credentialing: Acquiring an adequate number of medical professionals to staff an ACS 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 shortages. 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 ACS administrative personnel. One of the services the Department may be asked to provide in support of a local ACS operation is assistance in ensuring properly credentialed personnel are assigned to the site.

The Department uses the *State Emergency Responders and Volunteers of Florida* (SERVFL) system for managing public health and medical disaster responders (volunteers and staff teams). The system is based on standards and guidelines recommended by the Assistant Secretary for Preparedness and Response (ASPR) for the *Emergency System for Advance Registration of Volunteer Healthcare Professionals* (ESAR-VHP) program. 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

Non-affiliated volunteers will be sent to the American Red Cross or other sanctioned volunteer coordinating agencies for screening and credentialing prior to being utilized. At a minimum, a screening for criminal history and state professional licensure will be completed. Non-affiliated volunteers must work under the direct supervision of an affiliated volunteer or staff member.

5) Alternate Care Site Equipment and Supplies: As with many of its support operations during large-scale emergencies or disasters involving a medical component, the Department would likely be called upon to provide a great deal of assistance to communities through logistical operations. Included would be the provision of equipment, medical supplies, and pharmaceuticals to established ACSs. Original equipment/supply lists, developed for the former “Alternative Medical Treatment Site (AMTS) caches” that were located in each of the 7 RDSTF regions, demonstrate the types and numbers of equipment and supply items needed for an ACS operation. A list of these items can be found in the State’s *Alternate Care Site Operational Guidance* document. The SMRTs now carry these items as part of their overall cache of equipment and supplies. Supply and resupply will likely be needed for any extended ACS operations.

Some regions may have ACS items cached at venues such as theme parks, stadiums, or other large event sites. For planning purposes, given that the Department may be called upon to assist with logistical resupply of a local ACS, estimated types and amount of supplies normally used in an ACS have been listed in Attachment C of this SOP, titled, “*Recommended Supplies and Equipment for an ACS.*”

If requests are received, they will be processed in accordance with procedures detailed in the *Logistical Support Annex*. If such requests exceed the State’s capability to keep up with demand, federal assistance from the Strategic National Stockpile may be requested by the State.

6) Alternate Care Site Patient Tracking and Documentation: Patient tracking at an ACS is not unlike the process used for a mass casualty incident. At the very least, the *triage tag system* will be used to track patients until a more detailed process is implemented, once administrative resources arrive at the ACS. When that occurs, standardized patient tracking forms can be used for the duration of the patient’s stay at the ACS. Whatever system is used, it needs to be expedient so that tracking does not delay patient care.

The Department has implemented *EM Systems* as a statewide, standardized patient tracking system. If the State is requested to assist with the operation of an ACS, every effort should be made to incorporate the use of this system for the tracking of patients into and out of the ACS. If an ACS is open only 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. For patients that remain at the ACS, medical personnel must officially document the patient’s status and obtain patient information. If the patient stays at the ACS for treatment, a record 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 the patient is transported.

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

7) Alternate Care Site Activation and Support Sequence: While every ACS activation will be different (dependent upon the location, scope, duration, and type of incident), there is a basic sequence that such activations will follow. Reviewing this sequence will help support personnel in determining when support would be requested. Listed below is an *example* of a sequence of events that would likely be encountered when an ACS is established and State assistance is requested (State

assistance would likely commence at Step 15 for a State operated ACS and at Step 23 for local ACS support. Both of these steps are in **bold** type for easy recognition):

1. Incident occurs
2. Local units respond
3. Number of patients is determined to be unmanageable, creating a “surge” situation
4. The nearest hospital(s) is/are notified
5. Additional resources respond to the incident
6. A “mass casualty incident” (MCI) is declared, with additional hospital notification
7. The local MCI plan is activated
8. Mutual aid is initiated with local Emergency Management notification
9. The State Warning Point (SWP) is notified
10. Regional resources respond including any Metropolitan Medical Response System (MMRS) components
11. The FDOH Duty Officer is notified by the SWP and monitors situation, notifying the Emergency Coordinating Officer (ECO) and appropriate Department partners of the situation
12. Department Regional Emergency Response Advisors
13. (RERA) are notified with the RERA from the appropriate
14. Jurisdiction responding to provide intelligence on projected needs
15. Local hospitals initiate surge plans
16. The local jurisdiction recognizes medical surge will overwhelm capabilities of local hospitals
17. **The local jurisdiction determines an alternate care site is needed to assist with surge**

18. The Local Emergency Operations Center (LEOC) activates to support the incident
19. Local County Health Department representatives fill a liaison role at the LEOC for ESF 8 issues
20. The local ACS Plan is activated and an ACS facility is identified
21. The local ACS is established
22. Local ACS plans and the Department *ACS Operational Guidance* document are referenced for guidance
23. If patient contamination is evident, local hazmat teams are notified for gross decontamination, hospitals are notified for activating internal decontamination procedures, and the ACS is set up to accommodate decontamination operations at the site
24. If appropriate, the *Ambulance Deployment Plan* is activated to provide additional transport resources
- 25. The ACS operation requires State ACS-related cached materials or other assistance for start-up and/or operation**
26. State assistance is requested through a resource request channeled through Emergency Management
27. If appropriate, a disaster declaration is developed by DEM for the Governor's signature with input from the Department Surgeon General and ESF 8 ECO
28. As appropriate, the area's Regional Domestic Security Task Force is activated to act as a facilitator for additional resources that might be needed
29. ESF 8 establishes contact with appropriate local agency to obtain details of the requested assistance
30. The FDOH EOP Base Plan is activated
31. Patient tracking, if not already initiated, is established using *EM Systems*
32. ESF 8 agencies are contacted for notification and possible assistance purposes

33. As needed, additional SEOC ESFs are notified, activated, and staffed to support the local operation
34. Appropriate resources are deployed to the ACS
35. The Department internal process for emergency response is activated with decisions being made as to what “cells” need to be activated in support of the ACS
36. SMRT and/or other state resources are deployed for assistance
37. If the situation escalates or exceeds state capabilities to support the incident, EMAC or federal resources are requested
38. ESF 8 at the State EOC coordinates the state, EMAC, and federal assistance
39. Continuing ACS operation is supported by ESF 8
40. The medical surge problem begins to subside
41. A demobilization plan is put into effect and resources are released. As part of the demobilization plan, equipment and unused resources are returned to their normal locations and supply stocks are made whole in preparation for the next incident
42. Medical surge incident ends, the ACS is closed, and state support operations return to normal status
43. An After Action Report is initiated to capture “lessons learned” on the State ACS support operations

If an ACS is activated because a facility has been compromised and has to be evacuated, or if the incident is a pandemic with long-term implications, etc., the process will be markedly different. If the incident is of a very significant nature, the ESF 8 *Community Stabilization and Patient Movement Plan* may need to be further activated to support the critical health and medical components of the community. (When completed, a copy of the *Community Stabilization and Patient Movement Plan* will be available on the Department’s website.)

8) Alternate Care Site Logistical Support: An ACS may become a primary source for medical care during a disaster. If such an eventuality occurs, the most likely request for assistance would come in the form of

logistical support. The process for such support is contained in the Department's *Logistical Support Annex*.

9) Alternate Care Site Transportation: One key element of ACS operations will be adequate transportation of patients. While local resources will be assigned to this task, if an incident becomes large-scale it may be necessary for the *Ambulance Deployment Plan* to be activated to provide additional transportation resources. A copy of this plan is available on the Department's website.

10) Alternate Care Site State Support Organization: If the Department is contacted for ACS assistance, it will be useful, for planning and operational purposes, to obtain key information about the incident and local plans for ACS initiation/operation. Included would be such information as:

- Incident type
- Facility selected, including address and contact information
- ACS type
- Expected number of casualties
- Expected duration
- Other information that would assist the State in its support role

An *Alternate Care Site State Support Worksheet* has been developed to capture operational detail about a locally established ACS. A copy of the worksheet can be found in Attachment A of this SOP.

11) Florida Department of Health Operated Alternate Care Sites: A situation may arise whereby a local community is not able to establish a needed ACS. In such situations, as part of the State's responsibilities in the *Community Stabilization and Patient Movement Plan*, the Department and ESF 8 will need to be ready to establish and operate a local ACS. Operational details for initiating, operating, and demobilizing an ACS can be found in the FDOH guidelines titled, *Alternate Care Site Operational Guidance*. This guidance includes a "Quick Start Guide", which provides basic procedures for quickly getting an ACS operational. The Department will need to work closely with the impacted community in identifying the ACS location, size, scope of service, and expected duration. Every effort should be made to garner local resources to provide ACS services and then augment them with Department resources.

12) Alternate Care Site Demobilization: Once the need for an ACS is over it will be necessary to demobilize the site. This would include (but is not limited to) the following:

- Creation of a Department internal demobilization plan

- Out-processing of all patients
- Forwarding of records to the proper authority
- Performing follow-up maintenance on equipment including repairs and decontamination
- Cleaning and returning the facility in its normal condition to the owner
- Returning equipment and supplies to their original location
- Restocking supplies used in ACS operations
- Completion of all appropriate documentation
- Announcement to the public and all impacted agencies that the ACS is being demobilized
- Notification to all affected parties that the ACS is being closed
- Demobilization of all Department operational “cells” and the return to normal operations
- Generation of an After Action Report on Department ACS support operations

The Department responsibilities in the demobilization process will likely focus on the return of equipment and supplies to their storage locations and ensuring that all response resources are returned to a posture so they are ready for the next incident. Inventory tracking systems can aid this process.

5. Authorities and References

A. Core Missions

Appendix 8 of the State Comprehensive Emergency Management Plan identifies core missions of ESF 8. Alternate care sites may directly support the following core missions:

Mission 2: Coordinate and support stabilization of the public health and medical system in impacted counties.

Mission 4: Monitor and coordinate resources to support care and movement of persons with medical and functional needs in impacted counties.

B. Florida Statutes

- Chapter 20.43(2)(a), Florida Statutes, Surgeon General
- Sec. 20.43(3)(f), Florida Statutes, Division of Emergency Medical Operations
- Chapter 154, Florida Statutes, Public Health Facilities

- Chapter 252.365, Florida Statutes, Emergency Management
- Sec. 252.35(2)(e), Florida Statutes, Cooperate with presidential and federal emergency directives
- Sec. 252.35(2)(g), Florida Statutes, Work with state emergency management program regarding logistics activities.
- Chapter 318.0011, Florida Statutes, Public Health: General Provisions
- Sec. 381.0011(4), Florida Statutes, Cooperate with state and federal authorities to suppress communicable disease, illness, injury and hazards to human health
- Sec. 381.0011(14), Florida Statutes, Perform any other duties prescribed by law

C. Local Alternate Care Site Plans

Local ACS plans on file with the Department can provide valuable information on local ACS operations. The list of counties with local ACS plans currently in place includes, but may not necessarily be limited to:

Alachua County	Broward County	Collier County
Desoto County	Duval County	Escambia County
Flagler County	Highlands County	Hillsborough County
Holmes County	Indian River County	Lee County
Leon County	Manatee County	Marion County
Martin County	Miami-Dade County	Monroe County
Okaloosa County	Orange County	Osceola County
Pasco County	Pinellas County	Sarasota County
Seminole County	Sumter County	Suwannee County
Volusia County	Walton County	Wakulla County
Washington County		

D. Emergency Medical Treatment and Labor Act (EMTALA)

EMTALA, and Medicaid/Medicare rules/issue, may impact ACS operations. Further information can be found by using the links in Attachment E, “References”, titled, “*EMTALA Requirements and Options for Hospitals in a Disaster*” and “*ACS Fact Sheet – Hospital ACSs During H1N1 Public Health Emergency.*”

6. Attachments

Attachment A – Alternate Care Site Support Worksheet

Florida Department of Health Alternate Care Site Support Worksheet					
Worksheet #:		Date:		Time:	
Person Completing Worksheet:					
Incident Type:					
Incident Scenario:					
Incident Address:					
County:		RDSTF Region:			
ACS Local Point of Contact:					
LEOC Jurisdiction:					
LEOC Phone #:					
LEOC Point of Contact:					
County Health Department Jurisdiction:					
Responsible RERA:					
Nearest Hospital:					
Other Involved Hospitals:					
ACS LOCATION			ACS SCOPE		
Facility Name:				Anticipated Duration	
Facility Address:					
Facility GPS Coordinates:				Anticipated # Patients	
Facility Phone #:					
Nearest SMRT:				DECON of Patients	
Nearest FDOH Identified ACS:				Y / N	
ACS Type (from typing matrix)	1	2	3	4	
EMERGENCY DECLARATION					
Local	Y / N	State	Y / N	Federal	Y / N
ACTIVATION					
Local EOC	Y / N	Level	1 2 3	ESF 8 ECO	Y / N
State EOC	Y / N	Level	1 2 3	SMRT ("first out" capability)	Y / N

Florida Department of Health
Alternate Care Site Support Worksheet

Requested Assistance

Comments

Additional Notes

Attachment B – Federal Medical Station Deployment Criteria

Federal Medical Station (FMS) Profile

Purpose:

To help support overwhelmed communities in a mass casualty event by:

- Quickly turning a building of opportunity into a temporary medical shelter
- Responding a Division of Strategic National Stockpile/FMS logistical team for setup support
- Provide beds, supplies, and medicines to treat 250 patients for up to three days

Additional details:

- Used for in-patient, non-acute treatment or to establish a quarantine facility
- Utilizes a “modular configuration”
- Scalable according to the size of the incident
- Modeled for all age populations
- Transported by air or ground for rapid maximum geographic distribution
- Assets are managed and deployed by the Centers for Disease Control and Prevention (CDC) Division of Strategic National Stockpile under the direction of the Department of Health and Human Services
- Local community is required to provide some operational support

Configuration:

Each 250 bed FMS consists of three modules:

1. BASE SUPPORT – Administrative, food service, housekeeping, basic medical and quarantine supplies, personal protective equipment, 5 bed units with 50 beds in each unit.
2. TREATMENT – Medical/surgical items
3. PHARMACY – Medications

Methodology:

Technical teams from DSNS deploy with the FMS sets to provide set-up assistance. Federal, state, and local groups operate the stations. Most of the items in the set are expendable, with only a few recoverable items. Currently available FMS sets are “Type III” models and can be used for in-patient, non-acute treatment, or to establish a quarantine facility. Department of Health and Human Services and the Department of Homeland Security are developing other models, which will provide critical care, and special needs capabilities. State and local officials will locate and determine the suitability of an existing facility or structure that can be used as a FMS site.

Criteria:

One FMS set requires a minimum of 40,000 square feet of enclosed, climate-controlled space with the following required features:

- Adequate loading ramps, materiel handling equipment (MHE), and parking
- Sufficient existing communications/IT support and power supply (with back-up)
- Support services, including food and water, waste disposal, medical oxygen, laundry, mortuary services, etc.
- Refrigeration and controlled substance storage
- Bathrooms and shower capability

- Billeting support for 150+ FMS staff
- Security

Layout:

FMS is typically deployed in 50-bed increments, up to 250 beds. It can be augmented with additional beds/cots if required. The following pages contain layout examples (in 50-bed increments) and the required amount of space in square feet. These layout drawings are for planning purposes and intended to identify functional areas and estimated space requirements. The general layout for FMS should maximize patient flow and provide efficient inpatient management services. The admission and disposition area is the focus of the initial patient presentation and/or final disposition and should be located at the main entrance of the building. The inpatient bed area should be centrally located to all functional areas within the FMS. The inpatient bed area should allow at least two feet of clear floor space between the “heads” of the beds. Side-by-side spacing between cots should be approximately 4 feet. The bed/cot spacing should not restrict routine patient care activities and there should be complete access to the patient and enough circulation space to allow movement of staff.

Support and storage areas are best arranged around the periphery or upper floors of the building. The FMS traffic pattern should allow rapid access to every area with a minimum of cross-traffic.

FMS layout space determinants revolve around the patient bed areas and functional support areas. The functional support area dimensions remain mostly the same in each configuration while the patient bed/nurses station space and the space for supporting staff grows with each increase in bed increment. The required space for the patient bed areas and support staff areas are depicted on the following layout pages. Functional support areas and their approximate dimensions are listed as follows:

AREA	TOTAL SPACE REQUIREMENT
Administration / Admission Area	1614 sq ft (35 ft x 46 ft)
Common Area	1170 sq ft (36 ft x 32.5 ft)
Waiting Area	830 sq ft (25.5 ft x 32.5 ft)
House Support	760 sq ft (35 ft x 22 ft)
Medical Support	1614 sq ft (35 ft x 22 ft)
Pharmacy Area	280 sq ft (35 ft x 8 ft)
Treatment Area	1675 sq ft (35 ft x 48 ft)
Holding Area	1425 sq ft (35 ft x 41 ft)
Staff Rest Area	600 sq ft (30 ft x 20 ft)
Pallet Storage Area (in aisles along edges of FMS)	2718 sq ft
Bio-Med / Morgue	
Total	1120 sq ft (35 ft x 32 ft)
Bio Med	399 sq ft (18 ft x 22.5 ft)
Morgue	100 sq ft (8 ft x 12.5 ft)
Staging Area: Encompassing Latrine / Patient Wash / Housecleaning Areas	
Total	925 sq ft (20 ft x 46.5 ft)
Latrine	210 sq ft (21 ft x 10 ft)
Housecleaning Storage	45 sq ft (15 ft x 3 ft)

See Diagrams, below, for examples.

For spacing planning estimates, use the following dimensions:

GENERAL SPACING	
Aisle at "top" of station	448 sq ft (8 ft x 56)
Large Aisle on "left" side of station	1490 sq ft (149 ft x 10 ft)
Aisle on "right" side of station	780 sq ft (6 ft x 130 ft)

Walkways and Patient Bed areas: see following diagrams - For planning estimates, one "patient bed section" is approximately 456 sq ft (16 ft x 28.5 ft) when factoring ten 7-foot cots with 2 feet between the heads and 4 feet side by side spacing).

Other Factors to consider:

- Tri-wall shipping containers and pallets can be stacked or even disassembled to maximize space for other areas
- Patient walkways and aisles between patient bed "sections" must be a minimum of 8 ft wide to allow unencumbered maneuver of mobility-impaired persons and/or gurneys
- Storage and staging of dunnage

FMS Supply List

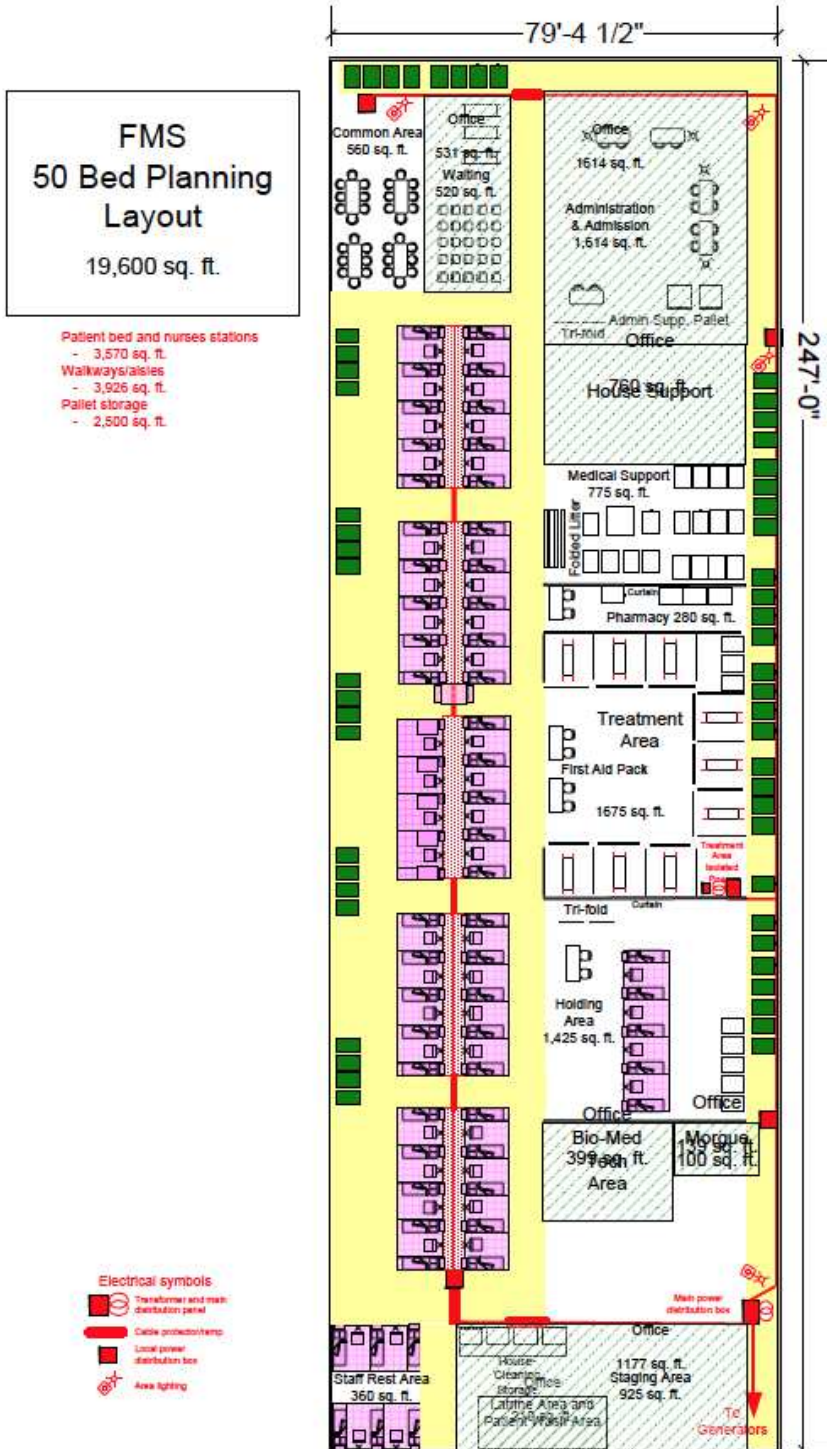
The FMS list of supplies is available from the Logistics Section. The supply list categories include the following:

- Pharmacy
- Pharmacy Hazard Items
- Reefer Items
- Controlled Substances
- Rapid Sequence Induction
- Base Treatment
- Special Needs
- Medical Care
- Bio-med Kit
- Personal Protective Equipment
- Emergency Treatment
- Nurse
- Administration
- Housekeeping
- Feeding
- Beds
- Bed Pack
- Hygiene
- General Supply

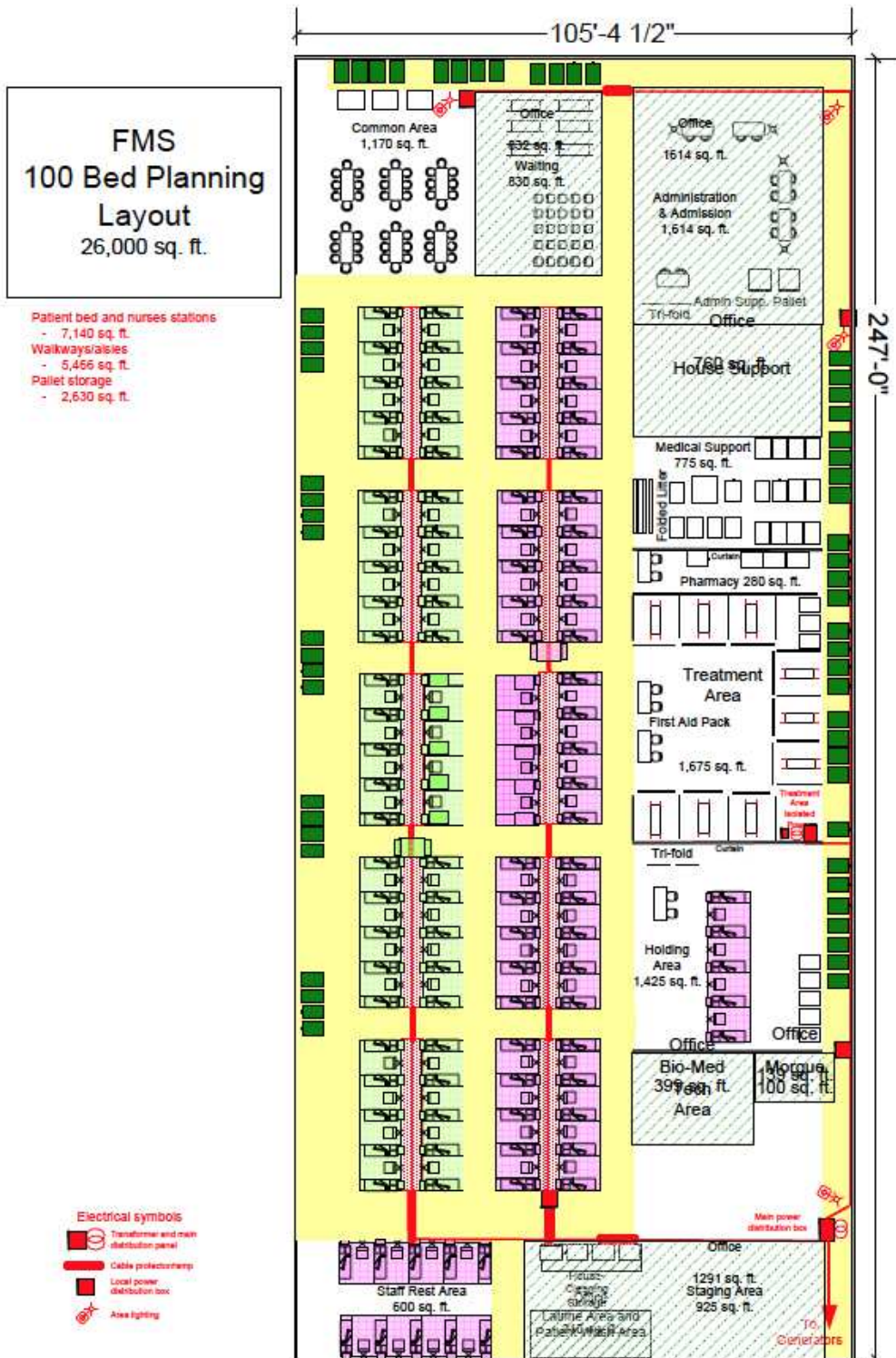
Planning Layouts

The following three pages show the layouts for 50, 100, and 250 bed FMSs.

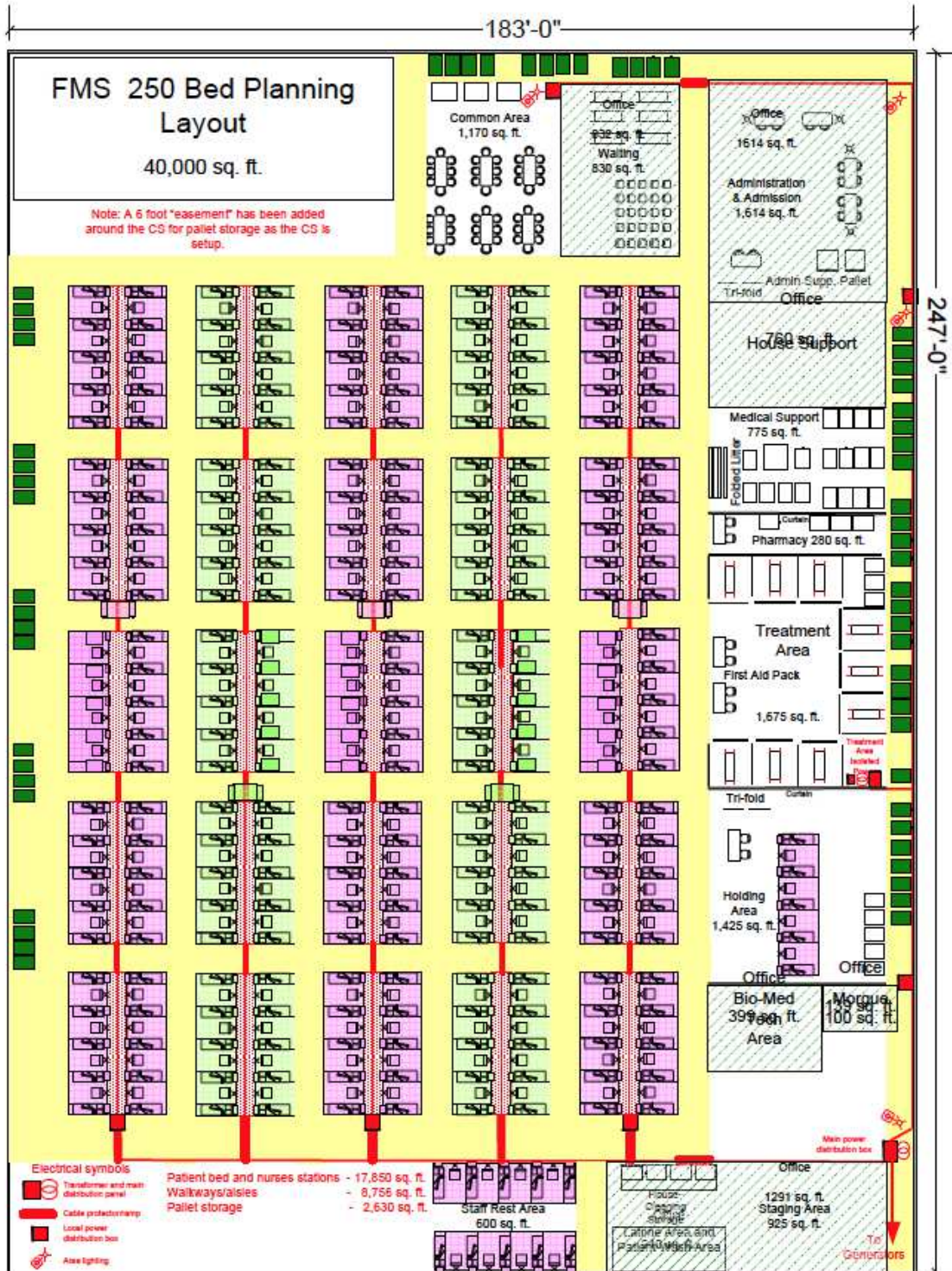
50-Bed Planning Layout Diagram



100-Bed Planning Layout Diagram



250-Bed Planning Layout



Attachment C – Recommended Supplies and Equipment for an Alternate Care Site

Estimated type and amount lists of ACS supplies have been developed by the U.S. Army Soldier and Biological Chemical Command (SBCCOM). These lists are contained in their document titled, “The Concept of Operations for the Acute Care Center” which was used to create the following tables which will provide a good sampling of equipment and supplies that the Department may be called upon to supply for ACS operations (50-bed application).

Equipment Considerations for Alternate Care Site: 50-Bed Unit

Equipment	Infectious	Non-Infectious	Quarantine
Automatic External Defibrillator	1	1	1
Beds/Cots (with extra)	52	52	52
Chairs correlation with staffing level	12	12	4
Desks correlation with staffing level	6	6	2
Fax Machine	1	1	?
Housekeeping Cart with supplies	1	1	1
Internet Email Access	1	1	1
IV Poles	50	50	0
Linens (sheets/pillows/pillow cases/hand towels/ bath towels)	100	100	100
Patient Commodes	4	4	1
Pharmacy Carts	2	2	1
Privacy Dividers	25	25	25
Refrigerators (food/meds)	3	3	1
Stretchers	2	2	0
Supply Carts	3	3	1
Telephones	5	5	5
Treatment Carts	2	2	0
Washing Machine	1	1	1
Wheelchairs	2	2	1

Patient Care-Related Consumables: 50-Bed Unit

Item Description	Calculations of Quantities	Total Item Count	Unit of Measure	Total
Alcohol pads (multiple widespread use)	2-4 Boxes per 24 hours	14-28	Box	1 Box
Catheters, intraosseous module blue (pediatric use)	May use 1/day max.	6-7/wk of 1 standard size	Each	7 Each
Intermittent IV access device (lock)	50 pts initially (first day) then 10%	250/wk	50/Box	5 Boxes
IV catheters, 18g with protectocath guard	40% of pts req IVs	150/wk	50/Box	3 Boxes
IV catheters, 20g with protectocath guard	40% of pts req IVs	150/wk	50/Box	3 Boxes
IV catheters, 22g with protectocath guard	10% of pts req IVs	25/wk	50/Box	0.5 Boxes
IV catheters, 24g with	10% of pts req	25/wk	50/Box	0.5 Boxes

protectocath guard				
IV fluid bags, NS, 1000cc (required by 60% of patients)	(50% of pts(25)/day x 3L/pt)x	315 L/wk	12/Case	18 Cases
IV fluid bags, D5 1/2NS, 1000cc (required by 40% of patients)	(50% of pts(25)/day x 3L/9t)x	210 L/wk	12/Case	18 Cases
IV start kits	Same # as intermittent access device	60	25/Box	2.5 Boxes
IV tubing w/ Buretrol drip set for peds	10% peds/wk	25/wk	20/Case	1.25 Cases
IV tubing w/ standard macrodrip for adults	Same # as intermittent	250/wk	48/Case	5 Cases
Needles, Butterfly, 23g	10% peds/wk	25/wk	50/Box	0.5 Boxes
Needles, Butterfly, 25g	10% ped/wk	25/wk	50/Box	0.5 Boxes
Needles, sterile 18g	1 box/day	7 boxes/wk	100/Box	7 Boxes
Needles, sterile 21g	1 box/day	7 boxes/wk	100/Box	7 Boxes
Needles, sterile 25g	1 box/day	7 boxes/wk	100/Box	7 Boxes
Syringes, Various sizes	3 boxes/day	21 boxes/wk	100/Box	21 Boxes
Saline for injection 10cc bottle	50 bottles/day	350 bottles/wk	24 /Box	14.5 Boxes
ABD bandage pads, sterile	10% pf [ts/day = 5 pads/day+35 pads/wk	7 boxes/wk	50/Box	7 Boxes
Band-Aids	1 box/day	7 boxes/wk	50/Box	7 Boxes
Basins, bath	20 pts/day	140/wk	100/Case	1.5 Cases
Bathing supply, prepackaged (e.g.Bath in a Bag (TM))	50 pts every day	350/wk		350
Bedpans – regular	40 pts/day initially then 10%	65/wk	50/Case	1.25 Cases
Toilet Paper	25 rolls/day	175 rolls/wk		175 Rolls
Blankets	50 pts/day; changed daily	50/day or 350/wk		350/Week
Carafes - 1 liter (for variety of uses)	30/day	210/wk		210/Week
Cart, supply	3/unit (1 for IV's;1 for Pt	3/unit		
Chux protective pads (many uses)	3/pt q3hrs = 24 chux/pt/day x 50 pts + 1200/day	8400/wk	50/Box	168 Boxes
Cots (have extras available to replace broken equipment)	50/unit plus 2 extra	52/unit		52/Unit
Curtains, privacy (wheeled)	25 (every other bed)	25/unit		25/Unit
Diapers – adult	10/day	70/wk	72/Case	1 Case
Diapers – infant	8/day/infant x 5 infants/day	280/wk	144/Case	3 Cases
Diapers – pediatric	5/day/ped x 5 peds/day = 25/day	175/wk	144/Case	1.25 Cases
Emesis basins	100/wk	100/wk	250/Case	0.5 Case
Facial tissue, individual patient box	1 box/pt/day	350 boxes/wk	200 Boxes	1.75 Cases
Feeding tubes, pediatric - 5 French	10/wk	10/wk	10/Box	1 Box

-8 French	10/wk	10/wk	10/Box	1 Box
Nasogastric Tubes (adult and child sizes)	10/wk	10/wk	10/Box	1 Box
Foley Catheters - 16F Kits (includes drainage bag)	>50% of pts wk	100/wk	10/Case	10 Cases
Gloves non-sterile, small/medium/large (latex and non latex)	6 boxes/day	42 boxes/wk	100/Box	42 Boxes
Goggles / face shields, splash resistant, disposable	6 boxes/day	42 boxes/wk	100/Box	42 Boxes
Gown, splash resistant, disposable	3/staff/shift = 36/day	252/wk	Box	42 Boxes
Mask, N95, for staff (particulate respirator)	36/day	252/wk	210/Case	1.2 Cases
Gown, patient	75/day	525/wk		
Mask, 3M 1800 for patient	150/day	1050/wk		
Gauze pads, non-sterile, 4x4 size,	400/day	2800/wk		
Hand cleaner, waterless alcohol-based	1 per handwash station/day x	28/wk	25 Bottles/Case	1 Case
Paper Towels	25 rolls/day	175 rolls/wk		175 Rolls
Lubricant, Water soluble		1-2 boxes wk	25 Boxes	0.5 Boxes
Medicine cups, 30ml, plastic	2/pt/day = 100/day	700/wk		700/Week

Administrative Consumables: 50-Bed Unit

Item Description
Pens – Black ballpoint
Pens – Red ballpoint
Stapler
Staples
Tape
Tape dispenser
Paper clips
Paper punch (3- or 5-hole based on chart holders)
Chart holders/Clip boards
File Folders - letter size, variety of colors
Name bands for Identification and Allergies
Batteries – 9V
Batteries – AA
Batteries – C
Batteries – D
Clipboards
Chalk or white boards
Dry-erase markers
Chalk
Trashcans and liners
Flashlights
Plastic bags for patient valuables

Floor lamps
Table lamps
Light bulbs
Plain paper
Filing cabinets – rolling
Black permanent markers
Yellow highlighter markers
Time cards
Generic sign-in, sign-out forms
Pre-printed admission Order forms
Blank physician order forms
Multidisciplinary progress notes
Nursing flow sheets
Admission history & physical forms (include area for Nrsg Hx)
Death certificates/Death packets

Oxygen and Respiratory-related Equipment Considerations: 50 Bed Unit

Item Description	Quantity
Bag-Valve-Mask w/adult and peds masks – adult 1600 ml reservoir	1
Cascade gauge for oxygen cylinders	14
Catheters, suction	20
Connector, 5 in 1	8
Cylinder holders for E Cylinder oxygen tanks	4
Mask, oxygen – non-rebreather, pediatric	10
Mask, oxygen – nonrebreather, adult	20
Nasal cannula, adult	40
Nasal cannula, pediatric	10
Nebulizer	1
Regulator, Oxygen (Flow meter)	14
Suction unit – Collection System	2
Suction unit – Portable	1
Suction unit Battery	1
Tank, Oxygen "E" cylinder (700 L O2)	4
Tank, Oxygen "H" cylinder (7000 L O2)	10
Tubing, oxygen – with connector	40
Tubing – suction, connector	10
Tubing, suction, 10F	10
Wrench, Oxygen tank	2
Yankaur Suction Catheter	10
Intubation equipment with oral airways/ET tubes; adult & peds	1 set
Ventilators	1

NOTES: Tables above Adapted from *The Concept of Operations for the Acute Care Center*, Appendix E, the U.S. Army Soldier and Biological Chemical Command (SBCCOM), 2003.

Given that primary ACS use usually centers on the provision of care to those with “minor” injuries, most ACS operations will not involve the use of oxygen therapy.

Attachment D – Acronyms

ACS	Alternate Care Site
AHCA	Agency for Healthcare Administration
AHRQ	Agency for Healthcare Research and Quality
ALF	Assisted Living Facility
ALS	Advanced Life Support
AMTS	Alternative Medical Treatment Site
ASPR	Assistant Secretary for Preparedness and Response
BLS	Basic Life Support
CDC	Centers for Disease Control
CEMP	Comprehensive Emergency Management Plan,
CERT	Community Emergency Response Team
CHD	County Health Department
DEM	Division of Emergency Management
DHHS	Department of Health and Human Services
DOD	Department of Defense
DSNS	Division of Strategic National Stockpile
ECO	Emergency Coordinating Officer
EM	Emergency Management
EMAC	Emergency Management Assistance Compact
EMS	Emergency Medical Services
EMTALA	Emergency Medical Treatment and Labor Act
ESARVHP	Emergency System for Advance Registration of Volunteer Healthcare Professionals
ESF	Emergency Support Function
FAST	Florida Advanced Surgical and Transport Team
FDOH	Florida Department of Health
FEMORS	Florida Emergency Mortuary Response System
FMS	Federal Medical Station
HVAC	Heating Ventilation Air Conditioning
IMT	Incident Management Team
LEOC	Local Emergency Operations Center
MHE	Materiel Handling Equipment
MMRS	Metropolitan Medical Response System
MRC	Medical Reserve Corps
NDMS	National Disaster Medical System
RERA	Regional Emergency Response Advisor
RDSTF	Regional Domestic Security Task Force
SEOC	State Emergency Operations Center
SERVFL	State Emergency Responders and Volunteers of Florida
SMRS	State Medical Response System
SMRT	State Medical Response Team
SNF	Skilled Nursing Facility
SNS	Strategic National Stockpile
SOG	Standard Operations Guideline
SOP	Standard Operations Procedure
START	Simple Triage and Rapid Treatment
USPHS	United States Public Health Service
VA	Veterans Administration

Attachment E: References

Agency for Healthcare Research and Quality ACS Selection Matrix

http://archive.ahrq.gov/research/altsites/altmatrix1_final.htm

FDOH Alternative Care Site Operational Guidance

<http://www.doh.state.fl.us/demo/bpr/PDFs/AMTSPlan2008.pdf>

Florida Hospital Beds and Services List (AHCA)

http://ahca.myflorida.com/MCHQ/CON_FA/Publications/docs/HospBedSrvList/Jul2012_HospitalBedsandServicesList.pdf

EMTALA Requirements and Options for Hospitals in a Disaster

http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/downloads//SCLetter09_52.pdf

ACS Fact Sheet – Hospital ACSs During H1N1 Public Health Emergency

<http://www.cms.gov/About-CMS/Agency-Information/H1N1/downloads//AlternativeCareSiteFactSheet.pdf>

Advanced Registration of Volunteer Healthcare Professionals

<http://www.phe.gov/esarvhp/pages/about.aspx>

State Emergency Responders and Volunteers of Florida

<https://www.servfl.com/>

FDOH Alternative Care Site Local Plan Development Guide

<http://www.doh.state.fl.us/demo/bpr/PDFs/AMTSLocalPlanDevelopGuide.pdf>

National Disaster Recovery Framework

<http://www.fema.gov/pdf/recoveryframework/ndrf.pdf>

National Response Framework

<http://www.fema.gov/pdf/emergency/nrf/nrf-core.pdf>

Florida Department of Health Plans and Annexes

<http://www.doh.state.fl.us/demo/BPR/bprdocumentation.htm>

Surge Hospital: Providing Safe Care in Emergencies

http://www.jointcommission.org/Surge_Hospital_Providing_Safe_Care_in_Emergencies/

Disaster Alternate Care Facilities: Report and Interactive Tools

<http://archive.ahrq.gov/prep/acfselection/dacprep.htm>

Hospital Information – Agency for Healthcare Administration (AHCA)

<http://www.floridahealthfinder.gov/CompareCare/ListFacilities.aspx>

Medical Surge Capacity and Capability: A Management System for Integrating Medical and Health Resources During Large-Scale Emergencies

<http://www.phe.gov/Preparedness/planning/mscc/handbook/Documents/mscc080626.pdf>

Attachment F – **Alternate Care Site Training Plan**

Training and exercise activities associated with this SOG are aligned with the current FDOH *Multi-Year Preparedness Training and Exercise Plan*, as well as current related Department and federal guidance and requirements. Included are:

- Annual local ACS plan tabletop exercises
- State ACS Full-Scale exercises
- Online familiarization training on ACS operations
- Hospital facility internal medical surge exercises
- Webinars for specific discipline ACS familiarization
- Training on associated plans and annexes with an ACS component

Attachment G - Record of Review and Approval

Prepared by: Terry L. Schenk, FDOH Bureau of Preparedness and Response

Reviewed by:

- Bobby Bailey, FDOH Bureau of Preparedness and Response
- Melanie Black, FDOH Bureau of Preparedness and Response
- Tom Belcuore, FDOH Bureau of Preparedness and Response
- Samantha Cooksey, FDOH Bureau of Preparedness and Response
- Kay Croy, FDOH Bureau of Preparedness and Response
- Dr. Russell W. Eggert, FDOH Bureau of Preparedness and Response
- Dr. Brad Elias, FDOH Bureau of Preparedness and Response
- Jon Erwin, FDOH Bureau of Preparedness and Response
- Richard McNelis, FDOH Assistant General Counsel
- Sonia McNelis, FDOH Bureau of Preparedness and Response
- Sandra Schoenfisch, FDOH Bureau of Preparedness and Response

Approved by: Mike McHargue,
Emergency Coordination Officer
Bureau of Preparedness and Response
April 11, 2013

Signature of approval On file