



ALTERNATE CARE SITE GUIDANCE

Alternate Care Site Operations Guide



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*Cover Photo: Iowa State University gym used as an Alternate Care Site during the flu epidemic of 1918.
Image courtesy of University Archives, ISU Library.*

EXECUTIVE SUMMARY

Over the past 10 to 15 years, the U.S. has experienced disasters such as Hurricane Katrina, Hurricane Sandy, the H1N1 pandemic, and other large-scale emergencies. It has become clear that medical surge is a major issue that must be addressed during such emergencies. The Florida Department of Health, therefore, has taken a number of steps to help local communities prepare for the operation of one medical surge solution, alternate care sites (ACS). Included are planning tools, online training modules, exercises, response resources, and guidelines such as this *Alternate Care Site Operations Guide*. This

guide has been designed to serve as a planning *and* operational resource. Guides such as this are often hundreds of pages long; however, in order to make this guide most useful, it has been limited to the key concepts and practices for ACS operations. Additionally, to provide even more concise guidance, a “*Quick Start*” guide has been added to the Appendix section to facilitate rapid implementation of an alternate care site.



An alternate care site set up at the Pete Maravich basketball arena, Louisiana State University, for Hurricane Katrina. 2005 - Photo courtesy of LSU

Guiding Principles

The following “guiding principles” have been used in the development of this ACS guide, and many of the principles can be applied to the *operation* of an ACS:

- All steps and actions taken during the planning and operational phases of an ACS shall **focus on patient care**. A **positive outcome for the patient** is *the* highest priority.
- This guide has not been designed as a “shelf” document, but rather an **operational guide** that will help to foster a rapid and effective response in the event of a catastrophic disaster. The overall guide includes a sub-guide (see Appendix for the ACS “*Quick Start*” Guide) that is operationally-focused, and condensed for quick field access and use.
- **Simplicity** has been a major guiding principle in the development of the guide to enhance its adoption and use.
- The guide has been designed to be **aligned with everyday operations** as much as possible to ensure a smooth operation during times of crisis.
- The guide has been designed primarily for **terrorism scenarios**, but is also adaptable for “**all hazards**” application.
- In keeping with good emergency management practices, (and the national mandate calling for utilization of the National Response Framework [NRF] and the use of National Incident Management System [NIMS]) the guide **incorporates the latest standards of incident management**.
- The guide has been developed through **consensus among key stakeholders and constituency groups**. This process is also critical in establishing an ACS, 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 will play in the establishment and operation of an ACS.
- The guide **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 guide is designed to **meld with other appropriate health and medical incident response plans**.

INTRODUCTION

Background

One of the key issues in medical disaster situations is the need to address medical surge. This has been demonstrated in previous situations our nation has faced, including the Spanish Flu pandemic of 1918, as well as more recent events like Hurricane Katrina in 2005. In these situations, one part of the solution to handling an excess of patients has been the use of alternate care sites. Such sites serve to free up hospitals (especially emergency departments) so that the more critical patients can be treated in those facilities.

Such sites can 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 stage for transport, patients who are victims of a disaster. This “interim” treatment facility concept is gaining nationwide acceptance, and is high on the list of federal priorities for healthcare system preparedness. The development of a local ACS plan, and then operationalizing the plan when a disaster strikes, can provide a significant solution to medical surge. This guide can serve as a resource to help communities initiate, operate, and demobilize an alternate care site established to help alleviate medical surge impact.

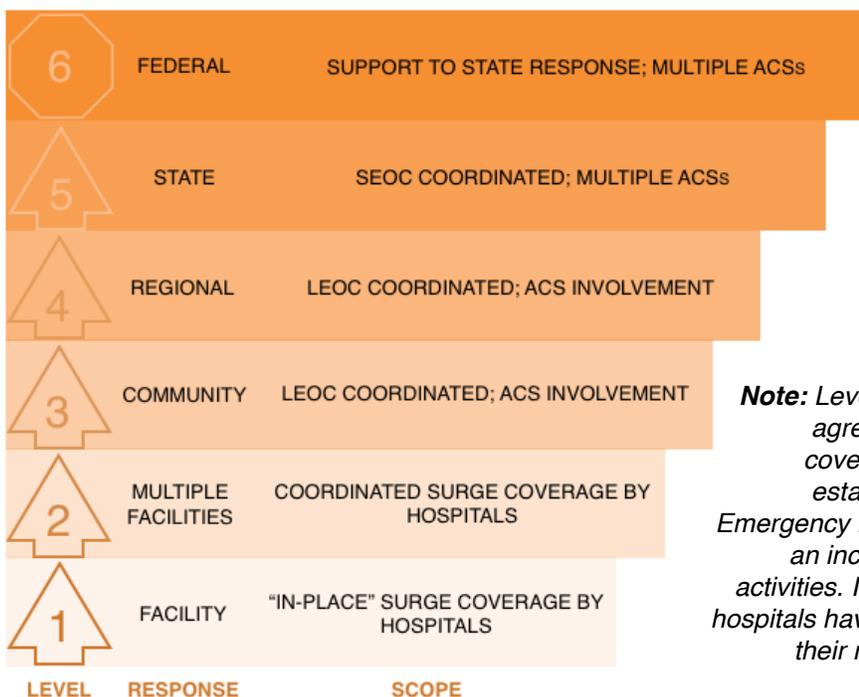
Purpose

The purpose of this guide is to identify the process and procedures whereby local jurisdictions, with State and Federal assistance as needed, can plan for and implement alternate care sites as part of their response to medical surge situations caused by terrorism or “all hazard” incidents.

Scope

In the State of Florida, alternate care site establishment and operation lies with local jurisdictions. This task will be a coordinated effort between *hospitals* and the *community*, with local Emergency Management serving in a coordination role. The scope of service provided will be dependent upon the type of situation causing the medical surge (i.e. a natural disaster, terrorism incident, pandemic, etc.). While the intended scope of *medical care* should be the treatment of minor illnesses/injuries, (thus freeing the hospital emergency departments to treat more seriously ill or injured patients) some capability will have to be in place to temporarily deliver a greater level of medical care, should the need arise. The scope of this document is to provide guidance to local communities on ACS operations.

If ACS establishment/assistance is required from the State, assistance guidelines and procedures can be found in the Florida Department of Health’s *Alternate Care Site Standard Operating Procedure* located at: http://www.floridahealth.gov/programs-and-services/emergency-preparedness-and-response/preparedness-planning/_documents/alternate-care-site-sop.pdf



Surge Response Levels

The methods used to handle patient surge generated by a large-scale emergency or disaster will be dependent upon the type of scenario presented. These methods can be divided into six surge response levels, as shown at left.

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

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.
4. Especially in cases of terrorism, victims may be contaminated, necessitating decontamination prior to treatment, and their admission to a hospital facility. It is imperative that hospitals remain uncontaminated so that they can deal with not only more seriously injured victims of an incident but also with routine medical emergencies that occur on a daily basis.
5. Hospitals can expect to receive casualties directly from the scene (self-transport) 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. In order to decontaminate, triage, treat, and transport patients, a timely and effective mass casualty management system must be implemented.
7. 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.
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 psychophysiological patients in such disasters.
10. One solution to deal with the large numbers of people requiring medical assistance is to establish an alternate care site to handle 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, alternate care sites will be established *through* local emergency management.
12. Local county health departments will play an integral role in the establishment and operation of an alternate care site.
13. Most patients and their families will view alternate care sites as “short-term” treatment facilities, and will expect treatment in a hospital as soon as possible.
15. A high level of cooperation and coordination among various agencies will be necessary to establish an alternate care site, and to operate it in an effective and efficient manner.
16. In order to have the capacity to deal with more seriously injured victims, hospitals may, after assessment, need to transfer patients with “minor” injuries *to* an alternate care site.

17. In situations that are regional, state, or national in scope, a local ACS may need to operate somewhat independently for the first 72 hours before outside assistance can be provided. Additionally, if the scope of the disaster is large, multiple alternate care sites may be needed.
18. 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 that they can provide continuing assistance to patients.
19. 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”.
20. The scope of the incident may be such that State or even Federal resources will be required to establish, enhance, or replicate an alternate care site.
21. A significant issue in large-scale ACS operations will be the increase in staffing needed for such sites, and for the hospital receiving facilities.
22. A well-organized command structure will be needed to efficiently and effectively manage an alternate care site operation.

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 ACS guide is a part of or complements these plans or annexes. This includes, but is not limited to, the:

- Comprehensive Emergency Management Plan
- ESF 8 Public Health and Medical Services Annex
- Public Health and Medical Response Plan
- Numerous other plans, guides, annexes, etc.

Please see the Florida Department of Health’s website for information on these, as well as other key plans and applicable documents.

<https://www.floridahealth.gov/community-environmental-public-health/emergency-preparedness-response/preparedness-planning/>

Pre-Incident Planning

In order for an ACS 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 ACS. The regional Healthcare Coalition (HCC) can be of assistance with this task.
2. Pre-arranging the necessary approval process for initiating an ACS. This may involve action by the local political body.
3. Pre-identifying structures or locations in the community which could serve as an ACS facility. This is an essential step to getting an ACS quickly operational.
4. Pre-arranging Memorandums of Understanding (MOU) with facilities that may be used as an ACS.
5. Forging agreements with health and medical service providers to supply personnel to help staff an ACS.
6. Pre-qualifying key personnel to serve in ACS command positions.
7. Stocking command vehicles with laminated *Quick Start* guides for establishing an ACS. (See Appendix section for a copy of this document)
8. Establishing call lists in communication centers (or pre-programming automatic dialers) for personnel/ agency notification when an ACS is initiated.
9. Identifying the procedures to follow, and the contact numbers to use for requesting various specialized response teams and resources available throughout the State.
10. Training personnel in various subjects relating to the operation of an ACS including incident command, triage, treatment, establishing an ACS, decontamination of patients, etc.
11. Conducting drills to exercise personnel in the establishment and operation of an ACS.
12. Pre-establishing agreements with law enforcement agencies to provide security (on short notice) for the ACS.
13. Pre-establishing agreements with meal providers so that 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 Go Packs" that would include a list of procedures and protocols, incident command worksheets, triage tags, vests, checklists, position task sheets, forms, etc. to use in quickly getting an ACS operational.
16. Preparing for quick acquisition and transport of specialized medical equipment to the ACS.
17. Pre-identifying the layout of an ACS for particular sites that are likely to be used.

18. Pre-identifying funding sources for various types and levels of ACS operation will come from. This may require a tiered approach to determine the appropriate scope (local, State or Federal).
19. Creation of checklists so that tasks are easily identified and assigned when the decision is made to open an ACS. This would include the development of job responsibility sheets for each position in the command structure.

Key Stakeholders

Planning for, establishing, and operating an ACS successfully will require a cooperative effort among a variety of constituent groups and stakeholders. This would include, but is not limited to:

- Emergency Medical Services
- Fire Departments
- Emergency Management
- Hospitals and other healthcare facilities
- Local, State, and Federal Public Health Departments
- Law Enforcement
- Various local government agencies
- Healthcare Coalitions
- Volunteer organizations including the Medical Reserve Corps, American Red Cross, Salvation Army, etc.
- Special teams including State Medical Response System (SMRS) assets, hazmat, etc.
- Mental health agencies
- Faith-based community

The chart on page 5 explains various roles community partners / key stakeholders can play. This chart is also featured in the *ACS Quick Start Guide*.

AGENCY	ROLE(S)
HOSPITALS	treatment, staffing, supplies, facilities, pharmaceuticals
COMMUNITY EMERGENCY CLINICS	treatment of Yellow- and Green-tagged patients
COUNTY HEALTH DEPARTMENT	staffing, coordination, public health issues
FIRE DEPARTMENT / EMERGENCY MEDICAL SERVICES	transport, temporary staffing, patient decontamination
PRIVATE AMBULANCE SERVICE	transport
MEDICAL EXAMINER'S OFFICE	fatality assistance
LOCAL TRANSIT COMPANIES	large-scale transport
MEDICAL RESERVE CORPS	staffing
COMMUNITY EMERGENCY RESPONSE TEAMS	non-medical staffing
SALVATION ARMY	volunteers, feeding assistance
AMERICAN RED CROSS	feeding assistance, volunteers, facility operations
LOCAL NON-PROFIT AND FAITH-BASED ORGANIZATIONS	volunteers, facilities, supplies
LAW ENFORCEMENT	ACS security, enforcement of isolation/quarantine patients, traffic control, investigation
PRIVATE SECURITY AGENCIES	ACS security
SCHOOL DISTRICTS	facilities for ACS, transportation, kitchen facilities
COLLEGES AND UNIVERSITIES	facilities, staffing from medical disciplines
PRE-SCHOOL AND NURSERY SCHOOLS	child care
CELL PHONE SERVICE PROVIDERS	phone bank, communications, Internet service
LOCAL POWER PROVIDERS	infrastructure support
CABLE TV PROVIDERS	communications
LOCAL TV STATIONS	communications
PUBLIC WORKS / ROAD DEPARTMENTS	sanitation, facility ingress / egress
LOCAL AND REGIONAL AIRPORTS	facilities, transportation, APOE / APOD areas
VETERINARY AGENCIES AND OFFICES	staffing, pet care assistance, animal housing
MILITARY	facilities, staffing, transportation, security
LARGE COMMUNITY BUSINESSES (WALMART, SAM'S, COSTCO, LOWES, HOME DEPOT)	supplies
REGIONAL SMRS ASSETS	ACS start-up and operation
FLORIDA DEPARTMENT OF HEALTH	State Medical Response System assets, support, logistical supply, behavioral health assistance
FEDERAL	Federal Medical Station (FMS), support

Triggers

As identified in the *Alternate Care Site Local Plan Development Guide*, it is important to have triggers in place for the initiation of an ACS. While each community will have to develop their own set of *triggers* for ACS initiation, some general guidelines for instituting an ACS are as follows:

- 1) The incident is of such magnitude that it is a foregone conclusion that medical surge will be a significant problem for hospitals, and that alternate care sites will need to be established.
- 2) The incident involves contaminated patients that not only need to be assessed and treated, but also decontaminated prior to being admitted to a hospital.
- 3) The closest hospital, or even closest *several* hospitals, are being surged beyond their capacity, and internal surge plans implementation will not take care of the problem.
- 4) An incident is of such magnitude that the establishment of an ACS on-site or near the incident is preferable to transporting large numbers of Green-tagged patients.
- 5) The incident is a pandemic or other situation that is impacting multiple communities, negating significant help from other jurisdictions.
- 6) The incident is a mass casualty incident that meets pre-determined Mass Casualty Incident (MCI) Plan criteria for ACS implementation.
- 7) Normal facilities are no longer operational due to the incident (such as a hurricane strike that closes multiple hospital facilities), necessitating alternate locations for treatment.

Again, each community will need, in their ACS Plan, to develop their own criteria for establishing an ACS or multiple ACSs. In addition to using criteria for ACS implementation, a group of decision makers should be identified who have the authority, for their particular agency or responsibility area, to authorize ACS establishment. Such a group could include (but would not be limited to) the County Health Department Director, County Emergency Manager, Local Hospital Directors, Medical Director, or other key officials charged with emergency operations decision making.

AUTHORIZATION FOR ACS USE, AND EMERGENCY MEDICAL TREATMENT AND LABOR ACT (EMTALA) IMPLICATIONS

Questions often arise as to the legal authority for local jurisdictions to establish ACSs for emergency situations. Legal guidance indicates that such disaster response authorization is covered under Chapter 252 of Florida Statutes, and any Governor's Executive Orders which may be issued pertinent to the emergency.

Additionally, a great deal of latitude accrues to local political officials, such as County Commissioners, in addressing response to emergency or disaster situations.

Another question that comes up when ACSs are considered for medical surge is compliance with the EMTALA. Guidance on how this act applies to ACS operations can be found in the memorandum titled, "*Emergency Medical Treatment and Labor Act (EMTALA) Requirements and Options for Hospitals in a Disaster.*" (see link in Appendix Section C). Additional information can be found in the periodical, *Disaster Medicine and Public Health Preparedness* (Volume 3 / Supplement 2 - 2009) titled, "*Implications of the Emergency Medical Treatment and Labor Act During Public Health Emergencies and on Alternate Sites of Care.*"

Activation and Notification Scheme

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

TYPICAL SEQUENCE FOR GETTING AN ACS 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 ACS.
2. The “type” of ACS to be opened, 1, 2, 3, or 4, is decided, an appropriate ACS location / facility 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 ACS Incident Commander, and requests response of the closest SMRS assets, if setup/operational assistance is needed.
4. ACS Incident Commander and local Medical Director select the Command Staff and lead positions in the General Staff. All command personnel then report to the ACS.
5. ACS Incident Commander communicates with the scene Incident Commander, and advises when the ACS will be ready to receive patients.
6. ACS Command Post is established at the selected site.
7. ACS Incident Commander and staff (especially the ACS Logistics Chief) select areas for patient reception, decontamination, triage, treatment, logistics storage, and other key functional work areas.
8. ACS Safety Officer identifies and corrects any initial hazards.
9. Security Officer sees that the ACS is made secure and establishes check-in point for entrance into the ACS.
10. ACS staff selects and assigns other ACS organizational chart positions.
11. Communication links are established with the scene, the LEOC, and the local hospital(s).
12. Fire Department hazmat teams are requested to establish decontamination stations. Such stations may be needed at the scene, the ACS, and at the hospital(s).
13. Personnel from appropriate agencies are requested to serve as general workers in getting the ACS set up and operational.
14. Additional command structure personnel begin arriving at the ACS, and start to organize their particular aspect of the operation. They are assigned to a supervisor, and receive a briefing.
15. All personnel arriving at the ACS sign in, and are briefed prior to beginning their work.
16. Safety Officer advises personnel what level of Personal Protective Equipment (PPE) is necessary, sees that the equipment is issued, and oversees compliance.
17. Planning looks at the staffing needs for the ACS, and determines staffing sources. An assessment is made as to whether SMRS 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 layout of the physical structure of the ACS, 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 ACS perimeter.

TYPICAL SEQUENCE FOR GETTING AN ACS OPERATIONAL

21. All personnel consult pre-designated checklists for tasks and responsibilities of their particular area.
22. Medical Director and Triage Officer obtain the latest information from the hospitals 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 for internal communications. Additionally, a list of phone numbers for personnel and agencies is formulated and distributed.
24. Finance / Administration establishes a staff check-in / check-out procedure.
25. Planning establishes a patient check-in, tracking, and check-out procedure.
26. Logistics works to acquire food and beverage supplies for ACS patients and staff.
27. Initial patients begin arriving at the ACS. *
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 the ACS.
30. Planning continues assessment of the need for additional personnel, and works to acquire the necessary staffing for the ACS. 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 ACS.
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 ACS.

NOTE

** It should be noted that feedback from several exercises involving the use of ACSs 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 ACS can be as 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 ACS to handle the patient load. The Planning Section should monitor this closely, and provide guidance to the ACS Incident Commander on the need for additional facilities.*

ACS ACTIVATION

Typing Matrix

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

1. Term of operation (long, medium, short, MCI extension)
2. Anticipated duration (in hours) of ACS 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

This ACS Typing Matrix provides insight into the various levels of ACS operation, resources needed, patient numbers, and timeframes involved.

	TYPE 3 ACS	TYPE 2 ACS	TYPE 1 ACS
TYPE 4 ACS			
MCI RESPONSE - EXTENSION < 8 HOURS	SHORT TERM 8 - 24 HOURS	MEDIUM TERM 16 - 36 HOURS	LONG TERM > 36 HOURS
< 500 PATIENTS	> 500 PATIENTS	> 1000 - < 1500 PATIENTS	> 1500 PATIENTS
EXAMPLE NATURES: transportation accident building collapse industrial accident LOGISTICS: Single SMRT TEAMS: Local Regional	EXAMPLE NATURES: bomb burn blast decontamination situation LOGISTICS: 2 SMRTs Regional assets TEAMS: Local Regional SMRT	EXAMPLE NATURES: decontamination situation radiological biological LOGISTICS: Multiple SMRTs Regional assets State assets TEAMS: Local Regional SMRT Hospital staff	EXAMPLE NATURES: Pan Flu significant respiratory major disaster LOGISTICS: Multiple SMRTs Regional assets State assets Federal assets TEAMS: Local Regional SMRT / DMAT Hospital staff Non-traditional medical personnel

Timing

To be of greatest value, an ACS 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 timeframe even if it does not have all of the components in place. In other words, an ACS 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 ACS assembled their response resources at their own agency, and then reported to the ACS. This will limit confusion at the ACS when multiple agencies are summoned for assistance.

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 ACSs to manage a large number of casualties, and keep hospitals from being overwhelmed with patients. As such, an ACS should be prepared to treat from **10 to 50 patients per hour**, or **120 to 600 patients over a 12 hour period**.^{*} If a single ACS is inadequate to deal with this level of throughput (which may be likely if significant decontamination or lengthy treatment becomes a reality), then multiple ACSs 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 ACS. This makes it critically important for planning and operational managers to foster an immediate response of a large number of ACS 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. Numbers will also vary according to resources available with small/rural operations trending towards the lower end of the scale, and large/urban operations trending towards the upper end of the scale. The estimated throughput is also based on the provision of “minimal” treatment (treatment of Green-tagged patients).*

ACS ESTABLISHMENT

Patient Criteria

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

- Green-tagged patients
- People who do not have critical injuries
- Psycho-physiological patients (no *physical* injuries)
- People who “self admit” themselves to an ACS for minor care

- Patients sent to an ACS 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 Red-tagged or Yellow-tagged, 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 ACS would have to assess and treat these categories of patients until a hospital is ready to accept them.

Considerations

Factors that need to be considered by emergency management and health officials in making the decision to open up an ACS 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 ACS 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 ACS if the hospitals are impacted by the incident, either directly or via contamination

Facility Selection

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

1. A facility large enough to accommodate ACS components, including the operational aspects of decontamination, triage, and 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 sector 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/or food distribution
14. An open area that could serve as a landing zone for helicopters

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 ACS. 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 ACS, 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 ACS, 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.

Additional Options for Ancillary Sites

One consideration for situations where a Type 1 ACS is opened, and medical conditions of the Red- or Yellow-tagged patients 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 ACS. 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 eighteen-wheel trucks. These types of resources 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 six 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)

ACS ORGANIZATION

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 ACS 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 an event that precipitates the need for an ACS, the key players should already be assembled in the LEOC under their emergency support function (ESF) categories, and should be available to initiate and support the operation of an ACS.

To further organize for utilizing ACSs 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.

Organizational Structure

To establish and operate an ACS, 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 (ICS). This approach 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 ICS organizational structure, an ACS would have both Command Staff and General Staff positions. Positions assigned in the Command Staff section would include:

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

Lead positions in the General Staff section would include:

- ACS Planning Chief
- ACS Operations Chief
- ACS Logistics Chief
- ACS 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)
- Resources 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 ACS Incident Commander has the latitude to expand, shrink, or modify the organizational structure of the ACS but should stay within the guidelines of the system for consistency and standardization. The sample structure shown on the next page does not include Branches or Divisions/Groups, but in a large ACS, they may be necessary. (see organizational chart on page 13)

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, local plans should adopt, incorporate, and follow 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. Chapter 10 is directly applicable to ACS operations and should be referenced when an ACS is established. (see link in Appendix Section C)

INCIDENT COMMANDER

COMMAND STAFF	GENERAL STAFF
Safety Officer	Planning Chief
Liaison Officer	Operations Chief
Public Information Officer	Logistics Chief
ACS Medical Director	Finance / Administration Chief

GENERAL STAFF

PLANNING CHIEF	OPERATIONS CHIEF	LOGISTICS CHIEF	FINANCE / ADMIN. CHIEF
Laboratory Unit Leader	Triage Unit Leader	Resources Unit Leader	Cost Unit Leader
Medical Intelligence Unit Leader	Decontamination Unit Leader	Ground Transportation Unit Leader	Procurement Unit Leader
Staffing Unit Leader	Security Unit Leader	Communications Leader	
Credentialing Unit Leader	Transportation Unit Leader	Facilities Unit Leader	
Reunification Unit Leader	Morgue Unit Leader	Supply Unit Leader	
Volunteer Resources Unit Leader	Treatment Unit Leader	Food Unit Leader	
Patient Tracking / Records Unit Leader	Physicians		
	Nurses		
	Certified Nursing Assistants		
	Emergency Medical Technicians		
	Respiratory Therapists		
	Paramedics		
	Professional Assistants		
	Medical Clerks		
	Medical Assistants		

Position Responsibilities

Each position in the organizational structure of an ACS 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 ACS operational quickly and effectively. Specific duties for each position need to be developed so that prepackaged checklists can be created, and included in ACS “Command Go Packs.”

Command Staff

ACS Incident Commander

The ACS Incident Commander is responsible for directing the ACS 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 ACS.

ACS Medical Director

The ACS Medical Director is responsible for providing medical direction, and top level medical decision making for the ACS. 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.

ACS Safety Officer

The job of the ACS Safety Officer is to monitor the ACS 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, in monitoring hazard areas such as decontamination stations, triage areas, etc.

ACS Liaison Officer

The establishment and operation of an ACS will require cooperation and coordination among a number of different agencies. The ACS 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 ACS.

ACS Public Information Officer

When an ACS is established, it will be a media event. Media will be seeking information on all aspects of the ACS service, so it is crucial to have an ACS Public Information Officer in place to address their needs. Additionally, there will be information that the Command Staff of the ACS 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. Also, if a Joint Information Center (JIC) is created for a large-scale incident, the ACS PIO should be included.

General Staff

ACS Operations Chief

The Operations Chief is responsible for overseeing the operational aspects of an ACS. 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 to address security issues.

ACS Planning Chief

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

ACS Logistics Chief

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

ACS Finance / Administration Chief

The Administration / Finance Chief is responsible for the documentation and cost aspects of the ACS. The position is responsible for accounting for personnel hours, tracking costs, facilitating the purchase of goods and services required to run the ACS, 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 decon stations, decontamination of patients, protection of personnel, control of runoff, and disposal of / or decon of equipment.

Triage Unit Leader (Operations)

The Triage Unit Leader oversees the triage and re-triage of patients arriving at the ACS, 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 oversees the transport of patients to hospital facilities, and maintains contact with hospitals so that 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 ACS. This includes coordinating the efforts of law enforcement personnel, ensuring internal security, protecting patients and staff, securing the perimeter of the ACS, and carrying out the details identified in the Security section of the plan located on pages 24-25.

Morgue Unit Leader (Operations)

The Morgue Unit Leader is responsible for the establishment and operation of a temporary morgue at the ACS, and will coordinate the efforts of additional mortuary resources summoned to the ACS.

Medical Intelligence Unit Leader (Planning)

The Medical Intelligence Unit Leader is responsible for acquiring and processing medical information for the ACS. 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 ACS 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.

Patient Tracking / Records Unit Leader (Planning)

The Patient Tracking/Records Unit Leader is responsible for tracking the patient in and out of the ACS, and for creating patient records.

Staffing Unit Leader (Planning)

The Staffing Unit Leader is responsible for forecasting the need for ACS 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 ACS are properly credentialed. This includes both paid and volunteer positions.

Volunteer Resources Unit Leader (Planning)

The Volunteer Resources Unit Leader is responsible for overseeing and coordinating the volunteer resources that are used in the operation of an ACS.

Reunification Unit Leader (Planning)

The Reunification Unit Leader is responsible for establishing and operating the Reunification Center, and for seeing that tasks associated with releasing people from the ACS are properly carried out.

Communications Unit Leader (Logistics)

The Communications Unit Leader is responsible for facilitating communications at the ACS. 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 ACS, exclusive of medical transportation 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 ACS, working with building/property representatives to maintain the facilities, and for seeing that the facility is returned to its original status when the ACS is demobilized.

Food Unit Leader (Logistics)

The Food Unit Leader is responsible for securing and distributing food and beverages to patients, and to ACS staff.

Supply Unit Leader (Logistics)

The Supply Unit Leader is responsible for acquiring and distributing all of the supplies and services necessary for ACS operation.

Cost Unit Leader (Finance/Administration)

The Cost Unit Leader is responsible for tracking all of the expenses incurred by the ACS, and for assisting the Finance/Administration Chief in handling ACS 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 ACS.

Medical Personnel

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

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

The number of each position will be dependent upon the type of ACS established, as it relates to the scope of the incident. Staffing calculations are made by the Planning Section.

These positions will function in the Operations section under the direction of the ACS Medical Director, the Operations Chief, and the Treatment Unit Leader.

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 ACS. 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 ACS organizational structure, volunteers will have to be registered and tracked as they carry out their work at the ACS. Section leaders should 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 State Emergency Response and Volunteers (SERVFL) system will be a source for identifying health professional volunteers.

Staffing

A key issue in the establishment and operation of an ACS is staffing. Initial staffing for an incident will likely come from the emergency medical services, which is 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 ACS operational in a short timeframe. (The State Fire Marshal / Florida Fire Chiefs Association Statewide Emergency Response Plan is designed to respond resources in an "immediate to one hour" timeframe.) These people will be augmented by County Health Department personnel, specialized medical response teams, and hospital emergency department personnel. As the duration of an ACS increases, it is likely that State Medical Response System assets or Disaster Medical Assistance Teams will be called in to provide service. If the ACS becomes a Type 2 or Type 1 operation of longer duration, additional hospital staff will need to be included in the staffing plan. During incidents of extremely long duration, or when multiple ACSs 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 ACS 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 these other sources.

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

Staffing Sources

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

- Fire Department and EMS personnel
- Private ambulance companies
- County Health Department personnel
- Specialized local and regional response teams
- State Medical Response System Assets
- Hospital emergency department personnel
- Medical Reserve Corps
- Local nursing and allied health students
- Volunteers including Community Emergency Response Teams (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 upon to help.

Health and Medical Staffing Levels

While various types of positions in the command structure will be needed to operate an ACS, 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 ACS (per 50 beds for a 12 hour shift) should include:

- 1 Physician
- 1 Physician Assistant
OR 1 Advanced Registered Nurse Practitioner
- 1 Respiratory Therapist
- 1 Case Manager
- 1 Social Worker
- 2 Medical Clerks
- 2 Housekeepers
- 2 Patient Transporters
- 4 Emergency Medical Technicians
- 4 Medical Assistants
- 6 Paramedics
- 6 Registered Nurses or Licensed Practical Nurses

(see link in Appendix Section C)

Credentialing

As cited in the Staffing section of this plan (page 16), 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 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 ACS administrative personnel. Included will be standards and guidelines recommended by the U.S. Health and Human Services Administration for the Advanced Registration of Volunteer Healthcare Professionals (ESAR-VHP) program (https://aspr.hhs.gov/Pages/_TEMPLATES/Dev/ESAR-VHP-Register.aspx) on a statewide and nationwide basis.

At a minimum, the credentialing process should be able to verify the following information:

- Name
- Address and contact information
- Agency affiliation
- Licensure
- Level of training
- Level of experience
- Any pending legal action
- Qualification for assigned task

Training

In order for an ACS to open and operate smoothly, it is essential that personnel be trained in a variety of subjects. Fortunately, much of the training overlaps existing training requirements associated with terrorism response preparations. The U.S. Health and Human Services Hospital Preparedness Program can serve as a guide in this area. Training that would be beneficial to those operating an ACS 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

Technical Information

In the Incident Command System, Planning (specifically, 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 ACS)
6. Any other information that will help result in a positive outcome for the patient

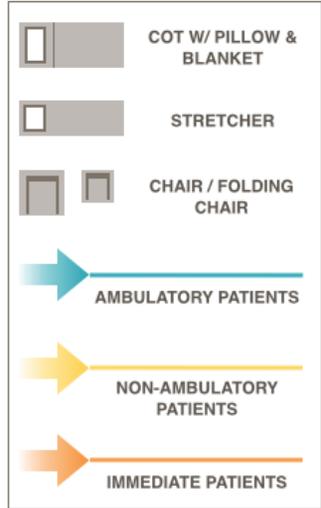
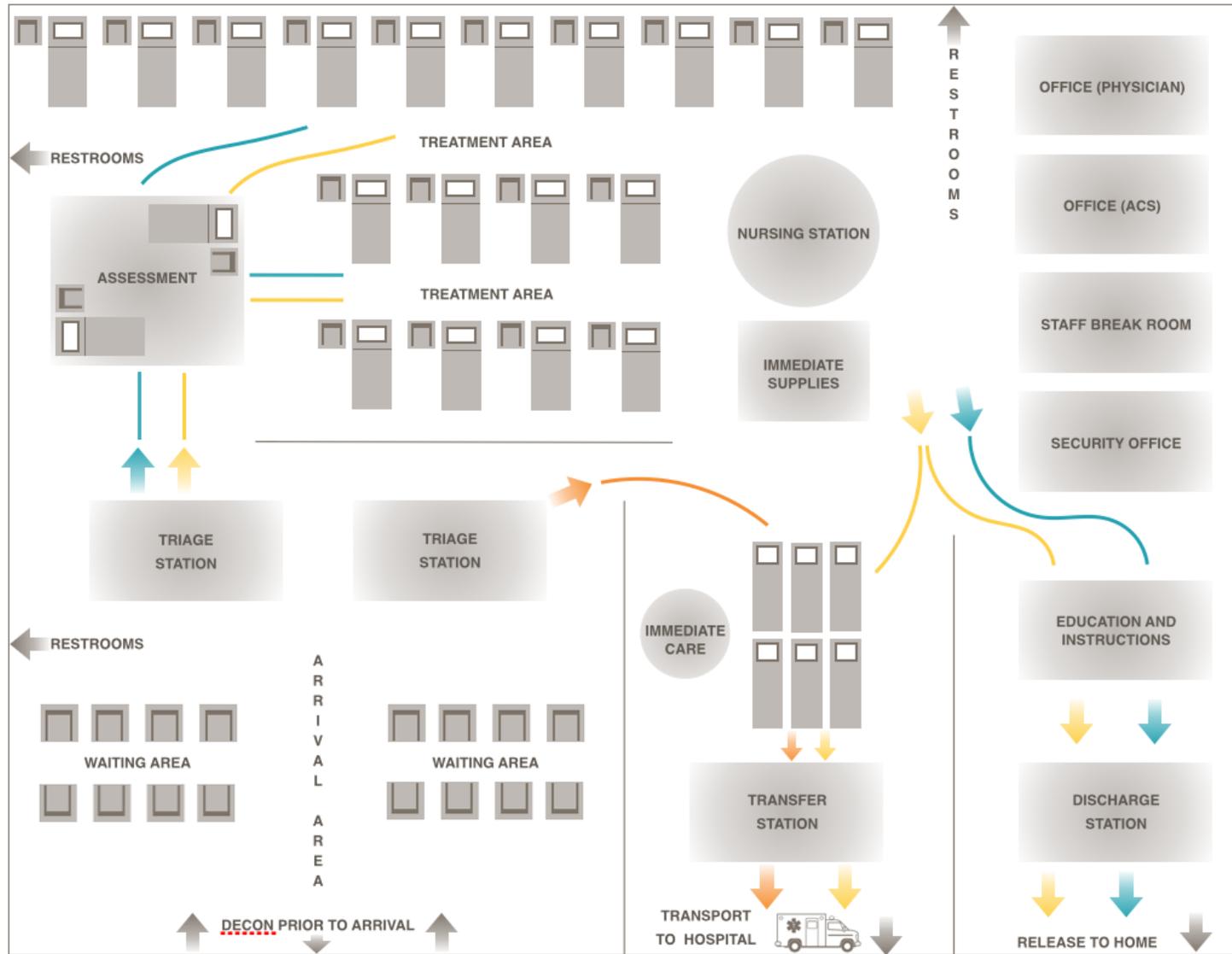
Facilities Layout

The layout of an ACS will, of course, be dependent upon the typing classification (see typing matrix on page 9), and the physical characteristics of the building or site chosen. In laying out an ACS, Logistics personnel should plan for the following components:

- Incident Command Post
- Perimeter security
- Security checkpoint
- Arrival area
- Parking area
- Operations Section area
- 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 ACS staff will likely be unfamiliar with the ACS host facility, it will be important for the Logistics Section to develop extensive signage within the ACS to provide directions, and to identify of key areas.

Sample ACS Layout



ACS OPERATIONS

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 ACS operation. Included are:

- Alternate Care Site Equipment
- Mass Casualty Trailers
- Urban Search and Rescue Teams
- Hazardous Materials Response teams
- Disaster Medical Assistance Teams
- Military Civilian Support Teams
- Incident Management Teams
- Public Information Response Teams
- Florida Incident Dispatch Teams
- State Medical Response System Assets
- Behavioral Health Response Teams
- Florida Emergency Mortuary Operations Response System Teams
- Emergency Radio Caches
- Emergency Disaster Incident Communications Units
- Disaster Community Health Assessment Teams
- State Emergency Response Teams
- Other key resources

As part of the planning process, jurisdictions should identify the procedures to follow, and the contact numbers to use to request these resources.

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 ACS is initiated in the first place as, 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 that 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 proper equipment to conduct decontamination
4. Securing trained personnel to carry out the decon tasks

5. Properly decontaminating patients
6. Establishing a decontamination procedure that facilitates movement of patients from a “hot zone” through decon 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 that “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 ACS, 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 that there will be additional units, beyond hazmat teams, that will have the capability to carry out these duties.

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.

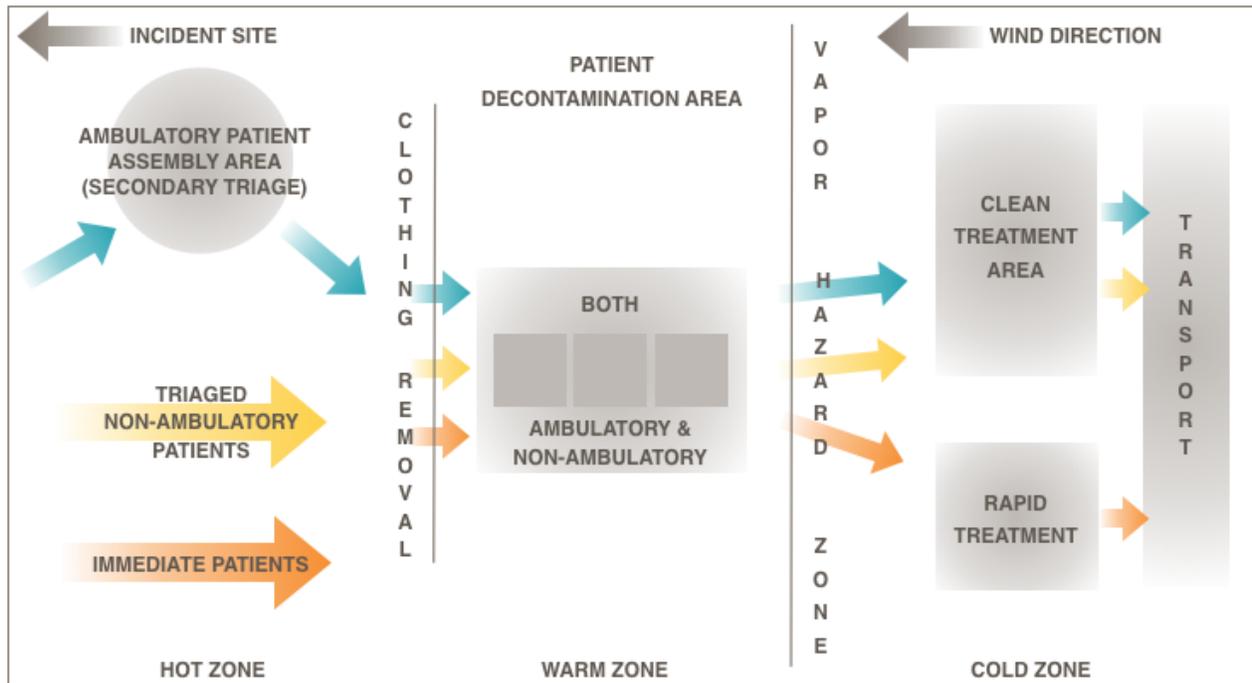
In addition to gross decontamination, hazardous materials teams or other assigned personnel also need to establish an area for fine or detailed decontamination, if necessary.

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*”.

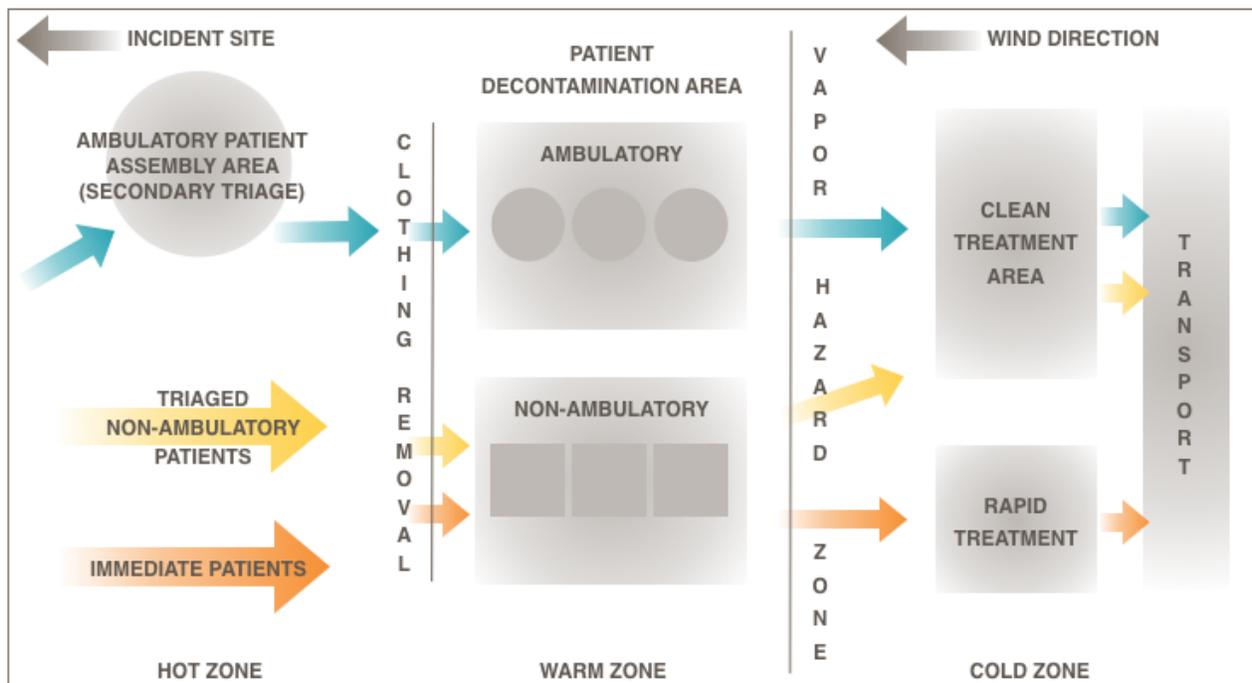
https://www.opcw.org/sites/default/files/documents/Victims_Network/Orange_and_Red/orange_red_02448.pdf

Decontamination Process Diagrams

SINGLE CORRIDOR



DOUBLE CORRIDOR



Triage

To deal with a large surge of patients, and to keep the process as simple as possible, the Simple Triage Rapid Treatment (START) and the JumpSTART systems of triage are annexed to this plan. (see Appendix D) 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.

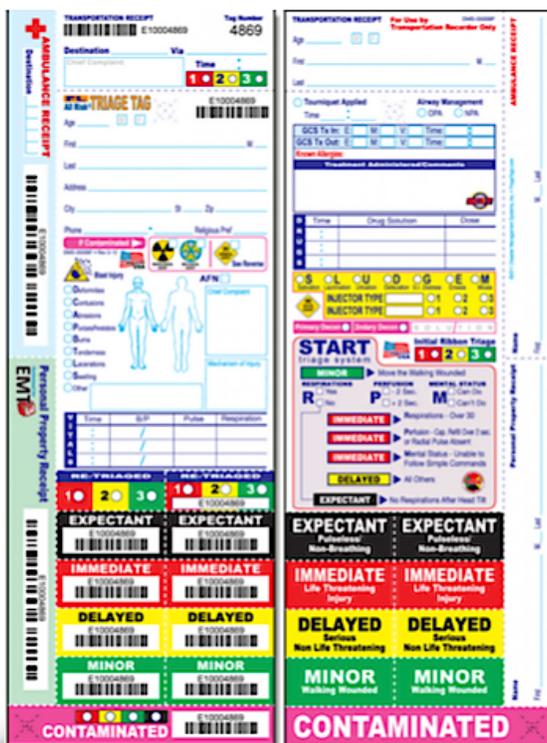
Using this system, patients will be triaged into one of the categories detailed at right.

(Patients who have been exposed to substances involved in a terrorism incident need to be monitored closely, as they may develop delayed symptoms.)

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 to re-triage them accordingly as needed. Additionally, triage may need to be done several times; that is, on the scene, at the ACS, and at the hospital.

Utilizing the START and the 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.

EXPECTANT
Patients in this category arrived deceased or die at the ACS. Patients in this category are the lowest priority for transport and should be transferred to the ACS temporary morgue.
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.
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.
MINOR
Patients in this category require a general assessment and then can be treated at the ACS. If necessary, they may ultimately be transported to a hospital. Patients in this category are the third highest priority for transport.



CURRENT FLORIDA TRIAGE TAG

The triage section at the ACS will need to:

1. Assess the triage that has been done at the incident scene prior to the patients being transported to the ACS
2. Triage patients that have not previously been triaged, and re-triage those that have
3. Use these systems and available kits to properly “tag” patients
4. Use the START and the JumpSTART systems to classify the patients as RED, YELLOW, GREEN, OR BLACK.
5. Maintain contact with the incident scene Triage Officer for collaboration
6. Take the necessary precautions, using PPE, so that they are not contaminated in the triage process
7. 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 ACS
8. Facilitate patient tracking

NOTE: Personnel operating at an ACS should use the “color-coding” scheme identified in the Florida FOG for triage equipment and personnel identification.

Treatment

The primary mission of an ACS is to decontaminate, triage, evaluate, and treat patients generated by a disaster. If feasible, patients in the Red and Yellow triage 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 ACS.) At a minimum, patients should be able to receive basic life support services (BLS) at an ACS, and preferably, some level of advanced life support services (ALS).

The treatment area should be set up so that staff and equipment resources are maximized. 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 ACS 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 ensure that the highest level of medical care possible is delivered to the largest number of people possible.

The Treatment Section at the ACS 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-tagged patients so that they can be transported to a hospital
- Evaluating medication and medical allergy issues
- Treating, and, if possible, releasing patients with minor illnesses or injuries
- Assisting patients with psychophysiologic problems
- Assessing the need for, and then requesting specialized medical equipment for patient care
- Addressing patients that require isolation
- Treating Red- and Yellow-tagged 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 on the need for additional beds or cots
- 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.

TYPICAL ACS PATIENT SEQUENCE

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 scene Treatment Section personnel
6. Patient is moved to the scene transport area, and either transported to a hospital, or to the ACS
7. Patient arrives at the ACS
8. Patient is logged into the ACS, 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 he/she is 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 Section 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 ACS 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 triage 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 ACS

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 ACS readmission procedures (if it becomes necessary), and they are given guidance on any follow-up care needed

Patient Tracking and Charting

Patient tracking at an ACS 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 when administrative resources arrive at the ACS. Once that occurs, standardized patient tracking forms can be used for the duration of the patient's stay at the ACS. 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 (EM Resource, EM Track, etc.) 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 tracking the patients if they are transferred to a hospital, or are released from the ACS

For patients that remain at the ACS, medical personnel must officially document a patient's status, and obtain patient information.

Since an ACS 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 ACS 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 ACS administration, obtaining information should not interfere with rapid decontamination, triage, assessment, treatment, or transport of patients.

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 ACS during prolonged operations. Additionally, there may be a need for critical incident stress debriefing (CISD) for personnel assigned to an ACS. Specialized teams have been developed for this purpose, and should be utilized as part of the support for ACS staff. ESF 8 at the SEOC can be of assistance in marshaling behavioral health or 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.

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 ACS. Issues that may need to be addressed include:

- Designated areas of the ACS that are handicapped-accessible
- Specialized transportation capabilities
- Specialized equipment, medication, and oxygen needs
- Specialized medical personnel, and additional volunteers
- Making the ACS more handicapped-accessible with portable ramps, portable showers, etc.
- Triageing some special needs patients into the Red or Yellow triage categories because of their special needs

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
- Pediatric Care specialists
- 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
- Release of pediatric patients only to authorized persons

Patients with Pets

People may have pets with them when they are impacted by a disaster, and may even bring pets with them when they arrive at the ACS. As such, the local Animal Control office, Humane Society, and/or local veterinarians should be included in planning efforts so that 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
- Veterinary treatment of affected pets
- Housing of animals belonging to people transferred to the hospital
- Coordination of “service” animals
- Safety and sanitary concerns
- Food and water
- Return of pets to their owners when they are released from the ACS

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
- Jewelry
- Other items collected during admission to ACS

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

Medical 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 purpose and location of the ACS
- What PPE hospital staff will need
- Number of anticipated patients
- Anticipated duration of the event

- Types of patients the ACS can receive back from the hospital

Most likely, patients who are transported to an ACS will arrive via ambulance, or in private vehicles. With some larger incidents, the scene Transportation Unit Leader may make arrangements for a large number of patients to be transported to the ACS 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 ACS, may need to be decontaminated prior to being released from the ACS.

The ACS 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; however, if an incident involves a large number of patients, alternative transportation methods may have to be employed.

Safety

One of the highest priorities in the operation of an ACS is safety. Under direction from the Safety Officer, 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 and around the ACS
- 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

Security

For the proper operation of an ACS, 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 ACS. 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 ACS 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 ACS 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 identification, monitoring quarantined private citizen vehicles, and controlling unauthorized access to the ACS.
3. **Internal Security** – This includes maintaining control of unruly and disruptive patients, dealing with perpetrators posing as patients, and facilitating patient flow through the ACS. Additional responsibilities include barricading “off-limits” portions of the ACS, and preventing unintentional cross-contamination. Additionally, a system of providing ACS 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 ACS 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 traffic cones and barricades to help establish ACS traffic flow.
5. **Access Control** - In addressing the issue of access to an ACS, security personnel should establish separate entrance/exit points for patients and staff. ID cards should be checked, and an internal ACS ID card system should be established if an incident is prolonged, such as a long duration Type 1 ACS 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 ACS. Once patients leave the ACS, 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 variety of venues. As such, it will be important for planners to develop contingency plans for ACS security that includes the use of mutual aid, private security resources, and volunteers. Additionally, when making ACS site selection, strong consideration should be given to sites that provide “inherent” security such as facilities with controlled access, fencing, etc.

If the ACS elevates to the level whereby State or Federal assistance is required, the Florida Department of Law

Enforcement and the Florida National Guard may have to be requested for assistance.

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 events. 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 Section 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 ACS.

Weather Issues

Florida is subject to a variety of weather conditions. Some incidents, such as hurricanes, might be the reason an ACS has 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, especially severe weather events
- The impact of rain, cold, heat, high winds, and flooding on the ACS operation
- Keeping ACS areas heated or cooled, as needed
- Consideration of water and air temperature during decontamination
- Structural soundness of the ACS facility
- The impact of weather-related power outages
- Specialized equipment needed to deal with weather issues

Ancillary Populations

Those operating an ACS 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:

- Psychophysiological 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 ACS as an entry point into the healthcare system
- Family and friends of people who have been transported to the ACS 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.

Temporary Morgue

Planning for an ACS should include the potential of dealing with fatalities. One of the first steps in organizing mortuary services for an ACS is to activate the Florida Emergency Mortuary Operations Response System (FEMORS). FEMORS' mission is to assist and support the local District Medical Examiner's Office, Florida Department of Law Enforcement, and other responding agencies, in the event of a mass fatality incident. If the scope of the incident increases to the level where Federal resources are being used, and the National Disaster Medical System (NDMS) is activated, Disaster Mortuary Response Teams (DMORT) would then be part of the response assets. DMORTs are directed by the NDMS under ESF 8 to provide victim identification and mortuary services. Teams are composed of:

- Funeral directors
- Medical Examiners
- Pathologists
- Forensic anthropologists
- Medical records technicians and transcribers
- Fingerprint specialists
- Forensic deontologists
- Dental assistants
- X-ray technicians
- Mental health specialists
- Computer professionals
- Administrative support staff
- Security and investigative personnel

Considerations for operating a temporary morgue include:

- Coordination with the local Medical Examiner's 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
- Coordination with local law enforcement agencies on investigation issues

ACS LOGISTICS

Facilities Management

The Logistics Section is responsible for overseeing the management of ACS 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 necessary supplies
- Disinfecting rooms, apparatus, and equipment
- Addressing maintenance issues that arise
- Signage for each aspect of the ACS operation
- Working with the Security Unit Leader to keep unused portions of the facility locked

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 which needs to be well informed before, during, and after disaster situations. Considerations for optimizing communications for an ACS include:

1. Having a 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 personnel contact lists, or preprogrammed automatic dialers, so that timely and proper notifications can be made
3. Good communications procedures between the ACS, field incident command, and the LEOC to coordinate resources, and to help in initiating an ACS
4. Utilizing base and portable radios that are included as part of State caches
5. Making use of 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 ACS
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.
8. Utilizing satellite communications, especially in dealing with large-scale disasters that may affect other forms of communications
9. Making use of Med 8 channels for communications
10. Establishing and using Internet connection through Wi-Fi, air card, or satellite resources
11. Use of EM Resource, or other software applications for information sharing
12. Having the Public Information Officer linked with a 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 of the ACS location, and the details about the services being provided. This will include the use of the media to disseminate key information
15. Providing patients with a the ability to make outgoing calls,
16. Ensuring that there are backup communications systems in place, in case primary means fail

Public Information and Communication

Once the decision has been made to open an ACS, public information and communication become very important issues. The ACS 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 ACS, including the establishment of scheduled briefings
- Providing the media with requested information
- Compliance with HIPAA regulations when talking about patients and patient care
- Getting word out to the public on how to access care at an ACS, and what types of patients are being accepted. This may include the implementation of an ACS “hotline”
- The process to be followed in checking on family members being treated at the ACS
- 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 ACS Commander on information to be released, and seeing that the ACS authority figure gets face-to-face time with the media

Specialized Equipment

While the SMRS assets may have the necessary equipment and supplies for a quick startup, additional resources will be needed if the ACS 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 planning process, have agreements in place with private vendors to receive rapid service.

Personal Protective Equipment

It is essential that staff personnel have adequate personal protective equipment 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 ACS, 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 appropriately-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 ACS should have the capability of providing some level of oxygen support to its patients.

Wheelchairs / Stretchers

Another important item for the ACS operation will be wheelchairs. These will be necessary to support the ambulation of patients to various locations within the ACS. 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.

Pharmaceuticals

While the need for pharmaceuticals should be somewhat limited, given the focus of an ACS being on treatment of Green-tagged patients, there may be some need for these resources. Hospitals should be able to provide assistance with this, unless the incident is of the magnitude that State and Federal support is needed to sustain the necessary level of pharmaceutical supplies.

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 ACS. This unit should not be committed to routine transport duties, but rather held in reserve in the event that an emergency occurs at the ACS, and immediate transportation of a patient or staff member is needed.

Portable Air Filtration System

To avoid cross contamination at an ACS, 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, ACS Logistics 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 ACS. 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.

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.

Forms

Various forms will help track key information in an ACS. Suggested forms that should be created and printed ahead of an incident include, but are not limited to:

- Patient Registration
- Patient Tracking
- Patients Belongings
- ACS Volunteer
- Memorandum of Agreement (Facility)

- Facility Condition Damage / Assessment
- ACS Staff/Credentialing
- ACS Staff Time Tracking
- Supplies Inventory
- Pharmaceuticals Tracking
- Patient Medical
- Patient Medications
- Patient Release
- Released Patients Instructions

Out-Processing

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

- Communication 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
- Time and date of patient discharge from ACS
- Patient signature that they are agreeing to be released from the ACS

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

Reunification

Depending upon the scope of the ACS, 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 ACS
- The process for re-entering the ACS, if necessary
- Home care instructions

To handle all of these tasks, a portion of the ACS needs to be identified as 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
- Patients can talk with a counselor about mental distress issues
- Patients can make a telephone call
- People can obtain information about a family member who was transported to the ACS
- Patients who will need transportation home from the ACS can make necessary arrangements

Demobilization

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

- 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’s Office
- Packaging and storage of ACS supply 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
- Returning site to original condition
- Obtaining a signed “acceptance” document from the facility owner/manager

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

Return of Facilities in a Decontaminated Condition

One of the most controversial issues in using a particular facility as an ACS, 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 are new technologies emerging that will enable a facility to be decontaminated easily. As part of the demobilization process of an ACS, 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.

ACS FINANCE AND ADMINISTRATION

Records

During the operation of an ACS, 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 ACS
- Goods and services used in the operation of the ACS
- Time sheets of all assigned personnel
- Location information of patients who were transported from the ACS
- 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 ACS.

Finance and Costing

Funding for an ACS is a complicated issue. Costs associated with a Type 4, and possibly a Type 3 ACS, will, most likely, be a community issue; whereas a Type 2 or Type 1 ACS 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 ACS 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 that proper payment is made for all ACS expenditures. Tracking of orders, invoices, personnel time cards, etc. will be essential, especially when the ACS activation is part of a declared disaster process.

CONCLUSION

Development of a plan for the implementation of Alternate Care 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 ACS. 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, excellent local ACS *operations* can be accomplished. By doing so, Florida can be the leader in yet another area for the homeland security of the United States of America.

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APPENDICES

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EMERGENCY SUPPORT FUNCTION (ESF) IDENTIFICATION**

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START AND JUMPSTART TRIAGE PROCEDURES**

Appendix A: Acronyms

ALS	Advanced Life Support	FEMORS	Florida Emergency Mortuary Operations Response System
ACS	Alternate Care Site	FOG	Florida Incident Field Operations Guide
BLS	Basic Life Support	HEPA	High Efficiency Particulate Air
CDC	Centers For Disease Control and Prevention	HIPAA	Health Insurance Portability and Accountability Act
CERT	Community Emergency Response Team	HRSA	Health Resources and Services Administration
DECON	Decontamination	HVAC	Heating, Ventilating, and Services Administration
DEM	Division of Emergency Management	JIC	Joint Information Center
DMAT	Disaster Medical Assistance Team	LEOC	Local Emergency Operations Center
DMORT	Disaster Mortuary Response Team	MCI	Mass Casualty Incident
EDICS	Emergency Disaster Incident Communications System	NDMS	National Disaster Medical System
EMS	Emergency Medical Service	MOU	Memorandum of Understanding
EDICS	Emergency Disaster Incident Communications System	NIMS	National Incident Management System
EMTALA	Emergency Medical Treatment and Labor Act	NRF	National Response Framework
EOC	Emergency Operations Center	PPE	Personal Protective Equipment
ESAR-VHP	Emergency System for Advance Registration of Healthcare Professionals	SEOC	State Emergency Operations Center
ESF	Emergency Support Function	SMRS	State Medical Response System
FDLE	Florida Department of Law Enforcement	START	Simple Triage and Rapid Treatment

Appendix B: Emergency Support Function (ESF) Identification

ESF 1	Transportation
ESF 2	Communications
ESF 3	Public Works / Engineering
ESF 4	Fire Fighting
ESF 5	Information and Planning
ESF 6	Mass Care
ESF 7	Unified Logistics
ESF 8	Health and Medical
ESF 9	Search and Rescue
ESF 10	Hazardous Materials / Environmental Protection
ESF 11	Food and Water
ESF 12	Energy
ESF 13	Military Support
ESF 14	External Affairs
ESF 15	Volunteers / Donations
ESF 16	Law Enforcement / Security
ESF 17	Animal and Agriculture Issues
ESF 18	Business, Industry, and Economic Stabilization

Appendix C: Internet Links to Specialized Information for ACS Operation

Emergency Medical Treatment and Labor Act (EMTALA)

<https://www.cms.gov/medicare/regulations-guidance/legislation/emergency-medical-treatment-labor-act>

Florida Incident Field Operations Guide (FOG)

<https://www.floridadisaster.org/globalassets/importedpdfs/flfog.pdf>

Guidelines for Mass Casualty Decontamination During a Terrorist Chemical Agent Incident

https://www.opcw.org/sites/default/files/documents/Victims_Network/Orange_and_Red/orange_red_02448.pdf

Medical Telecommunications and Transportation Florida Statute

https://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&URL=0400-0499/0401/0401ContentsIndex.html

Mega Shelters – Planning and Activation

<https://www.fema.gov/pdf/emergency/disasterhousing/mspg.pdf>

ALTERNATE CARE SITE SPECIFIC LINKS / DOCUMENTS

Alternate Care Site Guidance: Alternate Care Site Local Plan Development Guide

<https://www.floridahealth.gov/wp-content/uploads/2025/07/amtslocalplandevlopguide.pdf>

Alternate Care Site Guidance: State-Identified Potential Alternate Care Site Facilities

(Secured Document Maintained in FDOH Planning)

Alternate Care Site Standard Operating Procedure

<https://www.floridahealth.gov/wp-content/uploads/2025/07/alternate-care-site-ops.pdf>

Federal Medical Station Layouts (in ACS SOP, Pages 26-31)

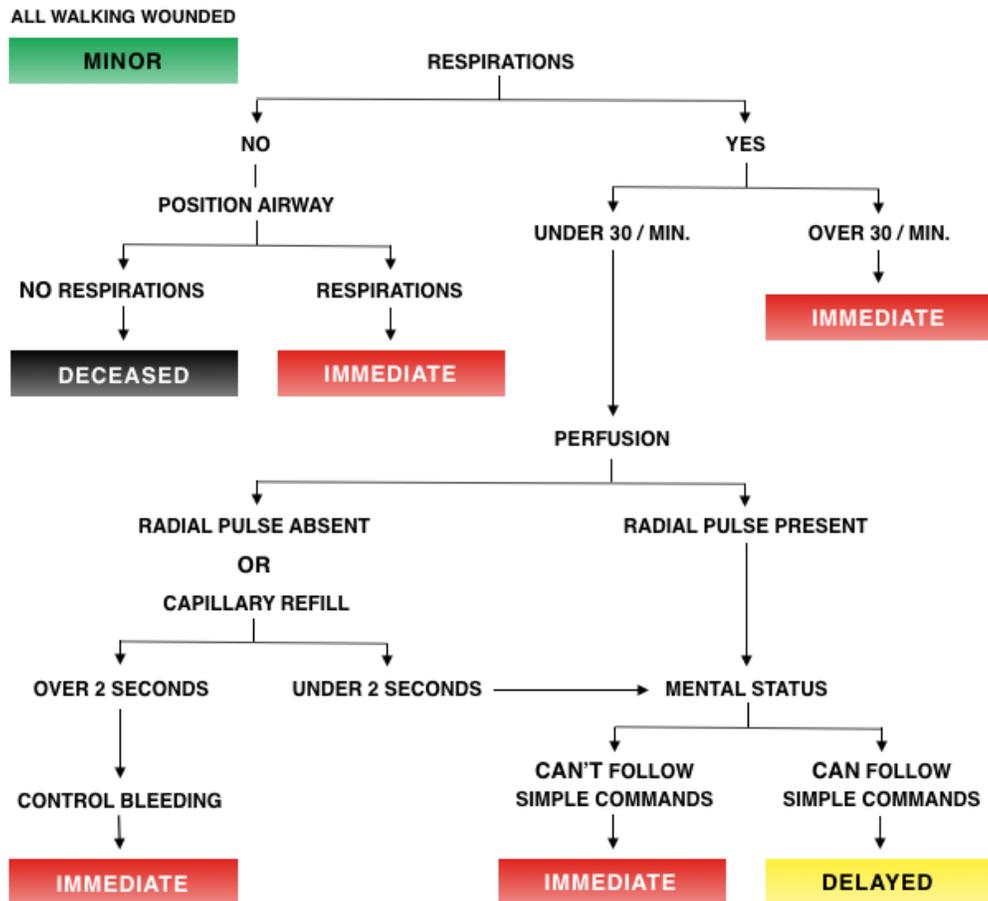
<https://www.floridahealth.gov/wp-content/uploads/2025/07/alternate-care-site-ops.pdf>

Agency for Health Care Administration Facility / Provider Locator

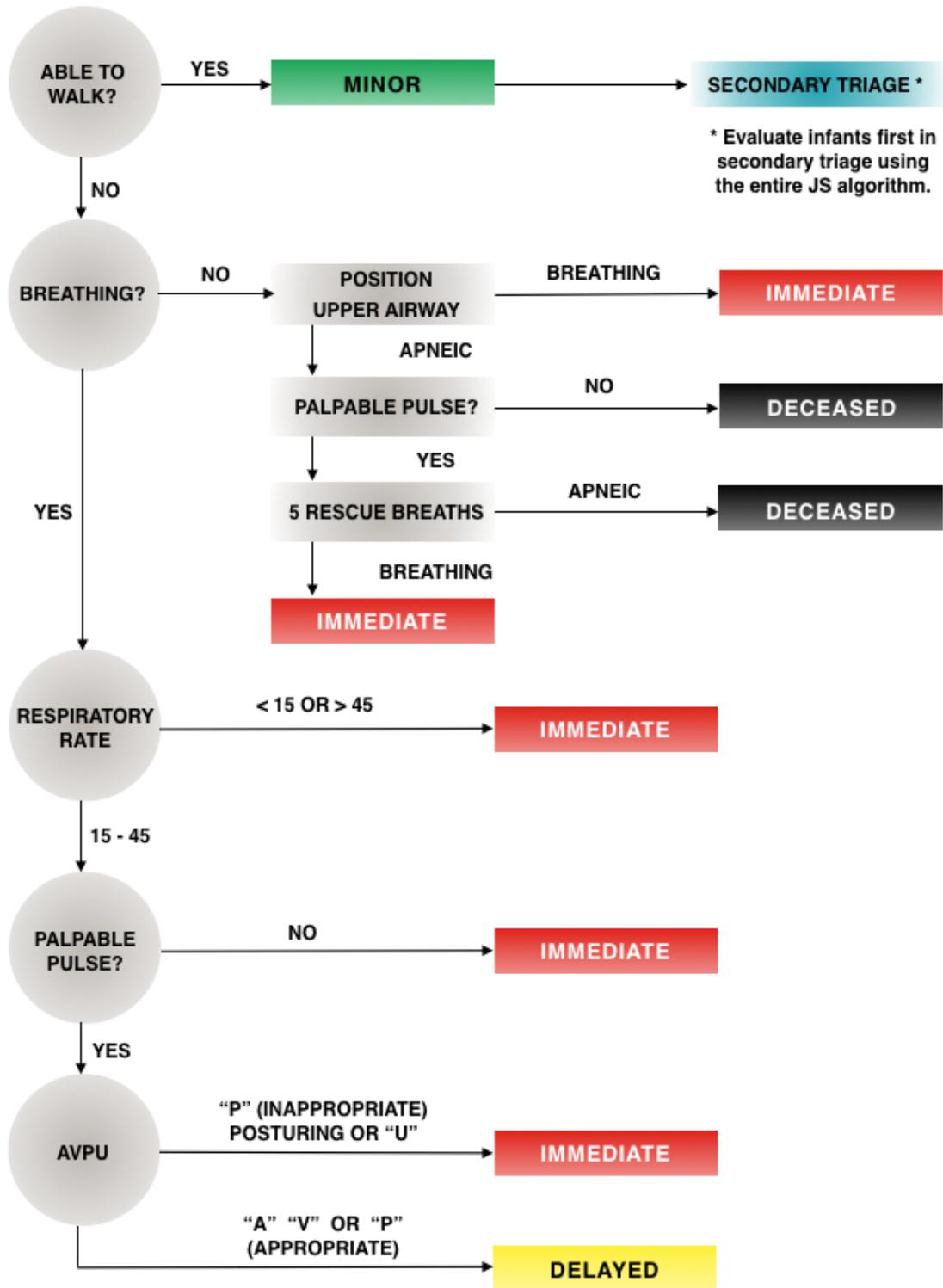
<https://quality.healthfinder.fl.gov/>

Appendix D: 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	1	Respiration is present only after repositioning the airway. Applies to victims with respiratory rate >30 / severe respiratory distress. Capillary refill delayed more than 2 seconds / no peripheral pulse. Significantly altered level of consciousness.	<ul style="list-style-type: none"> Serious signs/symptoms Known liquid agent contamination
DELAYED	2	Victim displaying injuries that can be controlled / treated for a limited time in the field.	<ul style="list-style-type: none"> Moderate to minimal signs/symptoms Known or suspected liquid agent contamination Known aerosol contamination Close to point of release
MINOR	3	Ambulatory, with or without minor traumatic injuries that do not require immediate or significant treatment.	<ul style="list-style-type: none"> Minimal signs/symptoms No known or suspected exposure to liquid, aerosol, or vapor
DECEASED/ EXPECTANT	4	No spontaneous effective respiration present after an attempt to reposition the airway.	<ul style="list-style-type: none"> Very serious signs/symptoms Grossly contaminated with liquid nerve agent Unresponsive to autoinjections



JumpSTART Pediatric MCI Triage



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ALTERNATE CARE SITE GUIDANCE

Alternate Care Site Quick Start Guide



ESTABLISHMENT CRITERIA

- What is the **type of situation**?
- What is the **anticipated duration** of ACS 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 size **organizational structure** is needed for operating the ACS?
- What **logistical support** is required?

FACILITY SELECTION CRITERIA

- What **size of facility** is needed?
- What is the **distance** between the scene and the hospitals, and what is a **good location** for the ACS?
- 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 **facility attributes** listed to the right?

FACILITY ATTRIBUTES

- Good ingress / egress, and parking
- Water / sewer connections
- Restrooms and shower facilities
- Electrical power and backup generator
- 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

PARAMETER	TYPE 4 ACS	TYPE 3 ACS	TYPE 2 ACS	TYPE 1 ACS
TERM	Extension of MCI	Short	Medium	Long
DURATION	< 8 hours	8 - 24 hours	16 - 36 hours	> 36 hours
PATIENTS	< 500	> 500	> 1000 < 1500	> 1500
EXAMPLE NATURES	transportation accident, building collapse, industrial accident	bomb, burn, blast, decontamination situation	decontamination situation, radiological, biological	Pan Flu, significant respiratory, major disaster
LOGISTICS	Single SMRS resource	Multiple SMRS assets, Regional assets	Multiple SMRS assets, Regional / State assets	Multiple SMRS assets, Regional / State / Federal assets
TEAMS	Local / Regional	Local / Regional / SMRS	Local / Regional / SMRS / Hospital staff	Local / Regional / SMRS / DMAT / Hospital Staff / Non-traditional medical personnel

COMMAND DECISION POINTS WORKSHEET

Justification criteria met to open ACS	_____	No	_____	Yes
Initial type of ACS	1	2	3	4
Size of facility needed	_____			
Location of facility	_____			
Command positions needed	_____			
Decontamination needed	_____	No	_____	Yes
Number of SMRS assets needed	1	2	3	4
Initial level of triaged patients expected	Deceased	Minor	Delayed	Immediate
Specialized response teams needed	_____	No	_____	Yes
If yes, what special teams?	_____			
Specialized resources needed	_____	No	_____	Yes
If yes, what special resources?	_____			
Level of staff PPE needed	_____			
ACS <i>authority</i> figure for the news media identified	_____			
Need for patient isolation or quarantining	_____	No	_____	Yes
Any major safety issues?	_____	No	_____	Yes
If yes, what are they?	_____			

**ORGANIZATION ASSIGNMENT LIST
(MODIFIED FOR ACS OPERATION)**

INCIDENT NAME	OPERATIONAL PERIOD DATE / TIME
INCIDENT COMMANDER AND STAFF	NAME
ACS INCIDENT COMMANDER	
ACS MEDICAL DIRECTOR	
ACS SAFETY OFFICER	
ACS LIAISON OFFICER	
ACS PUBLIC INFORMATION OFFICER	
AGENCY REPRESENTATIVE	
AGENCY	NAME
PLANNING SECTION	NAME
ACS 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	
LOGISTICS SECTION	NAME
ACS LOGISTICS CHIEF	
ACS RESOURCE UNIT LEADER	
COMMUNICATIONS UNIT LEADER	
GROUND TRANSPORTATION UNIT LEADER	
FACILITIES UNIT LEADER	
FOOD UNIT LEADER	
SUPPLY UNIT LEADER	

COMMUNITY ACS PARTICIPANTS AND ROLES

AGENCY	ROLE(S)
HOSPITALS	treatment, staffing, supplies, facilities, pharmaceuticals
COMMUNITY EMERGENCY CLINICS	treatment of yellow- and green-tagged patients
COUNTY HEALTH DEPARTMENT	staffing, coordination, public health issues
FIRE DEPARTMENT / EMERGENCY MEDICAL SERVICES	transport, temporary staffing, patient decontamination
PRIVATE AMBULANCE SERVICE	transport
CORONER / MEDICAL EXAMINER OFFICE	fatality assistance
LOCAL TRANSIT COMPANIES	large-scale transport
MEDICAL RESERVE CORPS	staffing
COMMUNITY EMERGENCY RESPONSE TEAMS	non-medical staffing
SALVATION ARMY	volunteers, feeding assistance
AMERICAN RED CROSS	feeding assistance, volunteers, facility operations
LOCAL NON-PROFIT AND FAITH-BASED ORGANIZATIONS	volunteers, facilities, supplies
LAW ENFORCEMENT	ACS security, enforcement of isolation/quarantine patients, traffic control, investigation
PRIVATE SECURITY AGENCIES	ACS security
SCHOOL DISTRICTS	facilities for ACS, transportation, kitchen facilities
COLLEGES AND UNIVERSITIES	facilities, staffing from medical disciplines
PRE-SCHOOL AND NURSERY SCHOOLS	child care
CELL PHONE SERVICE PROVIDERS	phone bank, communications, Internet service
LOCAL POWER PROVIDERS	infrastructure support
CABLE TV PROVIDERS	communications
LOCAL TV STATIONS	communications
PUBLIC WORKS / ROAD DEPARTMENTS	sanitation, facility ingress / egress
LOCAL AND REGIONAL AIRPORTS	facilities, transportation, APOE / APOD areas
VETERINARY AGENCIES AND OFFICES	staffing, pet care assistance, animal housing
MILITARY	facilities, staffing, transportation, security
LARGE COMMUNITY BUSINESS (WALMART, SAM'S, COSTCO, LOWES, HOME DEPOT)	supplies
REGIONAL STATE MEDICAL RESPONSE SYSTEM	ACS start-up and operation
FLORIDA DEPARTMENT OF HEALTH	State Medical Response System assets, support, logistical supply, behavioral health assistance
FEDERAL	Federal Medical Station (FMS), support

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 the diagrams found in Operations Guide (page 20)
- Properly **decontaminate patients**
- **Provide privacy** for patients
- Keep decontamination water within **acceptable temperature limits**
- Conduct **multiple decontamination** processes as necessary
- **Control decontamination runoff**
- Take steps to ensure 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

- **Asses 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 that they can be transported to a hospital
- **Evaluate** medication and medical allergy issues
- **Treat, and if possible, release** *minor* patients
- **Assist patients** with psychophysiological 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 casual agents
- Provide **BLS** and **ALS** level of service
- Consider that there may be **multiple agents** or mechanisms of injury/illness involved

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COMMAND POSITION TASK LISTS

ACS INCIDENT COMMANDER

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

ACS MEDICAL DIRECTOR

- Oversee all medical aspects of the ACS
- Provide guidance to the ACS Incident Commander on medical triage and treatment issues
- Work with the Operations Chief to oversee the medical operations of the ACS, 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

ACS SAFETY OFFICER

- Develop and enforce a safety plan for the ACS
- Conduct an initial survey of the ACS, and eliminate any safety hazards
- Monitor the ACS operation for safety issues, and correct deficiencies
- Assign additional safety staff personnel to assist in monitoring decontamination and other key ACS processes
- Ensure that the ACS 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

ACS LIAISON OFFICER

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

ACS 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 ACS for the media
- Prepare press releases on ACS activities, status, etc.
- Stay in close communications with the ACS Incident Commander in order to disseminate key information to the public
- Ensure that HIPAA rules are followed to protect patient privacy
- Get word out to the public on what types of patients are being accepted at the ACS, 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 *authority* figure so they get "face time" with the news media
- Remain available to answer questions the media may have about the ACS

ACS PLANNING CHIEF

- Address the staffing needs of the ACS, and ensure that the appropriate type and number of personnel are being acquired and assigned to the ACS
- Forecast needs of the ACS, 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 ACS
- Ensure that all personnel operating at the ACS 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 ACS

ACS OPERATIONS CHIEF

- Oversee all operational aspects of the ACS
- Ensure that the appropriate response teams and resources needed for the ACS 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 ACS, and to ensure that all of the proper equipment and supplies needed for the ACS operation are being acquired
- Ensure that the transportation aspect of the ACS operation is functioning effectively

ACS LOGISTICS CHIEF

- Oversee the logistical operations of the ACS
- Work with the Security Unit Leader and the Operations Chief to establish the layout of the ACS
- Ensure that the ACS SMRS assets have been ordered, and are enroute to the ACS
- Procure all equipment and supplies needed to operate the ACS, 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.
- Be cognizant of the logistical supplies available, including those that can be acquired from the Strategic National Stockpile, should the ACS 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 ensure that the facility is returned to the owner in as good or better condition than when it was received for ACS operations
- Facilitate all communications needs for the ACS, work with the Communications Unit Leader to acquire the necessary equipment, and establish a communications plan
- Ensure that all proper steps are taken to demobilize the ACS, including extensive cleanup and decontamination of the host facility

ACS FINANCE / ADMINISTRATION CHIEF

- Oversee all financial aspects of the ACS operation
- Account for all of the costs of operating the ACS, and facilitate the rapid acquisition of needed supplies and equipment
- Track hours-worked for all assigned ACS personnel
- Track information for, and initiate, State and Federal reimbursement processes
- Keep a file of all records associated with the ACS operation

MASTER QUICK START CHECKLIST

- ACS Incident Commander assigned
- ACS Command Staff positions assigned
- ACS General Staff positions assigned
- ACS Operations Guide referenced for detailed guidance
- ACS facility selected
- ACS Command Post established
- Communication links established with the scene Incident Command, the LEOC, and the hospitals
- Security established
- ACS Organizational Chart positions assigned
- Fire Department hazardous materials teams notified for decontamination duties
- General workers for the ACS requested
- Command and General Staff formulate ACS layout, with designated areas for each activity
- Staff check-in station established, and procedures developed
- All staff positions reference Operations Guide for tasks and responsibilities
- ACS SMRS assets requested
- Regional communication centers notified
- Brief command personnel
- Public Information Officer gathers initial information, and sets up a media gathering location
- Level of required ACS 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 ACS 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
- Specialized teams requested, as needed
- Safety Officer identifies and corrects any initial safety hazards
- A check-in procedure developed for those being admitted to the ACS
- Logistics arranges for food and water for the first 12 hour operational period
- ACS Incident Commander briefed by Planning Chief on the status of personnel resources
- Assessment is made on what types of patients (according to triage categories) will be treated at the ACS
- Medical staff assignments are made

NOTIFICATION CHECKLIST

- | | | |
|--|---|---|
| <input type="checkbox"/> Scene Incident Command | <input type="checkbox"/> Area Communication Centers | <input type="checkbox"/> Fire Departments |
| <input type="checkbox"/> Medical Director | <input type="checkbox"/> State Health Department | <input type="checkbox"/> Private ambulance transport services |
| <input type="checkbox"/> County Health Department | <input type="checkbox"/> SEOC / State Warning Point | <input type="checkbox"/> RDSTF |
| <input type="checkbox"/> LEOC | <input type="checkbox"/> ESF 8 | <input type="checkbox"/> FFCA SERP |
| <input type="checkbox"/> Law Enforcement | <input type="checkbox"/> RERAs | <input type="checkbox"/> SMRS |
| <input type="checkbox"/> Special teams and resources | <input type="checkbox"/> Hospitals | <input type="checkbox"/> 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	()
Communications Center	()
Private ambulance service	()
SMRS assets	()
State Health Department	()
Volunteer Service Agency 1	()
Volunteer Service Agency 2	()

LOGISTICS CHECKLIST

- | | |
|---|--|
| <input type="checkbox"/> Acquire and set up the ACS equipment | <input type="checkbox"/> Establish strong security measures |
| <input type="checkbox"/> Lay out the ACS, and allocate space to the individual task areas | <input type="checkbox"/> Create signage around the site for easy recognition of specialized areas |
| <input type="checkbox"/> Arrange for appropriate PPE for staff personnel | <input type="checkbox"/> Ensure that the power supply is adequate, and that backup generators are in place |
| <input type="checkbox"/> Acquire any needed garments or supplies to support the decontamination process | <input type="checkbox"/> Establish a strong communications plan and use the <i>Communications Checklist</i> to ensure that key areas are covered |
| <input type="checkbox"/> Establish oxygen supply delivery, if respiratory patients are being treated at the ACS | <input type="checkbox"/> Order any additional key supplies early to ensure that the supply chain is uninterrupted |
| <input type="checkbox"/> Arrange for cleaning service and waste disposal | <input type="checkbox"/> Order food and beverages for the first operational period |
| <input type="checkbox"/> Acquire an additional ambulance unit for standby | |
| <input type="checkbox"/> Arrange for portable air filtration systems to help control cross contamination | |

COMMUNICATIONS CHECKLIST

- | | |
|---|--|
| <input type="checkbox"/> Establish a communications plan | <input type="checkbox"/> Make use of regional radio caches or EDICS to facilitate communications |
| <input type="checkbox"/> Set up and distribute base and portable radios from the State radio caches | <input type="checkbox"/> In larger operations, establish a radio network with the Med 8 channels |
| <input type="checkbox"/> Assess and make use of host facility communications systems | <input type="checkbox"/> Utilize “broadband over the Internet” for data sharing |
| <input type="checkbox"/> Publish and distribute an ACS internal/external phone list | <input type="checkbox"/> Provide patients with ability to make outgoing calls |
| <input type="checkbox"/> Set up fax machines and Internet service | <input type="checkbox"/> Ensure that backup communications systems are operational in case primary ones fail |

SECURITY CHECKLIST

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

PLANNING CHECKLIST

- | | |
|---|--|
| <input type="checkbox"/> Establish a staffing plan | <input type="checkbox"/> Ensure staff personnel are credentialed |
| <input type="checkbox"/> Order necessary staff personnel | <input type="checkbox"/> Establish a lab/testing procedure |
| <input type="checkbox"/> Establish a Planning area | <input type="checkbox"/> Establish an out-processing procedure |
| <input type="checkbox"/> Set up a patient tracking and records system | <input type="checkbox"/> Set up a reunification area |
| <input type="checkbox"/> Establish a staff check-in station | <input type="checkbox"/> Implement a volunteer resources process |

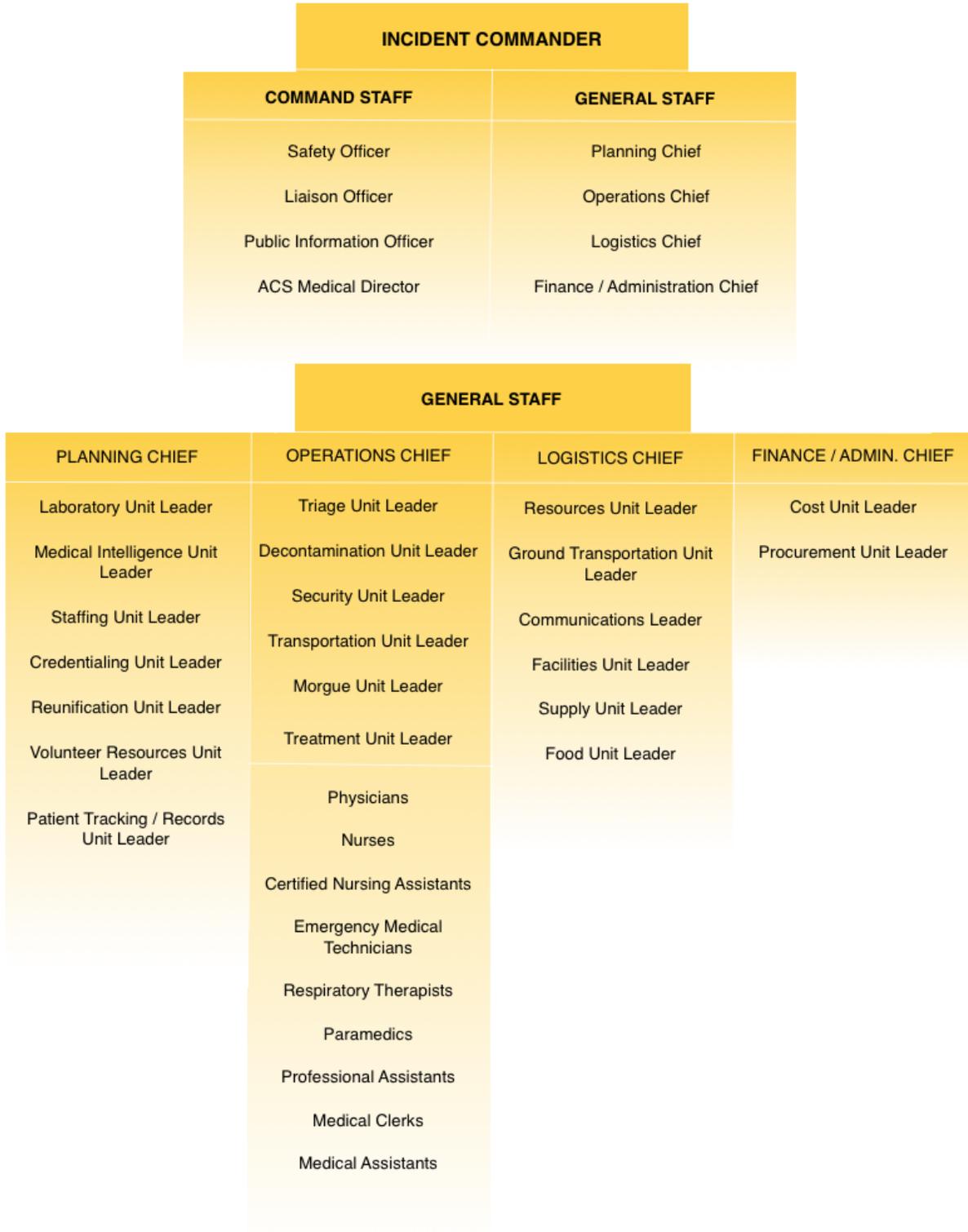
OPERATIONS CHECKLIST

- | | |
|---|--|
| <input type="checkbox"/> Establish decontamination station | <input type="checkbox"/> Establish a helicopter landing zone |
| <input type="checkbox"/> Establish triage area | <input type="checkbox"/> Set up an antidote administration process |
| <input type="checkbox"/> Establish treatment and transportation areas | <input type="checkbox"/> Establish a receiving process for patients coming <i>from</i> hospitals |
| <input type="checkbox"/> Implement security plan for the ACS | <input type="checkbox"/> Work with Safety Officer to develop a safety plan |
| <input type="checkbox"/> Order specialized teams / resources needed | |

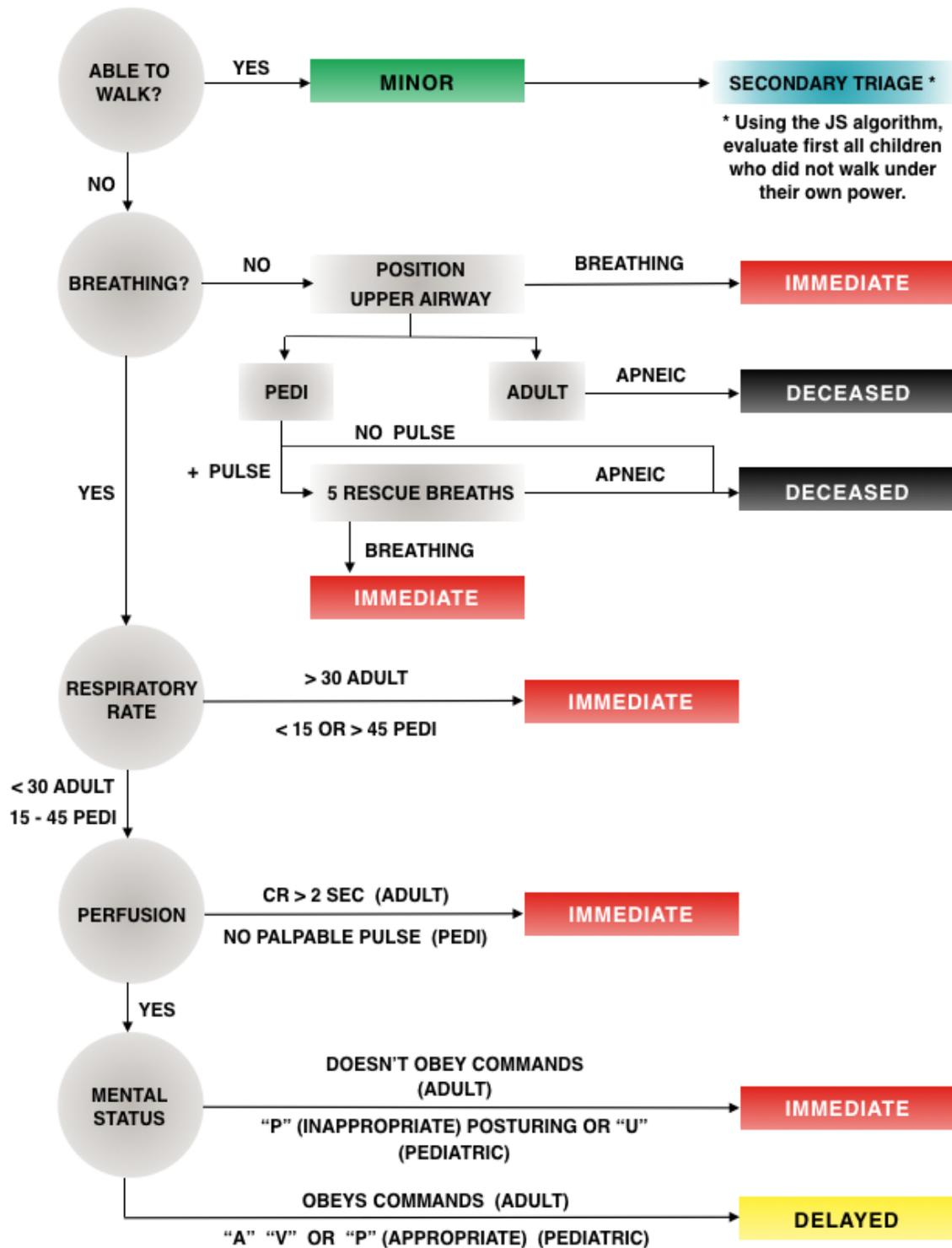
ADMINISTRATION / FINANCE CHECKLIST

- | | |
|---|---|
| <input type="checkbox"/> Track all costs associated with the establishment and operation of the ACS for later reimbursement processes
<input type="checkbox"/> Keep time sheets on all personnel assigned to the ACS | <input type="checkbox"/> Facilitate the purchase of goods and services, and coordinate with the Logistics section on financial issues |
|---|---|

ICS Organizational Chart



Combined START / JumpSTART Triage Algorithm



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