Region 2 Emergency Medical Disaster and Bioterrorism Plan

January 2022

Plan Administration and Handling Instructions

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Record of Change

Change No.	PG. #	Section #	Description	Change Date	Approved /Changed By
001	02		**ADMINISTRATION HANDLING INSTRUCTIONS added**	03 / 2012	
002	78	8.0	**Region 2 Tactical Interoperable Communication plan**	04 / 2015	
003	31	6.6	**Removed St. Mary's Hospital (Streator)**	01 / 2016	
004	26	6.4	**Added County EMA / ESDA / Health Dept. contact info**	01 / 2016	
005	78	8.0	***Tactical Interoperable Communications plan (TICP)***	11 / 2016	
007	31-57	6.6	Reviewed / updated Hospitals information	01 / 2017	
008	20-22	3.12	Added Planning Matrix for At-Risk and Functional Access Needs Populations	10/2017	Change-JBalk
009	All	All	Update and revision – Updates Completed	04/2018	Revision-JBalk
010	All	All	Started revision - Reviewed	05/2020	Revision-JBalk
011	All	All	Started Revision and Updates – Updates Completed Changed Hospital and Regional Contact Information	01/2022	Revision - JBalk

Purpose

Disaster response involves many different community resources—from police and fire to medical providers, structural and environmental engineers, and transportation and housing experts. The hospital plays a small but crucial role in this larger picture. The hospital is the epicenter of medical care delivered to those who are injured. Running a hospital is an enormously complex task under the best of circumstances; preparing a hospital for a disaster is infinitely more complicated. The term “disaster” denotes a low-probability but high-impact event that causes a large number of individuals to become ill or injured

Disasters can range from large multiple-vehicle crashes to massive events such as the Oklahoma City Bombing, Hurricane Katrina, and the terror attacks of September 11. Disasters can be natural, such as earthquakes, floods, and disease outbreaks; or they can be man-made, such as transportation incidents, terrorist bombings, and biological or chemical attacks. Each type of threat presents different challenges to hospitals, which must be able to respond to each in some capacity. Given finite resources, however, hospitals must attempt to focus their resources on the most likely and potentially serious scenarios.

This plan enhances the region's ability to respond to disasters taking an “all-hazard” approach. It is understood that local medical disaster plans will take precedence over the regional medical disaster plan. This plan is designed to augment both the State Medical Disaster Plan and Local Medical Disaster Plan; taking into account specific needs within our region.

Development and Maintenance of Region 2 Plan

Plan Administration

Updating the Medical Disaster Plan will allow for better integration into local and state plans, in addition to adjusting to changes in medical care and the region.

Policy/Procedure:

1. The Region 2 Emergency Medical Disaster Plan will be updated as needed or at a minimum every two years.
2. The plan will be reviewed by representatives from:
    a. EMS Systems Managers
    b. Representatives from Region 2 Hospitals
    c. Regional IDPH Contact
    d. Regional IEMA Contact
    e. McLean County Disaster Council
    f. American Red Cross
    g. Region 2 Trauma Council
    h. Others as needed
3. The plan or policies will have a thirty-day review period. After that period, the plan or policies will be implemented. This plan will also be sent to the Illinois Department of Public Health for approval.
4. Any participating agency may suggest changes in the plan or policies.
5. A copy of the plan will be given to the following hospitals or agencies:
    a. Region 2 EMS Systems
    b. Region 2 Hospitals
    c. IDPH
    d. IEMA
    e. Local EMA within Region 2 upon request
    f. Others as needed

Notification of a Medical Disaster

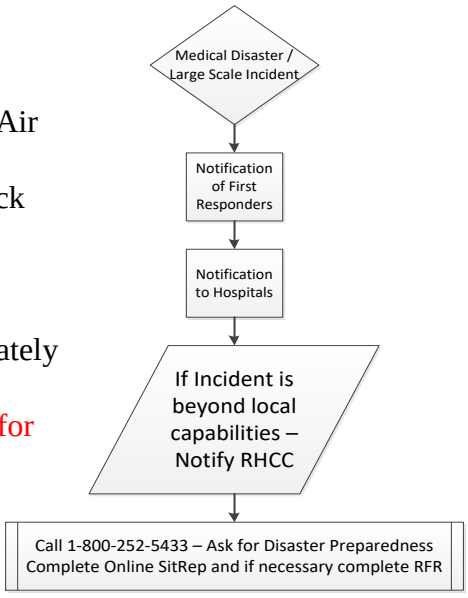
Notification of a medical disaster is crucial in getting the appropriate resources to the scene as quickly as possible. Mobilizing resources is not the greatest challenge in responding to large-scale disasters. Research shows that no matter how shocked people are, they nearly always struggle through it. Almost every analysis of past disasters points to communications as a limiting factor in disaster response. In many instances, communications failures have been blamed directly for adding to the toll of death and destruction. Part of this communication is simply a notification that an incident has occurred and additional resources are needed.

Regional Medical Disaster

In the event a Medical Disaster

- ✓ **EMS/Pre-Hospital Request:** The ranking on-scene medical provider (possibly the incident commander) will notify their local Emergency Management Agency (EMA) of a medical disaster. In addition, the ranking on-scene medical provider will contact their designated Resource Hospital and notify them of the medical disaster. Contact must be made with the Medical Control Physician or ECRN (Emergency Communications Registered Nurse) on duty.

- ✓ **Hospital Request:** Upon notification that a hospital will activate their Hospital Emergency Operations Plan. The Medical Control Physician, Hospital Administrator, or designee at the Hospital will determine if the local medical community has the appropriate resources to deal with the medical disaster. Items to consider are:
  - Hospital bed availability
    i. Update current bed availability in EMResource
  - Availability of EMS transportation resources (BLS, ALS, and Air transportation resources)
  - Current staffing models and the ability to perform staff call-back
  - Medical supply inventories and additional supply availability
  - Blood supplies



- ✓ If a Medical Disaster is declared the impacted hospital should immediately notify
  - Regional Hospital Coordination Center 1-800-252-5433 ask for Disaster Preparedness. Give the information requested and await a call back from Disaster Preparedness
  - Complete the online SitRep (Situation Report) and RFR (Request For Resources) available electronically on the website (www.osfsaintfrancis.org/disaster) under the RHCC tab

- ✓ The RHCC Hospital may:
  - Dispatch a medical response team (RMERT) to the impacted hospital or to the scene of the incident(s) to decompress the medical community affected by the disaster
  - If it is determined the impact of the incident has exceeded the availability of resources in the region. The RHCC will make a request to the Illinois Emergency Management Agency for additional supplies, resources, and/or additional staff.
  - Serve as a resource center for the contacting hospital
  - In the event a medical facility requires evacuation. The RHCC working in unison with the Illinois Department of Public Health and/or the Illinois Emergency Management Agency will work to determine the best destination for the evacuated patients.

Region 2 – SitRep (Situation Report)

PURPOSE

This standard operating procedure (SOP) addresses healthcare facilities in the Region 2 Healthcare Coalition in the use of the Online SitRep.

BACKGROUND

The Region 2 Healthcare Coalition is a group comprised of Regional Hospitals, Public Health Officials, Emergency Managers of City and Counties, and other healthcare entities within IDPH EMS Region 2. The region is comprised of 18 counties and 25 hospitals serving over 1 million persons in population. The Region 2 Healthcare Coalition also maintains Regional Response Assets housed within Regional Hospitals.

SCOPE

This SOP lays out the procedures for the use of the online SitRep in support of:

A. A catastrophic incident or any event/incident involving multiple jurisdictions—especially incidents or events in which regional resource requests are anticipated and/or the activation of a Mutual Aid Agreement (MAA) is likely.

B. Situational awareness and planning support for a regional response to ensure that all actions are accomplished within the procedures and priorities established

ASSUMPTIONS

A. Assumptions

1. The Hospital or Agency is in Region 2
2. The individual completing this form is the liaison for their facility with the RHCC.
3. This form is not to make an Emergency Notification to the RHCC. Emergency Notification must be made by phone to the RHCC or delegates.

USING THE SitRep FORM

A. When to use the form:
   1. When a hospital or agency opens its Command Center or activates their Emergency Response Operations
   2. During a Mass Casualty Incident or any event involving a Mass Influx of patients
   3. When the ChemPak is deployed or requested.
   4. During an incident that may require the use of MAA (Mutual Aid Agreements)
   5. During an incident that may require the request for regional resources. (Any requests for resources should be made using an RFR –Request for Medical Resources)
   6. During any Events of Significance such as large fires, significant weather events, or any emergent incident or event that may cause a significant change in daily operations for the facility.

B. How to use the form:
   1. When describing the event or incident please use the following guidance:
      i) Who – Who is this event impacting, including agencies outside of the reporting hospital.
      ii) What – What has happened? Please give a brief description of the event or incident.
      iii) Action – What actions have you taken or what actions will you be taking to respond to this event or incident.
      iv) Any Requests – Have you made any requests to the RHCC, City/County EOC, or any other agency involved. (Remember when making requests to the RHCC, please complete the RFR – Request for Medical Resources found on the Website).

C. How to access the form:
   1. Browse to the OSF Disaster Preparedness Website
   2. Log in to the RHCC Materials
   3. Click on the SitRep
   4. Make contact with the RHCC or delegates to inform them an updated Sitrep has been sent.

Areas of Responsibilities

A. Facility or Agency
   1. Complete the online SitRep or Hard Copy SitRep
      i) If completing the Hard Copy you must make contact with the RHCC or delegates to inform them an updated SitRep has been sent.
   2. The SitRep must be completed within 30 minutes of the beginning or recognition of the incident. The goal is 15 minutes from the beginning of the incident or recognition of the incident.
      i) If the incident duration exceeds 1 (one) Operational Period then a SitRep must be completed at the end of each Operational Period.
      ii) The SitRep should also be completed every time the Incident Objectives change.

B. RHCC
   1. Once the RHCC has received the SitRep, the information will be compiled and disseminated to the region within 30 minutes of reception.

EMS System-Wide Crisis

Natural and technological crises may place an intense demand for prehospital and hospital resources on one or more of the EMS Systems in Illinois. The potential exists for these crises to occur or evolve without adequate warning or notification. Such crises may include an environmental emergency, epidemic/pandemic, or terrorist act involving a nuclear, chemical, or biological agent.

As a result, EMS and emergency department personnel must be cognizant of evolving trends in the influx of patients with similar signs and symptoms. Recognition of an impending or active system-wide crisis will better prepare hospitals and local ambulance providers to handle any type of situation.

Policy/Procedure: The following outlines how and when recognition/notification may occur:

1. Recognition
    a. Telemetry personnel, physician or Emergency Communicator Registered Nurse (ECRN) may be notified of a system-wide crisis by communication from the local EMS provider (i.e., mass casualty incident)
    b. ED staff may identify an increase in emergency department census including patients complaining of similar signs and symptoms or by noting an increasing number of emergency departments requesting an ambulance bypass. The telemetry personnel or ECRN should report these occurrences to the attending physician and/or charge nurse.
    c. EMS providers or their personnel notice they have an increased number of calls/transports with patients of similar signs and symptoms, they should report this information to their EMS System Coordinator and Resource Hospital.
2. Notification of Personnel
    a. Notification of System-Wide Crisis will be made to the RHCC Coordinator through OSF Saint Francis at 1-800-252-5433. Ask for Disaster Preparedness
    b. The reporting medical provider will report what county the System-Wide Crisis is occurring in.
    c. OSF Saint Francis will activate the RHCC
    d. The RHCC may also contact at his or her discretion:
        - OSF Healthcare Saint Francis Medical Center – Office of Disaster Preparedness
        - Local Public Health Infectious Disease or Emergency Coordinator
        - State and Local Emergency Management Officials
    e. The reporting hospital or EMS agency will fill out the Region 2 System-Wide Crisis Form online on the Disaster Preparedness Website or using the manual form (found here) faxed to the RHCC. If the manual form is used it will be faxed out to the RHCC Office: fax # 309-683-8361 also complete a SitRep found on the Disaster Preparedness Website
    f. If there appears to be a trend, Prehospital and/or hospital, of an increase in the frequency of patients with similar signs and symptoms, the RHCC Hospital Coordinator shall contact The IDPH Duty Officer
3. Plan of Action
    a. The EMS Coordinator of the affected system and RHCC will contact the involved hospitals and local EMS agencies within the EMS System to inform them of the crisis. The EMS System Coordinator will request that each involved hospital take steps to avoid ambulance diversion and alert them to the possible need of having to mobilize additional staff and resources and activate their Emergency Operations Plans.
    b. Hospitals that have to go on bypass will follow update EMResource as soon as possible
    c. The EMS System Coordinator and RHCC can assist local public health departments in their needs during the System-Wide Crisis.
4. All Clear: The RHCC Hospital Coordinator, Disaster Preparedness will contact all hospitals, EMS Systems, and ambulances with an "**all clear**" when the system-wide crisis is over.

NIMS / ICS

In order to ensure effective management of an incident, popper communications, and resource allocation, ICS (Incident Command System) is a component of NIMS (National Incident Management System) and will be utilized when the regional medical disaster plan is activated.

Policy/Procedure:

- EMS Agencies and Hospitals will utilize ICS (Incident Command System) during the medical disaster
    a. Hospitals will have an assigned Hospital Command Center for their facility's point of contact and control. Contact phone numbers are in the appendix.
    b. Under the Incident Command System, EMS Agencies will have a role as part of the Unified Command.
- If the Resource Hospital informs the RHCC of a medical disaster
    a. OSF HealthCare Saint Francis Medical Center may activate their Emergency Operations Plan (EOP) including activation of their Hospital Command Center.
    b. OSF HealthCare Saint Francis Medical Center will become the higher contact and coordinating authority for the Resource Hospital.
- OSF Healthcare Saint Francis Medical Center Disaster Manager or delegated designee has the overall authority for:
    a. Coordinating the regional resources available during the disaster
    b. Coordination of bed availability for the region, state, and possibly other states
    c. Implementing this plan as needed to assist in the coordination of response activities
- Succession of Command: In the event, the RHCC Coordinator is not available during a large-scale emergency or disaster, lines of succession are as follows:

    Primary Contact - Region 2 RHCC Coordinator

    1. OSF HealthCare Saint Francis Medical Center - Disaster Manager
    2. OSF HealthCare Saint Francis Medical Center - Disaster Coordinator
    3. OSF HealthCare Saint Francis Medical Center - Disaster Educator
    4. Peoria Area EMS - System Manager

Communications

It is essential to ensure communications between public safety agencies, hospitals, and other healthcare entities. Disasters have been known to disrupt the ability to use communications devices we are firmly used to using daily. Devices such as VoIP phones, cellular devices, network communications such as e-mail, and instant messenger. Network infrastructure has been damaged or disrupted due to physical damage, power systems failures, etc thus causing a disruption in internet/cloud-based services including shared drives and patient care reporting.

Policy/Procedure:

1. Hospital contact information will be updated in the Region 2 Plan by the RHCC Hospital to include:
    a. 24-hour contact number of the hospital.
    b. 24-hour Fax number.
    c. Hospital Command Center phone numbers

2. Hospitals will maintain the standard MERCI 1 frequency (155.340) for pre-hospital to hospital communications, as well as using MERCI 2 frequency (155.280) for hospital-to-hospital communications.

3. Hospitals will maintain StarComm 21 radio as directed by the Illinois Department of Public Health. Hospitals will use zone “B” channel “EMS R2” the RHCC calling channel is zone “B” channel “EMS” once the regional facility establishes communications with the RHCC on the calling channel “EMS” in zone “B”. Tactical Communications will move to the “EMS R2” channel also in zone “B”.

4. Hospitals will try to establish a relationship with an amateur radio operator (ARES, RACES) group that could establish communications within a hospital operating 24 hours a day until commercial services are restored.

5. Refer to Region 2 Hospitals Tactical Interoperable Communications Plan (TICP)

Mass Casualty Triage

At times prehospital and hospital personnel may find themselves in a situation where the number of injured patients exceeds the available healthcare providers and resources to care for the injured. In these situations, the patients must be triaged in order to do the most good for the greatest number of patients. Triage assessments are based on the severity of the injury, resources available, and also take into consideration if patients are contaminated with a hazardous substance.
If everyone "speaks the same language" during a mass casualty event, confusion will decrease, and more patients will be saved, therefore the START (Simple Triage and Rapid Treatment) and JumpSTART method of triage will be implemented.

Policy/Procedure:

1. Prioritize patients according to the START and JumpSTART system.
   Establish treatment areas for all four categories of patients.
   a. **Immediate/Critical** (Red treatment area)
   b. **Delayed** (Yellow treatment area)
   c. **Minor/Walking Wounded** (Green treatment area)
   d. Deceased (Do not move the deceased unless necessary to gain access to another victim)
2. Move through the entire scene rapidly assessing each patient, stopping only to fix immediate life threats. As you move through the scene, affix a triage tag or mark a patient according to their triaged priority.
3. Treat and transport those patients who are triaged **Immediate/Critical** first, guided by the resources available. Every attempt should be made to transport these patients to the highest level of care available unless that transport time exceeds 30 minutes. Those patients meeting Minimum Trauma Field Criteria should be transported to the highest level trauma center unless transport time exceeds 30 minutes.
4. Treat and transport those patients who are tagged **Delayed** next. In some instances, these patients may even be transported by means other than an ambulance.
5. **Minor/Walking Wounded**, those patients without life-threatening injuries should be treated and transported last. In some instances, these patients may even be transported by means other than an ambulance.
6. Non-viable patients, those who were triaged Deceased should not be treated or transported unless adequate resources and personnel are available. Patients who were triaged **Immediate/Critical** or **Delayed** must be treated and transported first!
7. Documentation: The patient's Triage Tag is considered patient documentation and must be attached to the run report or submitted as the run report to the Resource Hospital. The mass casualty tag is confidential patient information and becomes part of the patient's permanent medical record.

Triage Prioritization

Any disaster plan or program designed to handle a large volume of patients in a short period can only work if the triage process is rapid and efficient. The following method of prioritization should be used for triage, treatment, and transport to maximize the percentage of victims surviving a disaster.

Immediate (Red) Critical:

Victims whose treatment must be immediate and transport to the hospital should not be delayed. These victims must be treated first at the scene and transported as soon as possible. Victims may have one or more of the following problems whose chances of survival depend on immediate emergency care – airway and breathing difficulties, exsanguinating hemorrhage, open chest or abdominal wounds, severe head injuries or head injuries with decreasing level of consciousness, major or complicated burns, tension pneumothorax, pericardial tamponade, impending shock and complicating severe medical problems- poisonings, diabetic with complications, cardiac disease, pregnancy.

Delayed (Yellow) Urgent:

Victims, whose treatment and transportation can be delayed temporarily, may have one or more of the following problems that need medical attention prior to transportation, but do not need immediate care to survive: blunt abdominal or thoracic trauma, major extremity or soft tissue injury, dislocations, major burns, and electrical burns.

Minor (Green) Walking Wounded:

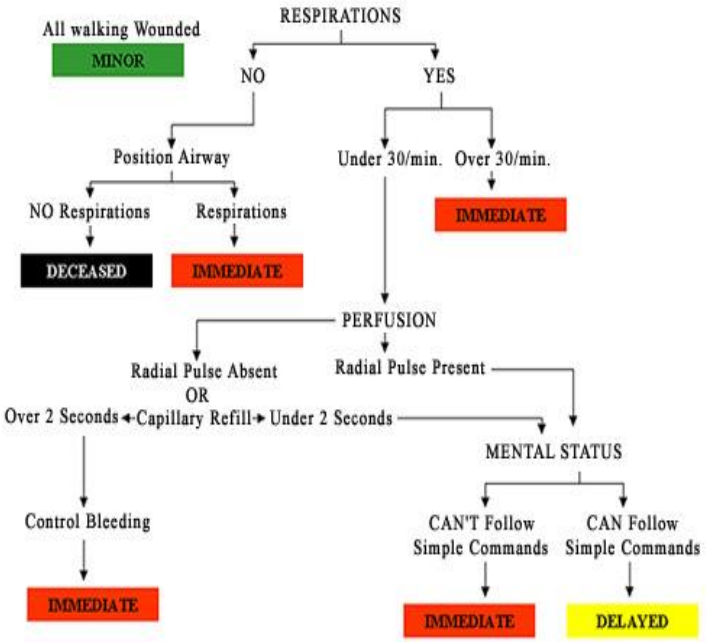
"Walking Wounded": victims whose treatment can be delayed until last. Victims who appear to be uninjured and need only observation or victims who may have one or more of the following problems that require only simple emergency care -fractures, sprains, lacerations, soft tissue injuries, and other lesser injuries.

Deceased (Black):

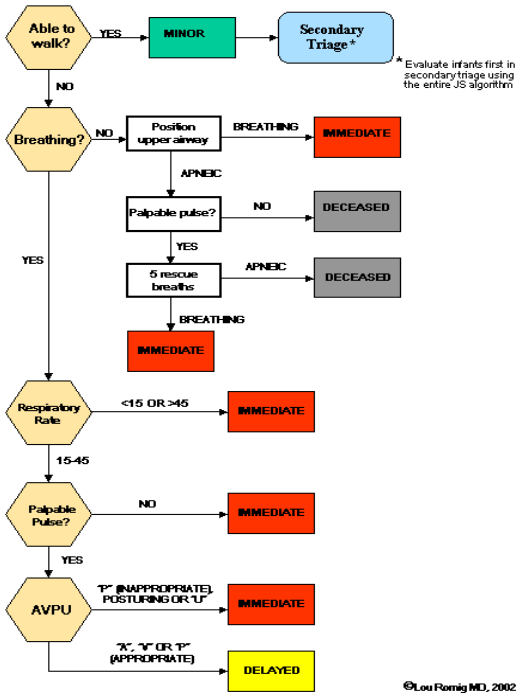
Victims who are triaged as dead, or have an injury considered to be incompatible with life. Note: Once the Red/Critical patient and the Yellow/Delayed patients are treated and transported. If resources are available to attempt resuscitation, that effort should be attempted… Unless the patient has an injury incompatible with life.

In the state of Illinois, IDPH requires the use of START and JumpSTART Triage.

START Triage Algorithm



JumpSTART Pediatric MCI Triage©



Surge Capacity

The ability to obtain adequate staff, supplies and equipment, structures, and systems to provide sufficient care to meet the immediate needs of an influx of patients following a large-scale incident or disaster.

Policy/Procedure:

Internal Surge Capacity

A critical influx of patients is detected when.

- A rapid influx or surge in patients presenting to the Emergency Department or inpatient setting resulting in significant stress to hospital resources.
- An influx of patients requiring specialized healthcare needs not immediately available at the facility.
- The hospital or medical facility is unable to handle any patients due to physical damage or workforce shortage.

Surged facility activates their Emergency Operations Plan and opens their Hospital Command Center

- Activate internal surge capacity plan:
  - Activating hospital's Emergency Operations Plan
  - Update bed availability in EmResource
  - Placing hospital on EMS Bypass
  - Performing staff callbacks

External Surge Capacity

- If internal hospital surge capacity plan is ineffective:
  - Contact the RHCC Hospital Coordinator at **1-800-252-5433**
  - Activate the Region 2 Plan
  - Update EMRESOURCE
  - If time and situation allows, complete the online SitRep
- RHCC / OSF Healthcare Saint Francis Medical Center will obtain regional bed availability from EMRESOURCE information will also contain surge capacity status.
- RHCC / OSF Healthcare Saint Francis Medical Center will assist in the coordination of the interfacility transfer of patients to appropriate hospitals within the region.
- Regional hospitals may have to activate their own Emergency Operations Plans including surge capacity plans to accept the incoming patients.
- To expedite patient movement and reduce the chance of mortality, a physician or designee may discharge and receive patients from one hospital to another.

Alternative Care Site (Surge Hospital)

- If the number of patients outstrips the region's internal surge capacity, external surge capacity will be utilized.
  - The RHCC Hospital will assist in coordinating the establishment of an Alternate Care Site.
  - Each Hospital in the region should have a pre-identified Alternate Care Site that can hold 100 or more patients. Facility-related items to consider are: Alternate Care Site Checklist
    - ✓Generator power
    - ✓Running water
    - ✓HVAC (Heating and Colling capabilities)
    - ✓Individual spaces for patient care wards
    - ✓Receiving and loading dock
    - ✓Area for surge hospital command and control
    - ✓Telephone or other communications within the facility
    - ✓Obtaining staffing for surge hospital

1. *Hospitals can determine their surge capacity by using the Surge Capacity Worksheet in the Appendix*

Ethical Objectives in Times of Crisis

Steward scarce resources to promote the common good of the people in Illinois by balancing these equally important and overlapping ethical objectives:

1. Protect the population‘s health by:
    - Reducing mortality and serious morbidity;
    - Minimizing disruption to basic health care and public health;
    - Recognizing health is holistic and more than just the physical needs of people.
2. Protect public safety and civil order by:
    - Minimizing disruption to public safety and other critical infrastructures.
3. Enhance community resilience by:
    - Promoting public understanding about and confidence in resource distribution;
    - Incorporate community input on planning and response process
4. Strive for fairness by:
    - Rejecting strategies that are discriminatory or exacerbate health disparities;
    - Reducing significant group differences in mortality and serious morbidity;
    - Making reasonable efforts to remove barriers to access.
5. Protect against systematic unfairness by:
    - Making reasonable efforts to reciprocate to groups accepting high risk in the service of others;
    - Rejecting strategies that are discriminatory or exacerbate health disparities.

Allocation of Resources and Services

1. Assess the probability that a scarcity of resources may occur and plan in advance how to address such scarcity.
    a. Scarcity of resources and services during a crisis may take many forms, and plans should address the anticipated nature, duration, and severity of the scarcity.
    b. At all levels of planning, efforts should be made to acquire, stockpile, and/or prepare for sufficient levels of resources and services to alleviate, as much as possible, the need to allocate these resources and services during a crisis.
    c. Extend supplies and conserve resources before reallocating; reallocate only as a last resort.
    d. Scale reallocating strategies to different levels of scarcity
2. Whenever possible, avoid making definitive decisions (such as who to treat/no treat or triaging to palliative care) alone, instead relying on pre-defined processes and/or team-based decisions
    a. Conditions of over-whelming scarcity limit autonomous choices for both recipients and providers regarding the allocation of scarce resources, but do not permit actions that violate ethical norms.

3. Do NOT reallocate based on:
    a. Race, gender, religion, citizenship, sexual orientation, pre-existing physical or mental disability unrelated to the medical diagnosis or need, or socioeconomic status (including ability to pay)
    b. Judgments that some people have greater quality of life than others
    c. Judgments that some people have greater "social value" than others
4. Generally, de-prioritize persons unlikely to benefit from the resource
    a. Access to palliative care resources and services should be provided to these persons in order to minimize pain and suffering

5. When necessary, prioritize essential or key workers to support critical infrastructures and the health of the population
    a. Prioritizing groups based on key worker status is only justified when it clearly supports critical infrastructures and the health of the population. Therefore, key workers are not always prioritized ahead of the general population and not all key workers are at highest priority to receive all of the resources.
6. Reallocate different resources to reduce overall mortality and morbidity (rather than resort to random processes from the start)
7. For the general public, consider:
    a. Medical need and urgency of treatment
    b. Adequacy of available resources to meet the need
    c. Anticipated good or acceptable response to available resources
8. When appropriate to prioritize essential workers separately from the general public, consider:
    a. Risk of occupational exposure as a result of the catastrophic incident
    b. Irreplaceability in the critical infrastructure workforce
    c. Anticipated good or acceptable response to available resources

Mutual Aid: Transport and Admitting of Patients

Mutual Aid is a voluntary agreement among healthcare agencies and facilities, for the purpose of providing assistance at the time of a great need. For purposes of this plan, a disaster is defined as an "overwhelming incident that exceeds the effective response capability of the impacted health care facility or facilities."
An incident of this magnitude will almost always create an impact at the regional level. Medical disasters impact facilities that are not directly impacted by the disaster by creating a cascading event. The disaster may be an "external" or "internal" event for hospitals and assumes that each affected hospital's emergency operations plans have been fully implemented. EMS agencies may have to send ambulances and personnel to impacted areas outside of their home coverage area. Hospitals may have to accept patients either from the scene of a disaster or from other impacted hospitals. Hospitals and EMS Systems that have no resources or bed availability at the time of the medical disaster should not be required to provide mutual aid.

Policy / Procedure:

1. RHCC Hospital system is activated by IDPH or the Region 2 Plan is activated by a regional hospital.
2. A request to update bed status in EmResource is sent to all Region 2 hospitals.
    a. Data collected from EmResource will be calculated and submitted to IDPH.
3. If a request for resources is received electronically (if the electronic form is unavailable then the faxed or emailed paper form is acceptable).
    a. The Disaster RHCC Hospital will access the latest bed information from EmResource or the faxed data forms completed by regional hospitals.
    b. The Disaster RHCC Hospital will attempt to acquire the requested resources through whatever channel is available.
    c. The Disaster RHCC Hospital will coordinate the acquisition of the requested resource.

    Resources could include but, is not limited to:

    - ✓ Medical and/or non-medical supplies
    - ✓ EMS Transportation-Ambulance/ALS/BLS/Flight/Aircraft
    - ✓ EMS Pre-hospital personnel/FRD/EMT/Paramedic, etc
    - ✓ Patient care beds, Disaster Beds, Surge Beds, etc
    - ✓ Hospital personnel-Nurses/Physicians/Allied Healthcare Personnel. etc

4. Patients that are sent from hospital to hospital will:
    a. Have all patient care records and copies of medical imaging.
    b. Have patient FACE sheet and contact information, if completed.
    c. Have EMTALA, state, and federal transport forms completed.
    d. Have verbal or written confirmation that the receiving hospital accepts the transported patient and a room number or room assignment prior to transport.

5. **The requesting hospital or EMS agency may be responsible for the expenses of the requested resource.**

Mutual Aid: Use of Pre-hospital and Medical Personnel

During a medical disaster, EMS Systems or hospitals may need specific medical personnel to help. A mutual aid agreement among the EMS Systems and Hospitals of Region 2 will expedite the use of needed medical personnel. Hospitals and EMS Systems should come to a consensus on the identifications and scope of practice of assisting outside medical personnel. In addition other factors to consider are the reimbursement, liability coverage and workers compensation of the pre-hospital and medical personnel.
The protection from liability during a disaster, regional or statewide, is covered in several portions of Illinois law. For pre-hospital personnel including RNs, reference EMS Act (210 ILCS 50.) For other providers such as physicians (745 ILCS 49/25) and nurses (745 ILCS 49/34-40)

Policy/Procedure:

1. Request is made to the RHCC for additional medical personnel. The additional medical personnel (RMERT members) could include but are not limited to:
    a. Nurses
    b. Physicians
    c. Pre-hospital personnel
    d. Respiratory Therapist
    e. Technicians
    f. Command / Communication personal
2. RHCC will:
    a. Once the "Request for Medical Resourcesl" Forms have been completed. The RHCC coordinator or the Disaster Manager will compile the total needs and attempt to fill them.
    b. Contact will be made with the Regional Hospital(s) that are able to send personnel and/or supplies to the requesting facility. An attempt will be made to obtain an estimated time when the resources will be arriving at the requesting facility.
    c. If needed, arrange transport for the requested medical personnel / Supplies to and from the receiving hospital.
    d. Send the receiving hospital an invoice of the cost of medical personnel to include:
        i. Payroll cost
        ii. Benefit cost
        iii. Supplies cost
3. The receiving hospital will:
    a. Ensure the safety and comfort of the medical personnel.
    b. Identify the medical personnel with photo identification.
    c. Assume the cost for the use of the medical personnel and reimburse the sending hospital(s) or EMS System(s).
4. OSF Disaster preparedness office will ensure proper license are maintained from RMERT personal.
5. Scope of practice:
    a. RMERT personal will follow their "Protocols / polices / procedures, unless directed on scene by an EMS Medical Control Physician. If an EMS Medical Control Physician is on scene, EMS providers may take orders from him/her.
    b. Nurses follow State of Illinois Nursing Practice Acts
    c. Allied health personnel follow their State of Illinois Practice Acts

Regional 2 Medical Emergency Response Teams (RMERT)

The mission of the Region 2 Medical Emergency Response Team is to improve disaster response and augment the existing medical service system for community emergencies in the event of a significant medical disaster involving the central Illinois area. The Region 2 Medical Response Team is able to provide a variety of services, including on-scene, out-of-hospital, or direct hospital emergency medical care. In addition, RMERT will assist with decontamination, if HazMat/WMD conditions exist, and augment the medical response of regional Fire, Rescue, EMS, Emergency Management, and Law Enforcement agencies.

Procedure/Policy:

1. Equipment:
    a. All RMERT equipment will be maintained by OSF Healthcare Saint Francis Medical Center and housed in the Peoria area.
2. Each Region 2 hospital must supply 2 or more members to RMERT. Members can be from the following patient care fields:
    a. Physician
    b. Nurse (RN)
    c. Respiratory Therapist
    d. Pre-hospital personnel
3. All team members must remain on their sponsoring hospital's payroll during RMERT activations. This is to ensure proper medical liability and workman's compensation are met.
    a. Hospitals must have a letter of support/workers compensation on file with the SFMC Disaster Preparedness Office for team members to participate.
4. A copy of team rosters, contact information, policy/procedures, and equipment lists will be kept at the Disaster RHCC Hospital and updated yearly.
5. Minimum training includes:
    - Quarterly RMERT training
    - Incident command training,
        - ✓ IS 100, IS 200, IS 700, IS 800
    - WMD/Terrorism Awareness for Emergency Responders
6. RMERT team members will receive two (2) T-shirts with RMERT logo.

Requesting the Region 2 Medical Response Team

The Region 2 Medical Emergency Response Team (RMERT) is a mobile medical team comprised of medical personnel including Physicians, Nurses, Prehospital personnel, and other allied healthcare professionals.

1. Criteria for activation of the medical response team are local hospital and EMS System resources are overwhelmed. Types of incidents to cause activation include, but are not limited to: Disaster / Mass Casualty Incident, Hazardous Materials Incident, Technical Rescue, Search and Rescue, Incident Management Support, and Special Events / Large Crowd Gatherings, and Natural disasters (e.g. tornadoes, floods, forest fires, public health emergencies, etc.)

2. Contact OSF Transfer Services 1-800-252-5433.
Ask to be connected to Disaster Preparedness personnel. You may have to wait for a callback

3. Give the Medical Communications Dispatcher the following information:

Type of event/nature of the emergency
The exact location of where the team should set up (minimum: 100' x100')
- **Provide GPS coordinates if available**
- **Address / Town / cross roads / etc.**

Number of casualties
Name and phone number of the contact person

Request for Resources (RFR)

PURPOSE

This standard operating procedure (SOP) addresses healthcare facilities in the Region 2 Healthcare Coalition that will request regional assets following an incident or in anticipation of a significant regional event.

BACKGROUND

The Region 2 Healthcare Coalition is a group comprised of Regional Hospitals, Public Health Officials, Emergency Managers of City and Counties, and other healthcare entities within IDPH EMS Region 2. The region is comprised of 18 counties and 25 hospitals serving over 1 million persons in population. The Region 2 Healthcare Coalition also maintains Regional Response Assets housed within Regional Hospitals.

SCOPE

This SOP guides the Requests for Regional Assets in support of:

A. A catastrophic incident or event involving multiple jurisdictions—especially incidents or events in which regional resource requests are anticipated and/or the activation of a Mutual Aid Agreement (MAA) is likely.
B. Situational awareness and planning support for a regional response to ensure that all actions are accomplished within the procedures and priorities established

SITUATION AND ASSUMPTIONS

A. Situation

A serious incident or event has occurred that has affected multiple jurisdictions within Region 2.

1. Regional resources are needed to facilitate the treatment or transport of patients
2. Or, Local Resources are extinguished and Regional Resources are requested to support a healthcare facility in the region.

B. Assumptions
    1. All Regional Assets will be requested by members of the Region 2 Healthcare Coalition

Cont'd on next page

REQUESTING REGIONAL RESOURCES PROCEDURES

A. Requesting Regional Resources

The following steps are intended to guide you step by step for requesting resources.

1. Regional Assets will be requested only after local resources have been extinguished, or plans to extinguishing local resources during an event or incident.
2. All Regional Asset Requests will be made to the RHCC or RHCC staff.
3. When making requests for regional resources please use the following order:
    a. Make contact the RHCC or RHCC Staff by phone
        i. Contact OSF Emergency Services at 1-800-252-5433
    b. Once contact has been made, complete the Request for Resources (RFR) form on the OSF Disaster Preparedness Website under the RHCC Login
    c. If the online form is not available. You can find a copy of the Manual Form to fill out in the appendix of this document. (click here)
4. The RHCC or RHCC Staff is responsible for processing the requests and the dissemination of equipment
5. Any Regional Resources that are requested and delivered then become the responsibility of the requesting facility or agency.
6. Any consumable resources requested, delivered, and used during an event must be replaced before being returned. Or a documented plan must be developed for the replacement of the consumed good.
7. Any Maintenance costs, fuel/consumable costs associated with the use of requested assets are the responsibility of the requesting facility or agency
8. Any Regional Resources that are damaged, stolen, or found to be unusable or inoperable upon return will be replaced or associated replacement costs will be paid by the Requesting Agency
9. The RHCC staff will be notified as soon as possible when surplus resources are to be deactivated.
10. Once the resource is deactivated it is the responsibility of the Requesting Facility to make contact with the RHCC to Demobilize the Regional Assets. (see. *Region 2 Asset Demobilization Plan*)

AREAS OF RESPONSIBILITIES

A. Requesting Facility or Agency
    1. Must make the request for Regional Assets to the RHCC
    2. Is responsible for the use, maintenance, security, and replacement of consumables while using the requested assets
    3. Is responsible for cleaning and returning the asset back to their delivered state

B. RHCC
    1. Is responsible for processing the request
    2. Is to coordinate the shipment or delivery of the requested resource
    3. Is to coordinate with the Requesting Facility to demobilize the regional resources.

COMMUNICATION

The requesting facility or agency must maintain communication with the RHCC relating the status of the Requested Resources. Communication regarding the demobilization of the Requested Resources must be done between the Requesting Agency and the RHCC referencing the "*Region 2 Asset Demobilization Plan*".

Critical Incident Stress Management (CISM) Team

A critical incident is defined as
"any situation faced by personnel that cause them to experience unusually strong emotional reactions which have the potential to interfere with their ability to function."

In short...It evokes normal reactions from normal people to abnormal events.

During or after a medical disaster Critical Incident Stress Management teams may be needed for first responders or medical personnel that are experiencing reactions that may be hampering their ability to function. Hospitals and EMS systems should identify local CISM teams or mental health support personnel capable of providing CISM support. Debriefings and stress management services are most effective when conducted within 48 hours of the incident. In the event local support is incapable of providing such support, the Heart of Illinois Critical Incident Stress Management Team is regional resource capable of providing CISM services.

The CISM Team Coordinator may be reached by contacting:
OSF Healthcare Saint Francis Medical Center at **1(800) 252-5433** request CISM resources

Special Healthcare Needs Populations

During a disaster, specific populations with chronic healthcare needs may need to be assisted with treatments, assessments and re-stocking of needed home medical supplies.

Policy/Procedure:

1. Children with Special Healthcare Needs
    a. If a hospital or EMS System receives a specific request for assistance from a family with a child with special healthcare needs and the request is beyond the capabilities of the hospital or EMS System, contact the RHCC / OSF Saint Francis Medical Center-Hospital Command Center for additional assistance.
    b. Resources needed for the child will be arranged through the RHCC / OSF Saint Francis Medical Center- 1-800-252-5433.
    c. Assistance for Medical Transportation for the child can be arranged through the RHCC / OSF Saint Francis Medical Center -Hospital Command Center.
    d. Assistance for specific sheltering requirements may be arranged through the American Red Cross or a local shelter.
2. Adults with Special Healthcare Needs
    a. If a hospital or EMS System receives a specific request for assistance from a family or patient with special healthcare needs and the request is above the capabilities of the hospitals or EMS System, contact the RHCC / OSF Saint Francis Medical Center for further assistance.

Region 2 Healthcare Coalition Action Plan Matrix –**At-Risk/Functional and Access Needs Planning**

Vision: By working collaboratively with community partners, this matrix will help to ensure that no one group is more impacted than another in an emergency.

Aim: This matrix will help assure access to public health preparedness, response and recovery information and services for the most vulnerable and hardest-to-reach residents in _____ county through mutually respectful relationships with at-risk/functional and access needs populations and the organizations that serve them.

Abbreviations: AR/FP = At-Risk/Functional Needs Populations; **CBO** = Community Based Organizations that serve or reach one or more of the identified At-Risk/Functional and Access Needs populations;

Track	Objective (measurable outcome)	Action
I. Assess, Track and Evaluate *(Goal: Track and evaluate the preparedness, response and recovery needs of community based organizations that serve AR/FPs.)*	1. Identify CBOs serving all at-risk/functional and access needs population categories.	1.1 Develop listing of all CBO working with AR/FP
		1.2 Review previous work identifying CBOs
		1.3 Match CBOs to ARFP population categories
		1.4 Map out CBO on a GIS layer
		1.5 Prioritize which CBOs to work with base don population served and ease of access
	2. Identify emergency planning needs of CBOs.	2.1 Send out survey to CBO to determine effect of prior efforts (if any)
		2.2 List/categorize survey results from prior effort
		2.3 Review previous work done with agencies
		2.3 Ask CBOs to complete an evaluation on previous work, if any.
		2.4 Develop and implement an intake assessment on every new organization
	3. Track CBOs and plan development	3.1 Develop database to store & collect information
		3.2 Explore database options.
	4. Evaluate progress of planning.	4.1. Develop simple evaluation plan to measure success/ progress

Track	Objective (measurable outcome)	Action
II. Communication *(Goal: Essential information will reach residents in all necessary population segments prior to and throughout an emergency event.)*	1. Develop a planning task force with CBOs and community leaders for emergencies and non-emergencies.	1.1 Build an understanding of the communication web that exists at governmental and community levels.
		1.2 Determine functional scope of network: goals, membership, roles, responsibilities, protocols, non-emergency use.
		1.3 Coordinate communication with CBOs and community leaders on the task force.
	2. Coordinate with the Task Force to ensure that all populations receive emergency information.	2.2 Use CBO relationships to inform list of contacts at media outlets.
		2.3 Assist with message development (prior to and during emergency).
		2.4 Assist with translating more materials into alternate formats (priority languages, written and pictorial messages, large type, Braille)
		2.5 Updating CBO list for blastfax/email service; begin implementing with periodic/nonemergency transmittals
		2.6 Assist at least one at-risk population develop emergency communication pathways with like agencies (use as model)
III. Technical Assistance *(Goal: CBOs will be better prepared to continue delivery of service and have the skills/capacity to train their staff (and clients) to provide basic response and recovery services.)*	1. Identify who, what, and how to provide technical assistance for CBOs serving AR/FP populations.	1.1 Consider bringing in "Are You Ready?" training for the Task Force
		1.2 Gauge interest from task force to bring in the train-the-trainer for the "Are You Ready?" course
	2. Provide learning and knowledge exchange opportunities for CBOs on various preparedness topics.	2.1 Develop and implement a training program to reach out to local communities working with CBOs to bring the "Are You Ready?" course to the general public and those with at-risk/functional or access needs
		2.2 Develop strategy to engage targeted communities based on assessment, mapping and gap analysis information.
IV. Coordination *(Goal: At-Risk/Functional Needs planning activities will be integrated into all government, healthcare, community based*	1. Identify and engage key local governmental entities that serve at-risk populations.	1.1 Facilitate discussions and coordination with key governmental partners to identify gaps and available resources that can be utilized during a response and in preparing for a response.
		1.2 Assist in the coordination between cities and CBOs
		1.3 Work to integrate knowledge of AR/FPs into first responder planning
		1.4 Develop coordinated system to create pictorial and translated messages across governmental agencies.

Track	Objective (measurable outcome)	Action
organization and internal public health systems.)	2. Identify and engage key healthcare organization contacts that serve at-risk populations.	Will introduce and discuss at quarterly Healthcare Coalition meeting and reach other healthcare audiences as needed
		Discuss with the local medical societies the work and if a network of communication is feasible
		After discussion and input from these agencies will work to develop a plan which works to either keep the group updated, seek ongoing input, ask for their help reaching folks or all of the above
	3. Identify and engage key community based organization contacts that serve vulnerable populations.	3.1 Build on relationships established through local coalitions.
		3.2 Collaborate/coordinate with CBOs.
		3.3 Establish mechanism to include CBOs in the future planning and development of at-risk planning
	4. Identify and engage key stakeholders that serve/intersect with at-risk populations.	4.1 Schedule meetings and presentations with key stakeholders that serve/intersect with vulnerable populations to utilize internal capacity.
		4.2 Present work to date and plan to local government stakeholders
		4.3 Present work to date to Regional Coalitions

Organization and Assignment of Responsibility

Agreement/Signatures to the Region 2 Emergency Medical Disaster Plan

We have read The Region 2 Emergency Medical Disaster and Bioterrorism Plan of EMS Region 2 and **agree** to the responsibilities.

Dr, Matthew Jackson
Disaster RHCC Hospital
SFMC Disaster Medical Director

Jon Quast
Disaster RHCC Hospital
Region 2 RHCC Manager

☐ _____ _____

EMS System — EMS System Manager

☐ _____ _____

Resource Hospital — Resource Hospital Representative

SIGNATURES ON FILE

☐ _____ _____

Associate Hospital — Associate Hospital Representative

☐ _____ _____

Participating Hospital — Participating Hospital Representative

☐ _____ _____

Emergency Management Agency Representative — Emergency Management

☐ _____ _____

County Coroner / Medical Examiner Agency Representative — Participating County Coroner / M. E.

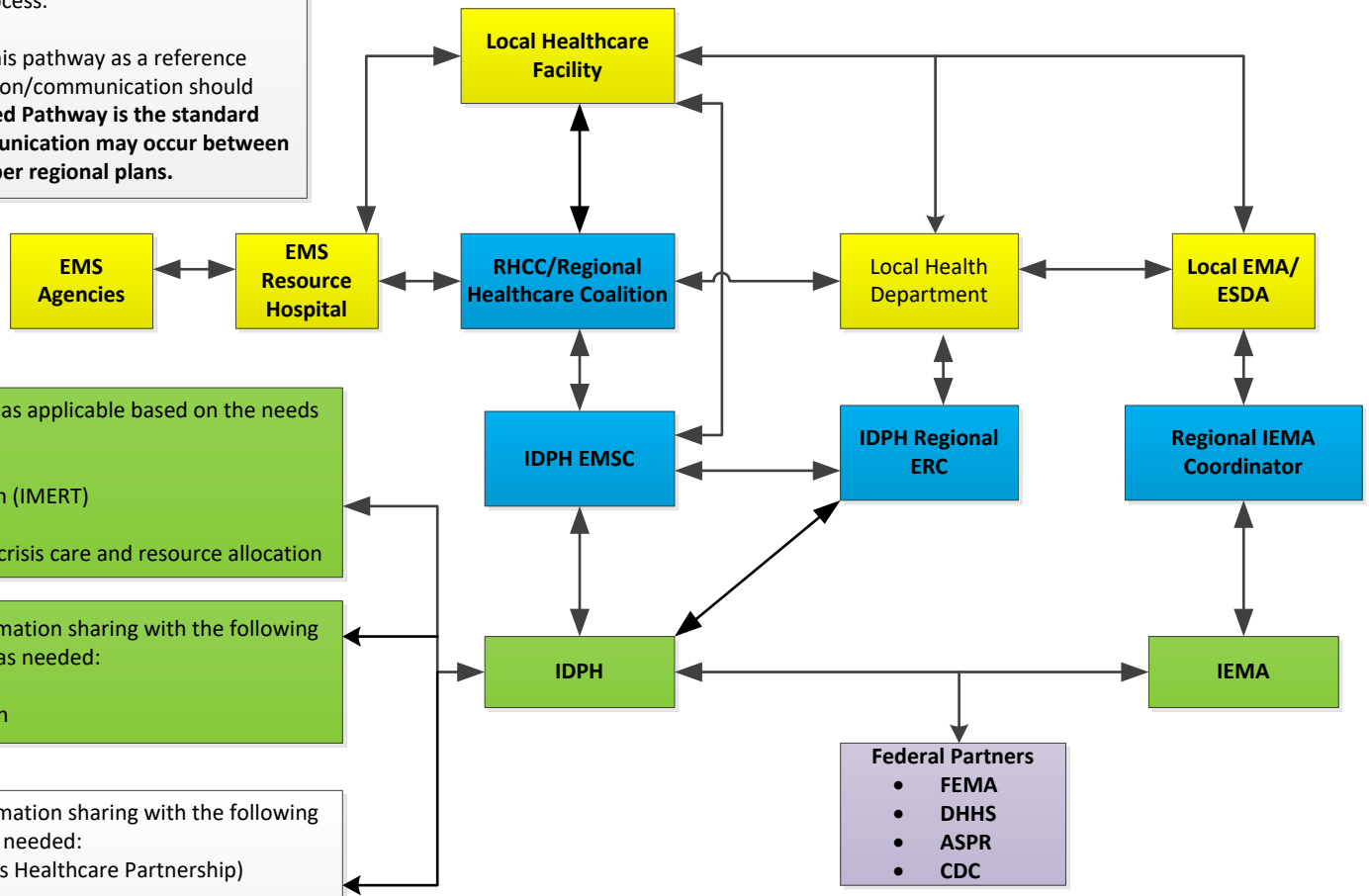
Region 2 Plans and Appendicies:

- Region 2 Hospital, County Health Department, County EMA and Communications Information
- Region 2 TICP (Tactical Interoperable Communications Plan)
- Region 2 Fatality Management Plan
- Region 2 WebSite - Region 2 SitRep, Region 2 RFR, and Region 2 EMS System Wide Crisis Form
- Region 2 Pediatric Surge Annex
- Region 2 Burn Surge Annex
- RHCC Job Action Sheets

IDPH Communication Pathway

Purpose: Outline which stakeholders will typically communicate and share information with each other when the plan is activated. Although there is some overlap, this Communication Pathway is different from the Request for Medical Resources (RFMR) process.

Instructions: All stakeholders should use this pathway as a reference guide to identify how the flow of information/communication should occur when the annex is activated. **Depicted Pathway is the standard flow of communication. Additional communication may occur between other entities and regional HCC partners per regional plans.**



Activation of the subject matter expertise, as applicable based on the needs of the incident.

- Pediatric Care Medical Specialist Team (IMERT)
- State Burn Coordinating center
- Medical, ethical and legal experts for crisis care and resource allocation

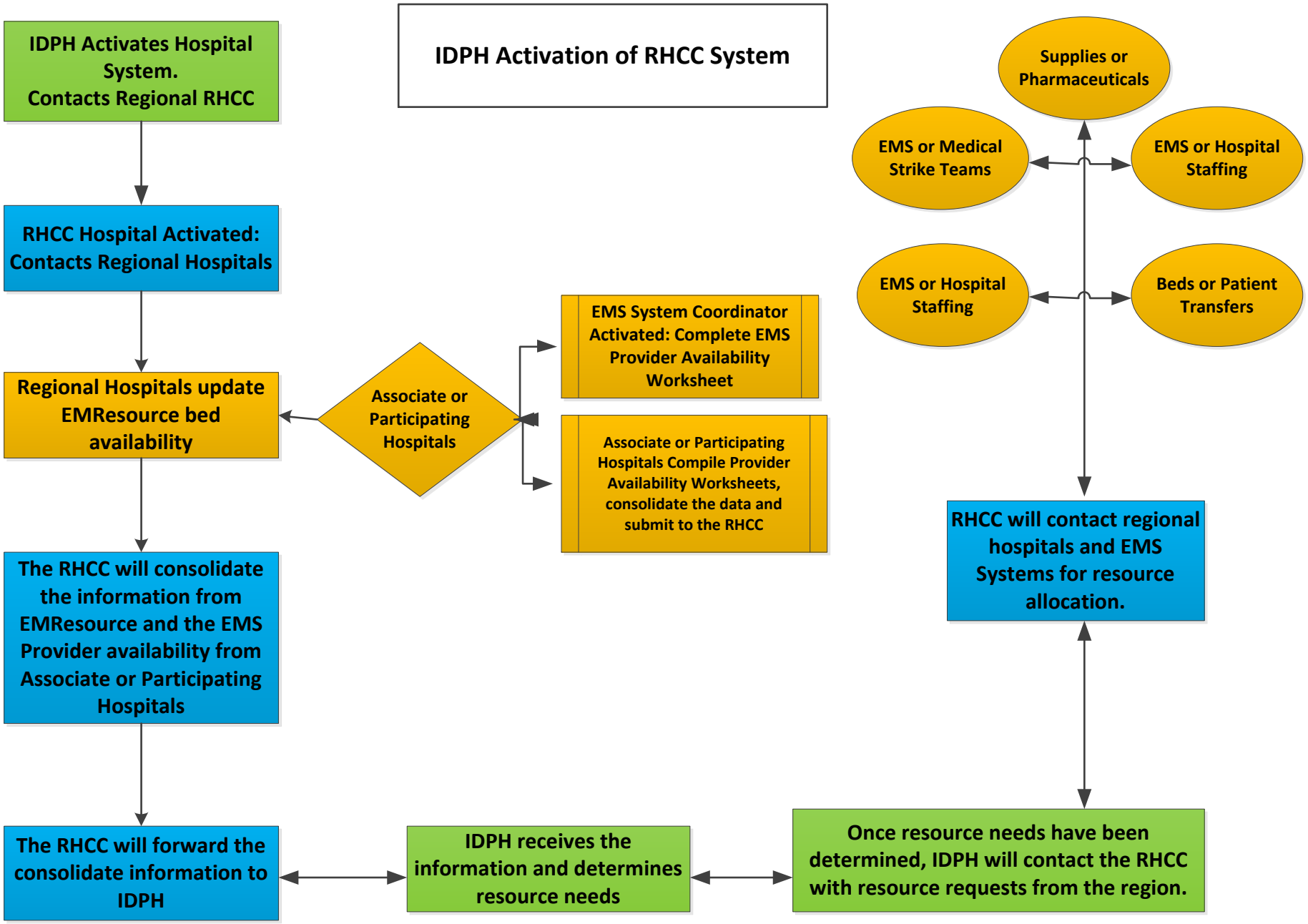
Situational awareness updates and information sharing with the following intrastate groups as needed:

- Other State Agencies
- Illinois Health and Hospital Association

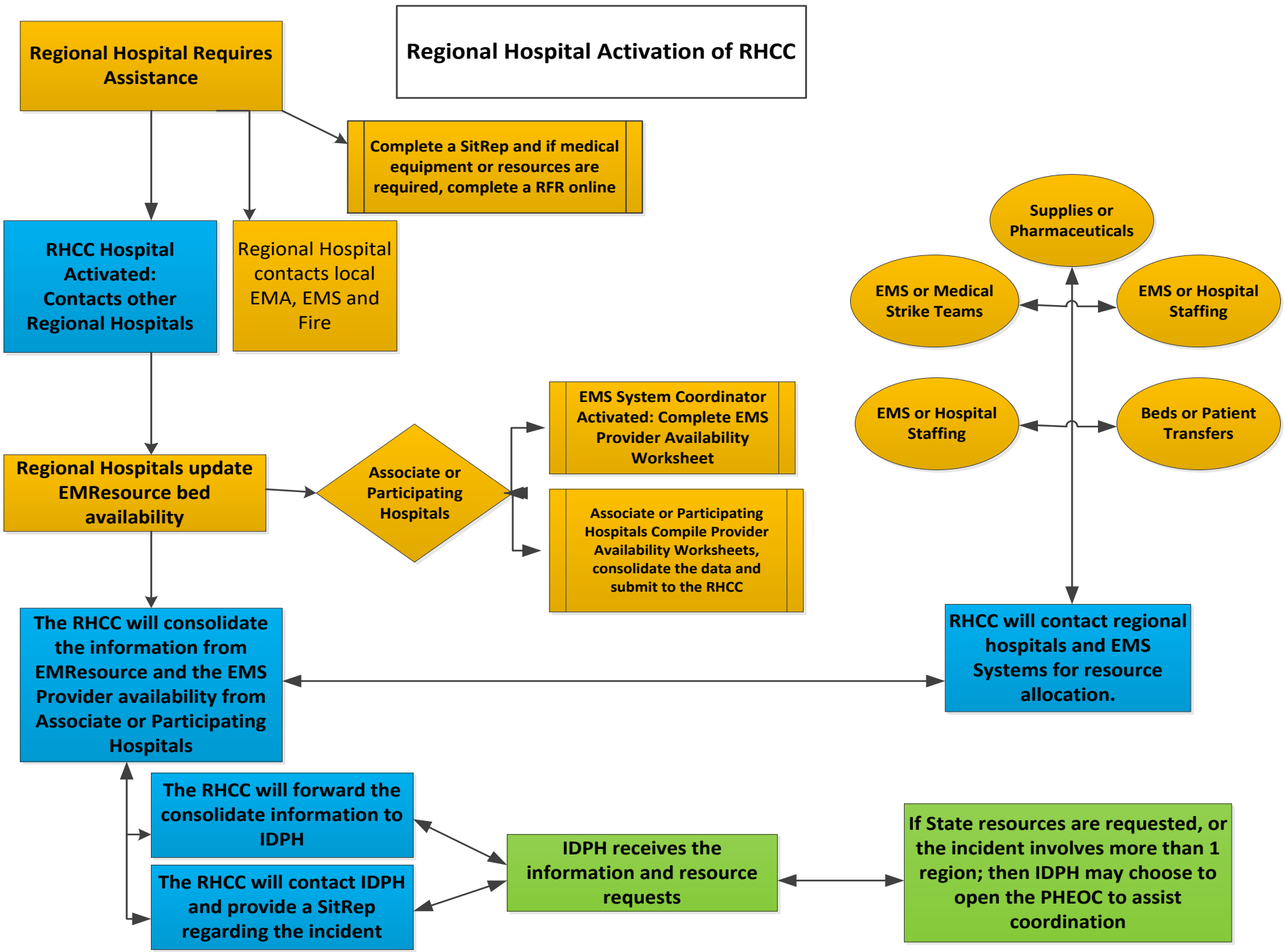
Situational awareness updates and infromation sharing with the following border states as needed:

- GLHP (Michigan: Great Lakes Healthcare Partnership)
- Iowa
- Kentucky
- Missouri

IDPH Activation of RHCC System



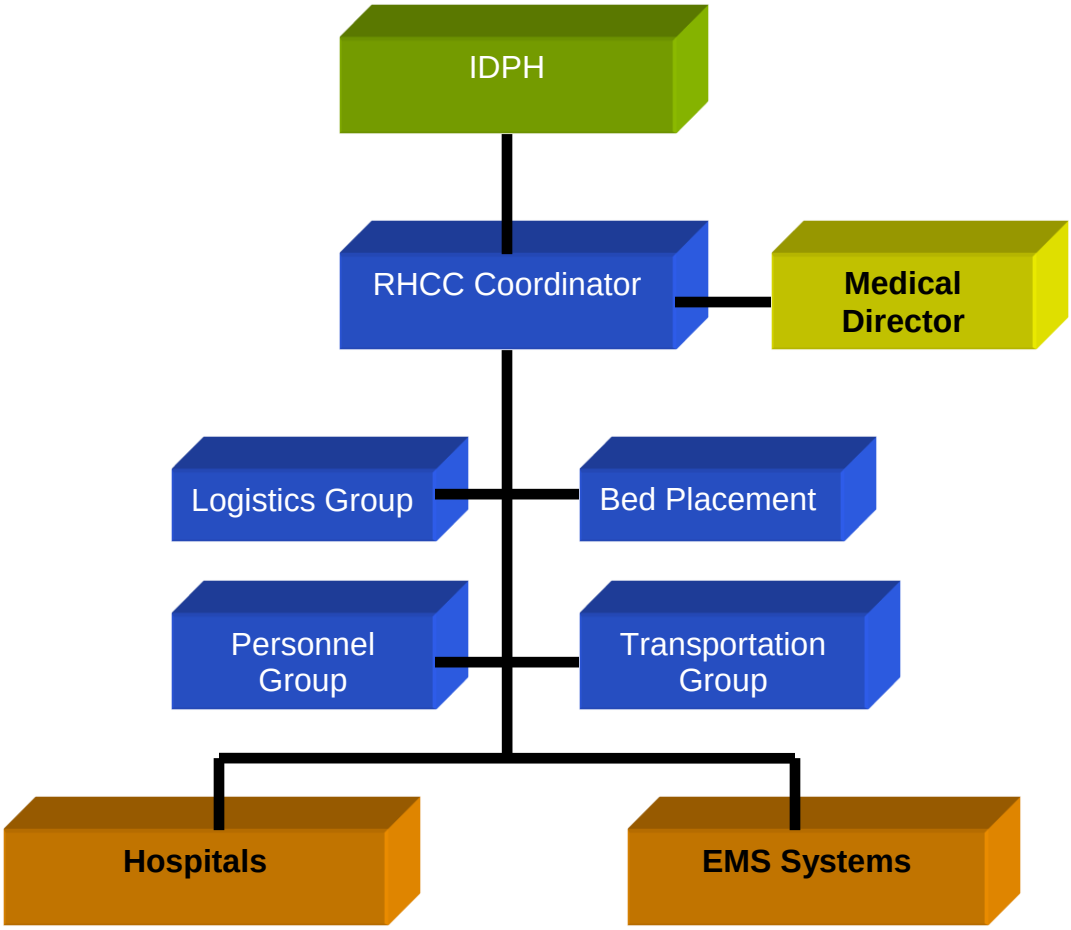
Regional Hospital Activation of RHCC



Surge Capacity Worksheet

Area Priority	# of Beds	Department	Oxygen	Suction	Cardiac Monitor	Emergency Power	Isolation / Quarantine	Sharps Container	Crash cart	Bathroom

RHCC Hospital Activation Organizational Chart



Region 2 Request for Resources: Resource Order Form
Please use the online Google Form if available

Organization Requesting Resources:	Point of Contacts Name:

Point of Contacts ICS Position or	Point of Contacts Direct Phone

Point of Contacts E-Mail address:

Resource Requested: *Please be specific. **You may only request one type of resource per form. For example you can order 25G syringes on this form and then 20G syringes on another form.

Quantity Requested:	Requested Delivery Date and Time

Requested Delivery Location: *Please be specific in your location. Include an address and specific instructions to your drop off location. If no address is available please give use GPS Coordinates using Lat Long to the drop off

Please Fax completed request form to the Region 2 RHCC at 309-683-8361. Please be sure and contact the RHCC office once the request has been completed and faxed. Main phone line to the RHCC office is 309-683-8360

RHCC USE ONLY Request Received: Requested Filled: Yes ☐ No ☐

Region 2 System Wide Crisis Form (manual form)

Date: _____ Time: _____

Name of Hospital

_____

Name of person filling in report / Title

_____

Direct Contact Phone Number

_____

Names of associate hospitals / participating hospitals requesting bypass or who have seen an increase in emergency department visits:

_____

_____

_____

Common signs/symptoms of patients who are coming to the emergency department:

_____

_____

Name(s) of EMS provider(s) in the area who have seen an increase in ambulance calls:

Name and time of EMS Coordinator or EMS Medical Director notification:

_____

Name

Time / Date

Date / Time / Name of person notified at Illinois Department of Public Health (i.e., Chief of EMS)

_____ _____ _____

Hospitals Only

Number of patient with same / like symptoms seen in last (6) hours: ____

EMS Providers Only

Number of patients transported to emergency departments by all Ambulances in your service with same / like symptoms: ____

Any Increase in response time: YES NO

Hospitals and Providers

Common / like complaints by patients:

Any other pertinent information:

Resource Hospital Contacted: YES NO

Person contacted at Resource Hospital: _____ _____
Name Title

How was information reported:
PHONE - FAX - PAGE - PERSON to PERSON - OTHER

Names / Organizations and / or titles of other persons contacted:

////LAST PAGE NOTHING FOLLOWS////