DISASTER MEDICAL SERVICES (NCESF-8)

2023

I. INTRODUCTION

A. PURPOSE

The purpose of this appendix is to provide coordinated state assistance to supplement local resources in response to medical care needs following a declared disaster event or at the request of emergency management.

B. SCOPE

The intent of Disaster Medical Services is to supplement county governments affected by the disaster from resources available within the Division of Health Service Regulation (DHSR), Office of Emergency Medical Services (OEMS), and resources available from the State Medical Response System inclusive of the State Medical Assistance Teams, the National Disaster Medical System (NDMS), Disaster Medical Assistance Teams (DMATs), Emergency Medical Services Systems, Health Care Organizations, and the Association of Rescue and EMS. The OEMS fulfills its role as lead ESF-8 agency by coordinating non-local medical assets to augment local needs as identified by mission assignments from emergency management.

Disaster Medical Services involves supplemental assistance to local governments in planning, response, mitigation, and recovery of a major emergency or disaster. These activities include, but are not limited to, assessment of medical needs, provision of medical care personnel and medical equipment and supplies, coordination assistance for transportation of medical supplies and personnel, coordination assistance for evacuation of patients, provision of emergency responder health and safety, provision of medical command and control, and Emergency Medical Services.

II. SITUATION AND ASSUMPTIONS

A. SITUATION

A significant natural disaster or man-made event that overwhelms the local jurisdiction's standard of care capability would define a need for a declaration of emergency. This may require that state medical care assistance be provided. Hospitals, nursing homes, community health centers, rural health centers, university health centers, assisted living facilities, funeral homes, hospital morgues, and other medical facilities may be severely damaged or totally destroyed depending on the disaster. Even undamaged or slightly damaged facilities may be unusable due to the lack of utilities. Staff may be unable to report for duty because of personal injuries or lack of communications and transportation.

Medical facilities that remain in operation and have the necessary utilities and staff will probably be overwhelmed with walking-wounded and seriously injured victims who are brought there immediately after the occurrence. In the face of increases in demand and the damage sustained, medical supplies (including pharmaceutical) and equipment will probably be in short supply. Most health care facilities usually maintain only a small inventory to handle their day-to-day short-term patient loads. Restocking of medical supplies could be hampered depending on communication and transportation disruptions. Disruptions in personnel, product, and physical plant could seriously impair access to healthcare in impacted areas.

Uninjured persons who require daily medications may have difficulty in obtaining these medications because of damage/destruction of normal supply locations and general shortages within the disaster area. Man-made events, such as those involving hazardous materials, could cause a demand for specialized medical care personnel and equipment. Intentional or unintentional exposures to infectious agents could create a need for specific levels of protection for healthcare workers and possible substantial decreases in the healthcare workforce. Isolation surge capacity needs could also create a need for alterations and augmentation of existing product, pharmaceuticals, and physical plant in healthcare facilities. In addition to physical injuries, the stress imposed on individuals affected by a disaster may produce a need for increased mental health outreach and crisis counseling to prevent or resolve further emotional problems.

B. ASSUMPTIONS

1. The initial resources within the affected disaster area will most likely be inadequate to treat all casualties at the scene or treat them in local health care systems.

2. Additional resources will be urgently needed to supplement local jurisdictions for triage, tracking of patients and medical resources, treatment of casualties in the disaster area, and transport to appropriate facilities. In a major disaster, there will probably be a need for transportation of patients, possibly by air, to the nearest metropolitan areas with sufficient concentrations of medical assets where patient needs can be matched with the necessary definitive medical care.

3. Damage to chemical and industrial plants, sewer lines, and water distribution systems and secondary hazards such as fires will result in toxic environmental and health hazards to the surviving population and response personnel including exposure to hazardous chemicals, and contaminated water supplies, crops, livestock, and food products.

4. Pandemic outbreaks will create needs for additional personnel, product, pharmaceuticals, and alteration in physical plant to meet surge capacity needs. Alternate care facilities, non-congregate sheltering, field hospitals and home care may be needed to augment existing healthcare facilities statewide.

5. Additional state and federal capabilities may be needed to supplement and assist the local jurisdictions.

6. Additional transportation will be needed to evacuate patients to the appropriate hospital or medical facility and to transport fatalities to funeral homes and hospital morgues.

7. Disaster conditions may increase the potential for injury or illness.

8. Emergency response personnel may be confronted with situations which can result in emotional distress causing disorientation, and which may hamper their ability to continue functioning in their current position. Supervisors of emergency response workers are encouraged to monitor these workers for indications of symptoms.

9. State Disaster Medical Services will be activated upon the request from a county or regional level emergency management entity for assistance following the occurrence and/or declaration of a disaster.

10. Disaster Medical Services personnel will have the capability to deploy with the State Emergency Response Team (SERT) All-Hazard Incident Management Teams, as well as with any resources sent to the impacted area.

11. In accordance with assignment of responsibilities in this appendix and further tasking by the lead state agency, each participating support agency will contribute to the overall response but retain control over its own resources and personnel.

12. The SERT Emergency Services Branch will be the primary source of medical response information for distribution to state officials involved with response operations.

13. Federal medical response and public health response will be coordinated with the SERT Emergency Services Branch.

14. The SERT Emergency Services Branch will not release medical information on individual patients to the general public to ensure patient confidentiality protection.

15. Appropriate information on casualties and patients will be shared with Red Cross as appropriate.

16. All deaths occurring as a result of a disaster fall under the jurisdiction of the Office of the State Medical Examiner. The management of mass fatalities will be coordinated through a joint effort between ESF-8 and the Division of Public Health.

17. Disaster Medical Services will coordinate requests with SERT Emergency Services for other healthcare resources through the Emergency Management Assistance Compact (EMAC) as necessary.

III. ORGANIZATION AND ASSIGNMENT OF RESPONSIBILITIES

A. LEAD STATE AGENCY

1. NC DEPARTMENT OF PUBLIC SAFETY (NCDPS)

NORTH CAROLINA EMERGENCY MANAGEMENT (NCEM)

a. Request medical assistance from other states and the federal government as required.

b. Arrange the transfer of packaged-disaster hospitals or components where feasible.

c. Provide identification cards and coordinate transportation in regulated areas.

B. LEAD TECHNICAL AGENCY

1. NC DEPARTMENT OF HEALTH AND HUMAN SERVICES (NCDHHS)

DIVISION OF HEALTH SERVICE REGULATION (DHSR)
OFFICE OF EMERGENCY MEDICAL SERVICES (OEMS)

a. Provide leadership in coordinating and integrating the overall state efforts that provide medical assistance to a disaster-affected area.

b. Coordinate and direct the activation and deployment of state resources of medical personnel, supplies, equipment, and pharmaceuticals with Public Health as needed.

c. Coordinate information gathering and sharing between federal, state, and local agencies in order to best guide the SERT's decision making ability.

d. Assist in the development of local capabilities for the on-site coordination of all emergency medical services needed for triage, treatment, transportation, tracking, and evacuation of the affected population with medical needs.

e. Establish and maintain the cooperation of the various state medical and related professional organizations in coordinating the shifting of Emergency Medical Services resources from unaffected areas to areas of need.

f. Coordinate with the SERT Military Support Branch to arrange for medical support from military installations.

g. Coordinate the evacuation of patients from the disaster area when evacuation is deemed necessary.

h. Coordinate the catastrophic medical sheltering response by implementing the Medical Support Sheltering Plan.

C. SUPPORTING STATE AGENCIES

1. NC DEPARTMENT OF HEATLH AHD HUMAN SERVICES (NCDHHS)

DIVISION OF MEDICAL ASSISTANCE (DMA)

a. Administer the North Carolina Medicaid/Medicare Program to provide medical services for public assistance recipients as listed in "Scope of Services, NC Medicaid/Medicare Program" to include hospital care, physician bills, laboratory and x-ray services.

DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES (MHDDSAS)

a. Provide available personnel and space at regional mental institutions in support of area mental health agencies as the situation warrants.

b. Coordinate and direct assistance in mental health and crisis counseling matters.

c. Maintain liaison with National Institute for Mental Health and other

appropriate federal agencies.

d. Confirm, consolidate, and evaluate information from local governments and determine the need for federal assistance with mental health problems.

e. Arrange for and support crisis-counseling service as needed.

OFFICE OF RURAL HEALTH AND COMMUNITY CARE (ORHCC)

a. Work with local and state leaders to design and implement strategies for improving health care access for rural and underserved residents.

b. Provide technical and financial assistance to underserved communities in developing and maintaining primary care health and dental centers.

DIVISION OF PUBLIC HEALTH (DPH)

a. Provide coordination for the delivery of medical goods to hospitals through the NC Medical Countermeasures (MCM) Plan.

b. Provide guidance on the evaluation and treatment of contagious diseases, chemical exposures and radiologic casualties.

c. Provide laboratory support to clinical laboratories in medical facilities.

d. Provide support, as requested, from the four (4) regional offices.

e. Provide guidance on health and safety measures for emergency workers including but not limited to Personal Protective Equipment (PPE), prophylactic medications and vaccines.

f. Provide support for mass fatality planning to include transportation and transfer of the decedents to the appropriate entity.

g. Provide guidance for sheltering models and staffing with Public Health Nurses and coordinate with OEMS for alternate healthcare staffing options.

h. Provide medical and non-medical administrative assistance as available and necessary to immunization clinics.

2. NC DEPARTMENT OF PUBLIC SAFETY (NCDPS)

NORTH CAROLINA NATIONAL GUARD (NCNG)

a. Provide limited emergency medical care to sick and injured people.

b. Provide manpower to assist in setting up temporary hospital facilities that have been provided by other agencies.

c. Assist with the transportation of disaster teams, medical personnel, and supplies into the disaster area.

d. Assist with the transportation and evacuation of victims to permanent facilities.

STATE HIGHWAY PATROL (SHP)

a. Assist with traffic control as requested by the State Emergency Response Team (SERT).

b. Assist emergency responders and other authorized responders to obtain access into controlled areas.

c. Provide logistics for Field Hospitals set up by State Medical Assistance Teams as needed based on type and size of disaster.

d. Assist SMRS deployments by providing space and logistical support for receiving, storing and distributing drugs from the Strategic National Stockpile.

3. STATE MEDICAL RESPONSE SYSTEM

a. Provide and/or coordinate appropriate medical treatment services for mobile, short-notice tasking medical facilities such as field medical services and medical coordination in the field, deployable, scalable field medical units, HAZMAT medical units, alternate care facilities, and medical support shelters.

b. Assist Public Health with mass prophylaxis and mass casualty triage.

c. Assist with National Disaster Medical System (NDMS) airhead or other patient transportation operations.

d. Provide health and medical services to SERT workers.

e. Prepare, maintain, and implement in cooperation with Public Health necessary procedures for receiving, storing, and distributing medications and supplies delivered to North Carolina from the Strategic National Stockpile.

f. Assist with responder rehabilitation.

g. Augment healthcare personnel in existing facilities.

4. NC ASSOCIATION OF RESCUE AND EMS, INC. (NCAREMS)

a. Assist in obtaining manpower, equipment and other resources as requested.

D. SUPPORTING VOLUNTEER AGENCIES

1. NORTH CAROLIA BAPTISTS ON MISSION

a. Provide logistical and medical assets for ESF-8 when available.

2. AMERICAN RED CROSS (ARC)

a. Provide supportive counseling for the family members of victims.

b. Provide non-medical administrative assistance as available and necessary to immunization clinics.

c. Provide information to families on available health resources and services.

d. Assist with other tasks in accordance with the current NC Memorandum of Understanding.

3. THE SALVATION ARMY (TSA)

a. Deploy trained personnel to provide emotional and spiritual care (ESC).

b. Coordinate with other SERT agencies and organizations to address unmet needs.

IV. CONCEPT OF OPERATIONS

A. GENERAL

The Department of Health and Human Services (DHHS) Division of Health Service Regulation (DHSR) Office of Emergency Medical Services (OEMS) serves as lead agency assigned to Disaster Medical Services. OEMS will be responsible for the provision and coordination of services to include personnel, medical product, physical plant, and pharmaceuticals to meet medical needs and thus provide access to healthcare for NC citizens before, during and after a disaster. Resources available within OEMS, the support agencies of Disaster Medical Services, private enterprise, and community voluntary agencies will be used to accomplish assigned missions. The lead agency will make available sufficient staff to be present in the State EOC to coordinate the activities of Disaster Medical Services.

North Carolina OEMS will use the Continuum System in addition to NC SPARTA to retrieve information on the status of healthcare facilities and obtain real time capabilities/resources to include personnel, transportation assets, specific medical products, pharmacy, and bed counts. This system will be used to disseminate information to NC healthcare facilities and EMS systems across the state. OEMS will use the NC Training, Exercise, & Response Management System (NC TERMS) to register, deploy, and track state assigned ESF-8 response and recovery personnel. NC TERMS will assist in the credentialing and mission tasking of all personnel deployed by OEMS for ESF-8 missions. NCOEMS will use the NC TERMS electronic program to deploy and manage all medical teams sanctioned by North Carolina Emergency Management and the lead state agency for ESF-8. NC TERMS will be used to assemble rosters of personnel, communicate deployment information, and track missions.

The NC Department of Agriculture & Consumer Services' (DA&CS) Multi-Hazard Threat Database will be used to monitor licensed facilities and EMS systems statewide potentially threatened by manmade and natural disasters. This database will serve as a mapping tool for the transfer, tracking, treatment, and transport of patients across the state during the disaster. The database will serve as a tracking and mapping tool to report progress of the re-establishment of medical care in licensed facilities and EMS systems during the recovery phase of a disaster.

The NC Disease Event Tracking and Epidemiologic Collection Tool (NC DETECT) will be used to provide statewide early event detection and syndromic surveillance, as well as situational awareness capabilities, to local, regional, and state public health practitioners and hospital-based users. NC DETECT currently is able to view data from emergency departments, the

Carolinas Poison Center (CPC), the Pre-hospital Medical Information System (PreMIS), a select group of urgent care centers in the Mecklenburg County region, the Piedmont Wildlife Center and the North Carolina State University College of Veterinary Medicine Laboratories.

As a federal resource, NDMS has established and maintains a network of hospital beds across the country with North Carolina being a part of this network. These are available upon activation of NDMS by the U.S. DHHS following a request through the normal disaster response channels. For support of emergency responses wholly within the state, information regarding the availability, location, and types of beds can be obtained from the statewide bed and resource tracking system known as Continuum.

B. NOTIFICATION

Upon occurrence of a potential or actual natural disaster or man-made event, the State EOC will be activated by the Director of Emergency Management. Disaster Medical Services SERT Liaison will be notified by the Emergency Services manager by telephone and email and advised of the situation.

C. RESPONSE ACTIONS

1. INITIAL

a. Notify relevant ESF-8 Partners.

b. Conduct initial assessments of medical needs.

c. Assess resource availability and applicability.

d. Provide technical support to EM for evacuation decisions.

2. CONTINUING

a. The SERT Emergency Services Branch will continuously acquire and assess information about the disaster. Primary source of information will be from the County EOC through the Branch Offices or county deployment teams. All information will be made immediately available to the Emergency Services ESF leads.

b. Resources, including personnel, will be deployed as needed and appropriate. State Medical Assistance Teams will be activated and deployed as needed through the OEMS and in consultation with the SERT Leader. When National Disaster Medical System assets outside

of the state are requested, the SERT Emergency Services Branch will coordinate through OEMS with NDMS or other HHS representatives for the deployment of those assets.

c. National Guard assets may be needed to support Disaster Medical Service requirements. Missions will be assigned to the National Guard through coordination with the National Guard representative in the State EOC who will activate and deploy the necessary military units. OEMS will coordinate medical missions with the NC National Guard as needed.

d. Medical transportation is the responsibility of the local authorities. The SERT Emergency Services Branch will request state, interstate, and federal medical transportation assistance when county or state resources are inadequate to meet the needs.

e. The SERT Emergency Services Branch will maintain a journal of Disaster Medical Service activities for each major action, occurrence, or event.

f. OEMS/ESF-8 will make recommendations and requests through Emergency Services to the SERT Logistics Chief for the use of the Emergency Management Assistance Compact (EMAC) when needed and as indicated by assessment data.

D. RECOVERY ACTIONS

1. INITIAL

a. Assess the status of all licensed facilities and their ability to render medical care to their communities post incident. This will include EMS Systems, hospitals, long term care facilities, state psychiatric facilities, assisted living facilities, group homes, community health centers, rural health centers, university health centers, and school health centers. ESF-8 will also assess the medical status of any state supported medical support shelter.

b. Plan with specific Division of Health Service Regulation staff, SERT partners, and affected facilities/centers to develop a strategy to reestablish healthcare. DHSR may establish a support cell and may ask for partners to assist with the planning and strategic plan development as needed. The support and planning team may include representatives from designated support agencies or other entities as deemed appropriate by the ESF-8 lead agency.

c. Implement any needed changes in normal State DHSR procedures as needed to re-establish safe care in facilities/centers. Reports on progress and associated timelines will be given to the SERT leader and the Director of Health Service Regulation.

d. Evaluate progress of reestablishment of facilities and centers and recommend appropriate changes to the strategic plan with the affected facilities/centers. Continue to provide guidance and technical assistance to the affected healthcare community and report the ongoing evaluation to the Director of Health Service Regulation.

V. DIRECTION, CONTROL AND COORDINATION

1. LOCAL

Locally available medical resources will be used to the extent possible to meet the immediate needs in the jurisdiction. Requests for assistance will be transmitted from the County EOC through the appropriate Branch Office and to the State EOC.

Local governments have annexes incorporated into their emergency operations plan that maintain comprehensive emergency medical plans, including provisions for coordination among all elements of the local medical system. Agreements exist between jurisdictions and other secondary providers. Counties use appropriate local mental health facilities and personnel and provide mental health and crisis counseling services to victims and emergency response workers affected by the disaster. Local governments may request Critical Incident Stress Management Teams directly or through the SERT Emergency Services Branch when necessary.

2. STATE

The SERT Emergency Services Branch is the primary coordination source of medical response and information for all state officials involved with response operations. Field response operations will be coordinated through the county EOC by state ESF-8. Support agencies may also be requested to provide information for the ESF-8 support cell to assist in coordinating Disaster Medical Services.

Once a local assessment has been completed and a medical support mission has been directed to ESF-8, local and state assets from the non-affected area may be mobilized to respond per the mission assignment. Those assets include activation of the State Medical Response System (SMRS).

OEMS will also coordinate the request and management of federal medical assets from the U.S. Department of Health and Human Services as well as the U.S. Department of Homeland Security. OEMS does this through existing liaison relationships with the National Disaster Medical System (NDMS) and the Interstate Resource Coordination Team (IRCT) from HHS.

OEMS can assemble support personnel through employees, partners, and/or relevant support agencies to assist the ESF-8 with the assessment and coordination of medical assets and capabilities. This "support cell" may be located in a reasonable and convenient location as requested by OEMS and will report to the ESF-8 lead in the Emergency Services Branch of the State EOC.

Throughout the response period, the SERT Emergency Services Branch will evaluate and analyze medical assistance requests and responses and will develop and update assessments of medical status. They will also coordinate requests for Critical Incident Stress Management (CISM) Teams. The SERT Emergency Services Branch will maintain accurate and extensive logs to support after action reports and other documentation of the disaster conditions.

3. FEDERAL

The Incident Management Team (IMT) from the U.S DHHS will be the lead for the Interstate Regional Emergency Support Function #8 (ESF #8 Health and Medical). The ASPR based IRCT will establish a Regional EOC and will provide administrative support to the regional response activities. The IRCT will then coordinate all requests with the Federal Coordinating Officer (FCO) and the State ESF-8 Lead Agency representatives.

NDMS will assist in determining specific medical needs and priorities. Disaster Medical Assistance Teams (DMATs) will assist in providing care for ill or injured victims at the site of a disaster at the state's request. Placement locations and specific missions of all NDMS or HHS assets will be coordinated by OEMS.