DISASTER MEDICAL SERVICES (ESF-8)

2025

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 and the North Carolina healthcare system affected by the emergency or disaster. Available resources include the NC Department of Health and Human Services (NCDHHS) Division of Health Service Regulation (DHSR), North Carolina Office of Emergency Medical Services (NCOEMS), and resources available from the State Medical Response System inclusive of the Healthcare Preparedness Coalitions, State Medical Assistance Teams, Emergency Medical Services agencies, health care organizations, and the NC Medical Reserve Corps. Additional resources, such as state contracts, out of state resources, and federal resources, may also be coordinated for this support. The NCOEMS fulfills its role as lead ESF-8 agency by coordinating non-local medical assets to augment local and healthcare system needs as identified by mission assignments from emergency management.

Disaster Medical Services involves supplemental assistance to local governments and the North Carolina healthcare system in planning, response, mitigation, and recovery of a major emergency or disaster. These activities include: supporting the healthcare system during incidents resulting in medical surge conditions; assessment of healthcare system status; provision of medical care personnel, alternate care sites, and medical equipment and supplies; maintaining continuity of healthcare through the establishment, operation, and/or support for healthcare services in state-operated shelters; support state-coordinated patient movement when local jurisdictions require regional, state, or federal assistance up to and include evacuation of existing healthcare facilities; and provision of emergency responder health and safety.

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, hospital morgues, and other medical facilities may be severely damaged or 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 communication 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 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 supplies 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.

3. 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.

4. 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. These may include exposure to hazardous chemicals, and contaminated water supplies, crops, livestock, and food products.

5. Pandemic outbreaks will create needs for additional personnel, products, and pharmaceuticals 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.

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

7. Additional transportation will be needed to evacuate patients to the appropriate hospital or medical facility and the transportation of casualties to appropriate locations.

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

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

10. Disaster Medical Services can be activated upon request from a county, regional level emergency management entity or healthcare entity for assistance following the occurrence and/or declaration of an emergency or disaster that overwhelms the local healthcare capabilities.

11. 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.

12. 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.

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

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

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

16. Appropriate information on casualties and patients may be shared with Red Cross as appropriate.

17. All fatalities 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.

18. Disaster Medical Services will coordinate requests with SERT Emergency Services for other healthcare resources through the Emergency Management Assistance Compact (EMAC) and federal support, such as National Disaster Medical System, 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)

NC OFFICE OF EMERGENCY MEDICAL SERVICES (NCOEMS)

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, pharmaceuticals and assets.

c. Coordinate healthcare system 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 coordination of all healthcare services needed for triage, treatment, transportation, tracking, and evacuation of the affected population with medical concerns.

e. Establish and maintain the cooperation of the various state medical and related professional organizations in coordinating the shifting of healthcare 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 clinical support and/or movement of patients from an impacted area when a higher level of care or an evacuation is deemed necessary.

h. Coordinate healthcare services for state-operated shelters by implementing the Healthcare Services in Shelters annex.

C. SUPPORTING STATE AGENCIES

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

NC MEDICAID

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 testing, and x-ray services.

DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE USE SERVICES (MHDDSUS)

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

b. Maintain liaison with National Institute for Mental Health and other appropriate federal agencies.

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

d. Coordinate with the SERT Human Services Branch to determine where mental health services are needed in shelters and communities.

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

OFFICE OF RURAL HEALTH (ORH)

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 North Carolina State Laboratory of Public Health (NCSLPH) testing services or facilitate reference testing services to support clinical laboratories throughout North Carolina.

d. Provide support from the four (4) Public Health Preparedness and Response (PHP&R) 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 NCOEMS for alternate healthcare staffing options.

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

i. The Local Technical Assistance and Training (LTAT) Command Center within the Office of the Chief Public Health Nurse (OCPHN) will provide guidance and support to Public Health nurses who are staffing general population shelters.

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.

3. NC STATE HIGHWAY PATROL (NCSHP)

a. Assist with traffic control.

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.

4. STATE MEDICAL RESPONSE SYSTEM

a. Provide and/or coordinate medical surge services when the healthcare system is overwhelmed by supplying the necessary equipment, assets, and/or personnel needed to provide medical care within healthcare facilities and/or field operational locations. These locations may include alternate care sites, field emergency medical care, medical support shelters and supporting through EMS resources.

b. Provide healthcare services to SERT workers, when requested.

c. Support Public Health when necessary with the receiving, storing, and distributing medications and supplies delivered to North Carolina from the Strategic National Stockpile.

d. Assist with responder rehabilitation.

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

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

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

NCOEMS serves as the lead agency assigned to Disaster Medical Services. NCOEMS will be responsible for the provision and coordination of services to include personnel, medical supplies and equipment, and temporary infrastructure to support the healthcare system during emergencies and disasters. Resources available within NCOEMS, the support agencies of the State Medical Response System, 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.

NCOEMS will maintain a system that is able to collect information on the status of healthcare facilities, their bed availability counts, and capture near real-time capabilities/resources to include personnel, healthcare assets, and medical supplies. This system will be used to disseminate information to the NC healthcare system across the state in accordance with the NCOEMS Situational Awareness and Information Sharing Annex. NCOEMS will use the NC Training, Exercise, & Response Management System (NC TERMS) to assist in the credentialing and personnel verification of all personnel deployed through the State Medical Response System for ESF-8 missions.

As a federal resource, the National Disaster Medical System (NDMS) has established and maintains a network of healthcare facilities across the country to support patient movement and evacuation from areas impacted by a disaster to reception facilities with North Carolina being a part of this network. These can be made available through a request to the U.S. DHHS Administration for Strategic Preparedness and Response Regional Emergency Coordinator.

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. Relevant ESF-8 Partners will be notified by the Disaster Medical Services SERT Liaison.

C. RESPONSE ACTIONS

INITIAL

a. Activate the NCOEMS Emergency Operations Plan and appropriate annexes.

b. Notify relevant ESF-8 partners.

c. Conduct initial assessments to determine healthcare gaps that exist or may exist based on the situation.

d. Assess resource availability and applicability.

e. Provide technical support to EM and healthcare leaders for medical surge planning to include evacuation decisions.

CONTINUING

a. The SERT Emergency Services Branch will continuously acquire and assess information about the disaster. The primary source of information will be from the County EOC through the Branch Offices, county deployment teams or direct from the ESF-8 lead. All information will be made immediately available to the Emergency Services ESF leads.

b. Resources, including personnel, will be deployed when available, as needed and appropriate. State Medical Assistance Teams and Medical Reserve Corp Units will deploy when available, as needed through the NCOEMS 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 NCOEMS 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. NCOEMS will coordinate medical missions with the NC National Guard as needed.

d. 911 services and EMS resources are the responsibility of the local authorities. Should additional patient transportation assets be needed to support local authorities with movement of patients as part of a hospital evacuation or to a State Medical Support Shelter, Disaster Medical Services will coordinate the requested assets directly. The SERT Emergency Services Branch will request state, interstate, and federal EMS resource assistance when county or state resources are inadequate to meet the needs.

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

f. NCOEMS/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.

g. Assess the status of adult care homes, nursing homes, acute care hospitals, dialysis centers and EMS agencies on their ability to render medical care to their community post incident. ESF-8 will also assess the medical status of other healthcare entities when requested or of any state supported medical support shelter.

h. Coordinate specific plan with SERT partners, regulatory staff, and affected facilities/agencies to recommend a strategy to reestablish healthcare. NCOEMS 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.

i. Recommend any needed waivers for regulatory procedures to re-establish safe care in facilities/centers. Reports on progress and associated timelines will be given to the SERT leader.

j. 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 SERT leader.

V. DIRECTION, CONTROL AND COORDINATION

A. 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 healthcare 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.

B. 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 and impacted healthcare entities 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).

NCOEMS 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. NCOEMS does this through existing liaison relationships with the ASPR Regional Emergency Coordinators from HHS.

NCOEMS 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” should be located in a reasonable and convenient location as requested by NCOEMS 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. The SERT Emergency Services Branch will maintain accurate and extensive logs to support after action reports and other documentation of the disaster conditions.

C. FEDERAL

The Federal Health Coordinating Official (FHCO) oversees the Incident Management Team (IMT) from the U.S DHHS and is the lead for the federal Emergency Support Function-8 (ESF-8). The ASPR IMT may establish a Regional EOC and may provide administrative support to the regional response activities. The FHCO can then coordinate all requests with the Federal Coordinating Officer (FCO) and the state ESF-8 lead agency representatives.

The ASPR IMT assists in determining resources to support specific healthcare needs and priorities related to the incident. Federal support may include staff, medical supplies, medical equipment, and various assets to assist in providing care for ill or injured patients at the site of an incident at the state’s request. Placement locations and specific missions of all HHS assets will be coordinated by NCOEMS.