ALTERNATE CARE SITE PLAN

Arizona Department of Health Services

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Record of Distribution

Date:	Recipient:	Platform:

Record of Changes

Date:	Change:	Location
		Entire plan

Purpose

This Alternate Care Site (ACS) Plan is intended to support statewide operations during an emergency or disaster that necessitates the activation of one or more ACSs within the state. The goal of ACS activation and operation is to maximize appropriate healthcare for the largest number of patients during a pandemic or other disaster causing a major surge in patient volume. In most cases, the operational, logistical, and administrative challenges of operating these sites will require partnership and collaboration between public and private sector entities.

This Plan is an annex to the Arizona Department of Health Services (ADHS) Emergency Response Plan (ERP) and can be used in conjunction with other annexes to guide the statewide public health and medical response to any type of emergency or disaster.

Scope

This Plan supports responses to all levels of public health emergencies requiring ACS activation and operation, from local responses with state involvement, to statewide and even national responses. In keeping with the ICS concepts of flexibility and scalability, all or part of the procedures contained in this Plan may be used to support ACS operations depending on the scope and reach of the disaster.

This Plan applies to all types of natural and human-caused disasters including chemical, biological, radiological, nuclear, and explosive (CBRNE); weather and natural disasters; terrorism; pandemics; and technological failures. It defines the various types of ACSs and supports the activation and operation of these sites at the local, state, or federal level.

The scope of this Plan encompasses coordination and support for at-risk populations, including limited English proficiency (LEP) populations, geographically isolated individuals, access and functional needs (AFN) groups, people with serious mental illness (SMI), and others requiring behavioral healthcare. Response strategies will take into account the medical and public health needs of groups such as people with disabilities, pregnant women, children, senior citizens, and other sub-groups as dictated by the response. The needs and challenges facing at-risk populations will be central to any ACS response and will be included in ADHS incident action planning to be addressed during interagency coordination.

Situation Overview

Health emergencies have the potential to overwhelm local healthcare systems. During a catastrophic public health emergency, communities may need to expand their healthcare delivery system to one that includes the role of an alternate care system. Depending upon the severity of the incident and availability of resources in the community, activation of one or more ACS(s) may be considered by community partners to address insufficient ambulatory care or hospital capacity.

Activation Types

Activation may be in response to:

1) Surge: large number of people seeking emergency and/or acute medical assistance at healthcare facilities (e.g., epidemic, mass casualty incident [MCI]).

2) Damaged medical infrastructure: Healthcare facility inoperability due to damage or resource shortages (e.g., explosion, flooding, etc.).

3) Combination of 1 and 2.

ACS activation and operation will require collaboration and coordination from a wide variety of public health and medical partners. These organizations may include:

- Arizona Burn Care Network,
- Arizona Department of Economic Security
- Arizona Emergency System for Advance Registration of Health Professionals (ESAR-VHP),
- Arizona Healthcare Acquired Infection (HAI) Multidisciplinary Advisory Group,
- Arizona Healthcare Cost Containment System (AHCCCS),
- Arizona Local Health Officers Association (ALHOA),
- Arizona Local Public Health Emergency Response Association (ALPHERA),
- Arizona Pediatric Disaster Coalition,
- Arizona State Board of Pharmacy,
- Arizona State Emergency Council,
- Arizona Tribal Executive Committee (AzTEC),
- Indian Health Services (IHS),
- Poison Control Centers (Phoenix and Tucson),
- Radiological Injury Treatment Network (RITN), and/or
- State-designated healthcare coalitions (HCCs),

During ACS activation, ADHS Health Emergency Operations Center (HEOC) staff will work with these partner organizations and systems to support the response. ADHS will send a liaison to serve as the Health and Medical Services Coordinator at the State Emergency Operation Center (SEOC), which is coordinated by the Arizona Department of Emergency and Military Affairs (DEMA). The Health and Medical Services Coordinator at the SEOC will be staffed by an ADHS representative with substantial experience managing public health responses. This liaison role is crucial to maintaining operational control and situational awareness during an ACS response.

Planning Assumptions

ACS activation, operation, and demobilization will be guided by this plan and applicable public health support and hazard-specific annexes. This plan was developed to support any type of disaster including the hazards identified in the *2014 Arizona Threat and Hazard Identification and Risk Assessment*. The following assumptions apply to the activation of this Plan:

- Local, state, and/or federal disaster declarations will be in place during a response requiring ACS.
- Many Arizona hospitals are routinely near or at capacity and may not be able to handle the surge in patients associated with a major disaster or public health emergency.

- Local emergency medical services will likely be the first entity to deal with mass casualty victims.
- During MCIs, hospitals can expect to receive self-transported casualties directly from the scene, even if triage, treatment, and transport services are in place at the scene of the MCI.
- Patients may seek emergency healthcare services at other types of medical facilities (i.e., locations other than hospitals).
- Many patients and their families will view ACSs as short-term and will expect care in a hospital setting as soon as possible.
- A high level of cooperation and coordination among agencies (local health departments, hospitals, emergency management, etc.) will be necessary to establish and operate an ACS.
- Steps will need to be taken not only to assist and protect victims of the disaster but also to protect healthcare staff so they can continue to participate in the response.
- Coordination with medical licensing is needed to ensure status as an outpatient facility is established.
- The scope of the incident may be such that state or even federal resources will be required to establish an ACS.
- A major challenge in ACS operations will be the extra staff needed to operate the facility.
- An Incident Command (IC) structure will be needed to efficiently and effectively operate an ACS.
- ACSs may rely on local public health assistance for logistical and other operational support.

Roles and Responsibilities

An ACS is a collaborative effort between community partners. A single facility or agency will not attempt to open an alternate care site in the absence of support from state and local public health, emergency management, EMS, and other medical partners. The table below outlines some of the functions the healthcare sector and the public health sector may address when activating and operating an ACS. The table is grouped into four main functions 1) overall, 2) electronic care, 3) ambulatory alternate care sites, and 4) non-ambulatory alternate care sites.

General Concepts for Healthcare and Public Health Sector Functions in ACS

Function	Healthcare Sector	Public Health Sector
Overall	Providers, private infrastructure, medical materiel support, medical care and decision making, clinical policy development/technical expertise	Organizational support, situational awareness, and liaison to emergency management and state/local government (including legal authorities and regulatory, policy, and logistical support [e.g., sites for care])
Electronic care: telephone triage, expanded hotlines, web-based assessment and prescribing, tele-medicine	Augment and unify telephone advice and prescribing systems; update and modify consistent advice	Set up public lines/resources when demand exceeds available augmented resources; provide mechanisms for backup to other call centers; facilitate phone script coordination; and/or address prescribing and practice regulatory issues
Ambulatory alternate care sites (e.g., flu centers or minor trauma care sites)	Augment existing clinics, and open new clinics in other spaces; assist in staffing public health clinics	Set up clinics in high incidence/impact areas where healthcare resources are inadequate; provide site and logistics support (and potential staffing from Medical Reserve Corps and other public sources); and/or address prescribing and practice regulatory issues
Non-ambulatory alternate care sites (hospital overflow; may include medical shelter for non-ambulatory patients)	Provide policy, medical direction, staffing, and special medical materiel support to site	Provide site and logistical support in conjunction with emergency management and legal/regulatory protections
Population-based interventions	Provide vaccinations and prophylaxis in conjunction with public health policy and directives (may include closed points of dispensing)	Coordinate overall provision of interventions, including public sites and their staffing

Source: Institute of Medicine, 2012

In addition to the functions identified for the healthcare and public health sectors in the table above, there are a variety of partners involved in an ACS response with their unique roles and responsibilities.

Hospitals and Out-of-Hospital Facilities

- Ensure facility-specific Incident Command System (ICS) has been activated to prepare for alternate care site.
- Contact and maintain communication with local emergency management and/or public health emergency preparedness partners to inform them of the need for ACS.
- Ensure that facility-level medical surge plans and hazard specific plans have been activated to address the incident at hand.

- Coordinate with medical licensing (ADHS Division of Licensing) to inform them of need for ACS. ADHS Licensing will coordinate with the Centers for Medicare and Medicaid Services (CMS) Survey and Certification if a cerfitied facility is involved.

Regional Healthcare Coalitions

- Ensure regional healthcare communications are established.
- Share situational awareness information with local and state public health.
- Ensure that coalition-level emergency response plans have been activated to address need for alternate care sites.
- Provide support including supplies and personnel.

Emergency Medical Services

- Ensure that EMS Incident Command protocols have been activated to support ACS operations (coordinate with dispatch).
- Establish and maintain communication with local EOC.
- Coordinate with hospital(s) regarding transportation and dispositions.

Local Public Health Departments

- Ensure that local public health emergency operations and Incident Command System (ICS) have been activated to support ACS operations.
- Establish and maintain coordination with hospitals and healthcare facilities.
- Coordinate with state public health (ADHS).
- Coordinate local public information messaging in coordination with ACS facility and state public health (ADHS) personnel.

Local Emergency Management

- Activate local EOC to support ACS operations.
- Provide local logistical support for ACS operations.
- Provide incident management oversight and operational support as needed.
- Coordinate local public information messaging in conjunction with ACS facility and state emergency management public information personnel.

State Public Health Department (ADHS)

- Activate the ADHS Health Emergency Operations Center (HEOC) and institute a Public Health Incident Management System (PHIMS) to support ACS operations.
- Establish unified command with the State Emergency Operation Center (SEOC) and local public health EOCs involved in the response.
- In conjunction with the SEOC, initiate volunteer health professional alerting and notification via the Arizona Emergency System for the Advance Notification of Volunteer Health Professionals (AZ ESAR-VHP) if required to support ACS operations.
- In conjunction with the SEOC, initiate medical materiel requests through the ADHS Strategic National Stockpile Coordinator HEOC as required to support ACS operations.
- Coordinate with DEMA public information staff to establish statewide messaging and a Joint Information System (JIS) if needed to support local public information efforts

- Maintain awareness with AHCCCS for coordination with CMS regarding waivers

AHCCCS

- Coordinate out of network waivers with CMS Region IX, ADHS Licensing, AHCCS, and third party payers (private insurance companies).

State Emergency Management (DEMA)

- Activate the State Emergency Operations Center (SEOC) to support ACS operations.
- Provide statewide logistical support for ACS operations.
- Provide incident management oversight and operational support as needed.
- Organize statewide public information messaging in coordination with ACS facility, local emergency management, and ADHS public information personnel.

Concept of Operations

This section outlines the public health and medical response components to an ACS operation. It also addresses the various types of facilities such as out-of-hospital care sites and alternate care facilities that can be activated during a response. Out-of-hospital care sites are existing non-hospital facilities that are routinely used for patient care. On the other hand, alternate care facilities are non-licensed facilities that may be temporarily activated to meet healthcare demands during a disaster. Both categories of alternate care sites are listed in the table below.

Category	Facility Type	Strategies
Out-of-hospital care sites	• Outpatient providers and facilities • Clinics • Surgical and procedure centers • Long-term care facilities	• Medical skills can be used in their regular practice environment or at an alternate care facility • Infrastructure can be expanded (i.e., longer hours of operation) if staff and resources are available • Infrastructure can be repurposed (e.g., a sub-specialty clinic adjusts hours or closes to enable the space to be used for acute care).
Alternate care facilities	• Electronic alternate care systems • Ambulatory care facilities • Shelter-based care • Non-ambulatory care/hospital overflow • Federal medical stations (FMS)	• Can be activated (made operational) during a disaster response • Can be established by government response entities and private healthcare institutions to address community needs

Activation

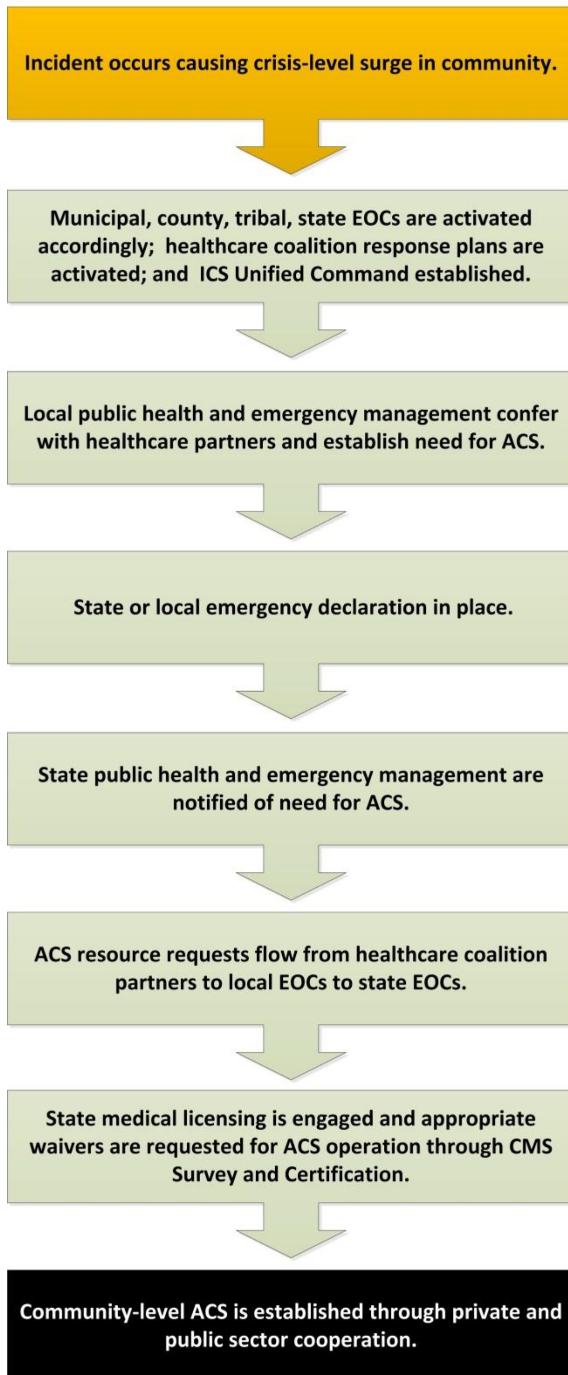
Activation of an ACS or multiple sites is a potential action that could be taken as a part of a disaster response. Activation of an ACS should be considered during initial meetings of the primary and cooperating agencies participating in the State Disaster Medical Advisory Committee (SDMAC) or other inter-agency policy group. See the *Arizona Crisis Standards of Care Plan* for more information on the SDMAC and its activation and composition.

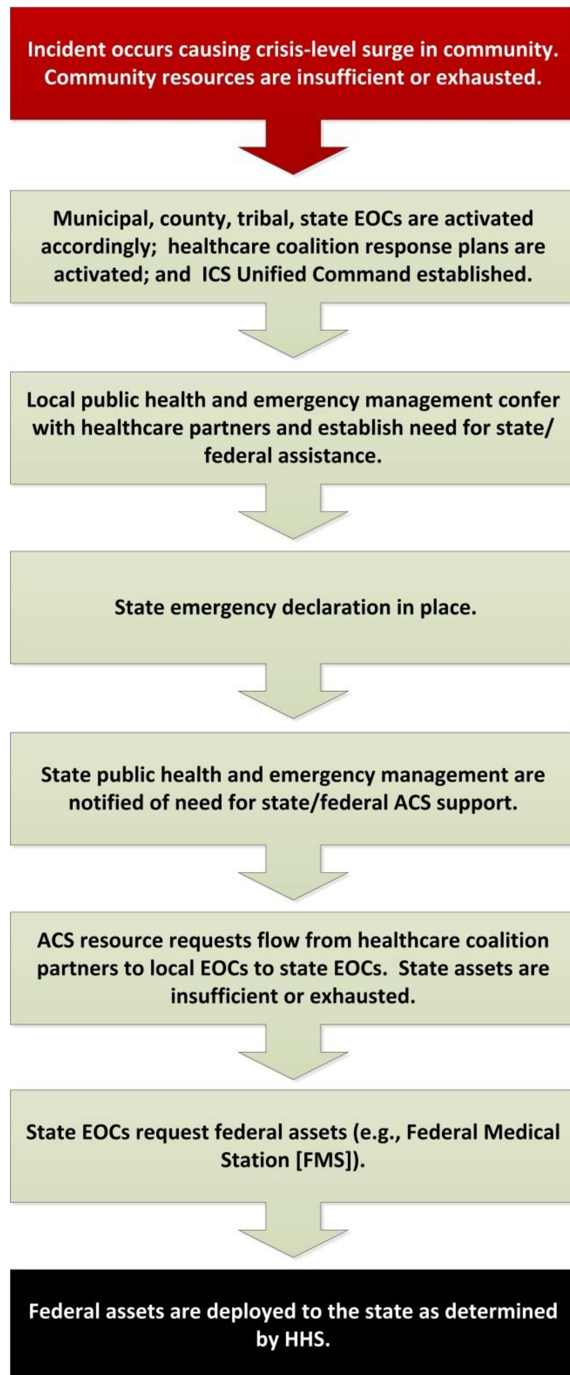
Prior to activation, regional attempts should be made to augment the healthcare system through regional and surrounding hospitals. If patients can receive adequate care in an existing medical facility within a reasonable time period, patients should be transferred appropriately.

Level of operations should also be considered at each operational period by the SDMAC. Before activation of an ACS, the SDMAC should consider the actual verses perceived need within the community and ensure that all alternative solutions have been exhausted. Solutions should be considered in the following order:

1. Hospital activating medical surge plan to accommodate more patients (e.g., canceling elective surgeries, discharging stable patients, relocating patients to other facilities),
2. Non-acute medical facility taking on acute care, or higher level responsibilities,
3. Non-medical facility used to provide medical care (e.g., ACS in existing structure), and
4. Temporary facilities being used to provide medical care (e.g., mobile ACS from Metropolitan Medical Response System [MMRS] or federal assets).

There are different activation processes and requirements for community-based ACSs and federal ACS support. These differences are outlined in the tables on the next page:


Community Support for ACS Operations
Incident occurs causing crisis-level surge in community.
Municipal, county, tribal, state EOCs are activated accordingly; healthcare coalition response plans are activated; and ICS Unified Command established.
Local public health and emergency management confer with healthcare partners and establish need for ACS.
State or local emergency declaration in place.
State public health and emergency management are notified of need for ACS.
ACS resource requests flow from healthcare coalition partners to local EOCs to state EOCs.
State medical licensing is engaged and appropriate waivers are requested for ACS operation through CMS Survey and Certification.
Community-level ACS is established through private and public sector cooperation.

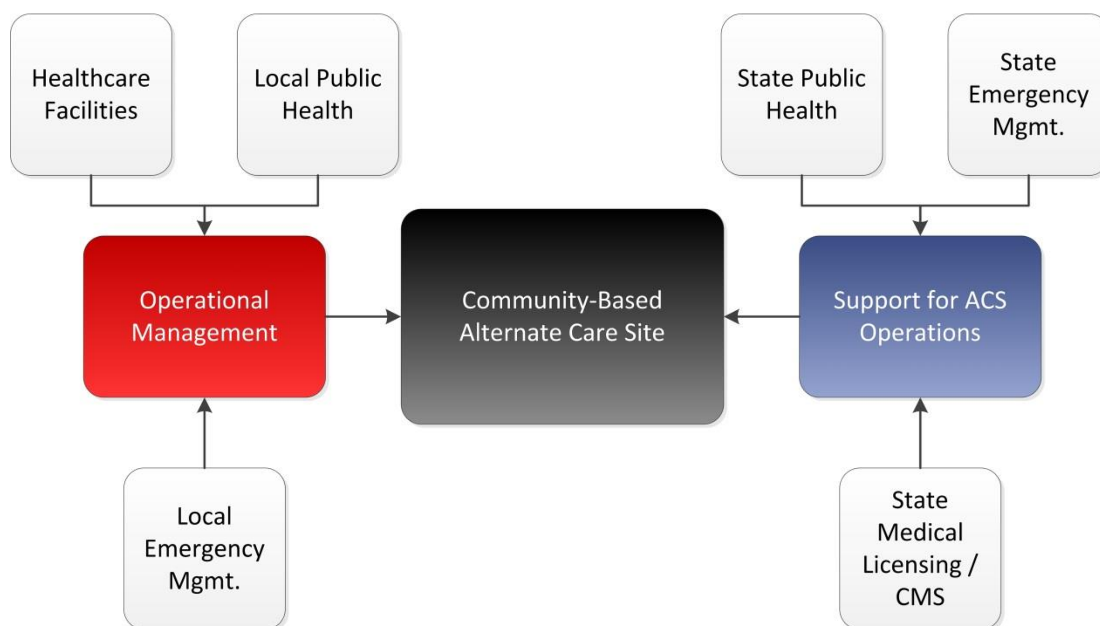

Federal Support for ACS Operations
Incident occurs causing crisis-level surge in community. Community resources are insufficient or exhausted.
Municipal, county, tribal, state EOCs are activated accordingly; healthcare coalition response plans are activated; and ICS Unified Command established.
Local public health and emergency management confer with healthcare partners and establish need for state/ federal assistance.
State emergency declaration in place.
State public health and emergency management are notified of need for state/federal ACS support.
ACS resource requests flow from healthcare coalition partners to local EOCs to state EOCs. State assets are insufficient or exhausted.
State EOCs request federal assets (e.g., Federal Medical Station [FMS]).
Federal assets are deployed to the state as determined by HHS.

Direction, Control, and Coordination

During an ACS response it is expected that local and state Emergency Operations Centers (EOCs) will be activated to support operations, and that a Unified Command (UC) will be established in accordance with the National Incident Management System (NIMS). Hospitals and healthcare facilities involved in the response will utilize the Hospital Incident Command System (HICS) to coordinate emergency operations at the facility level and to coordinate with local and state EOCs.

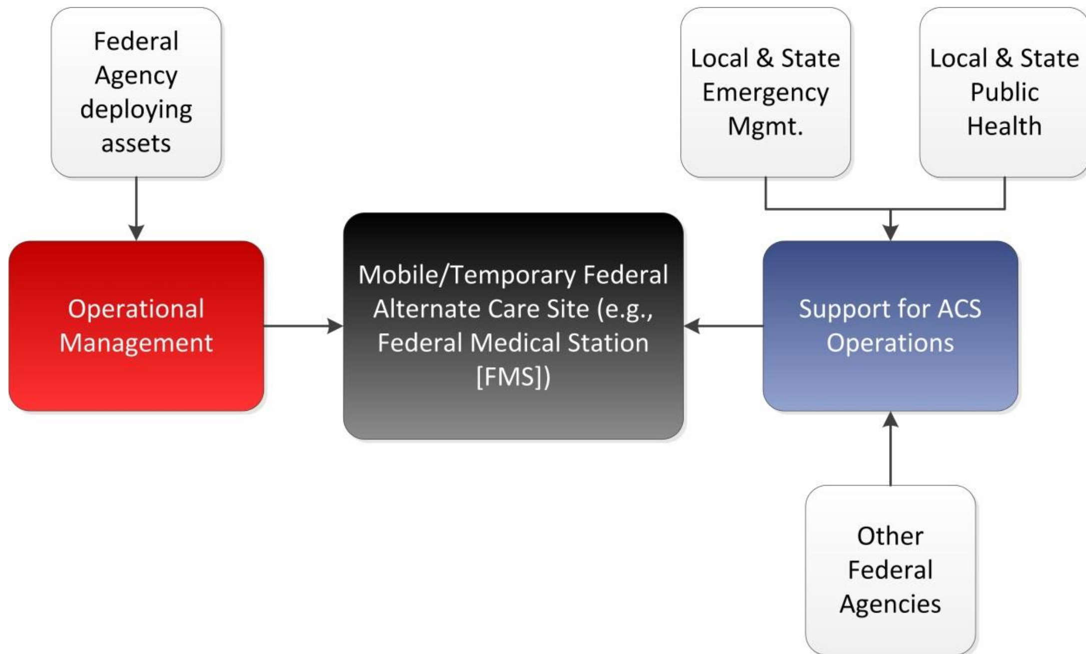
During community-based ACS operations, operational management remains at the local level with support from regional and/or state agencies. Healthcare facilities, local public health deparments and local emergency management agencies will be responsible for the operations of the ACS. Healthcare coalitions, state public health, and state emergency management will provide support for ACS operations. Support may come in the form of additional staff, supplies, communications, or public information coordination. Additionally state medical licensing (the ADHS Division of Licensing Services) and CMS will support the response by facilitating and issueing healthcare facility waivers for expanded opertions or scope of practice after emergency declarations. These relationships are depicted in the figure below:

Direction, Control and Coordination for Community-Based Alternate Care Site



During response operations involving the deployment of mobile or temporary federal assets, the operational management of the ACS will reside with the federal entity deploying the assets. In this case, local public health and emergency management, state public health and emergency management, and other federal agencies (e.g., FEMA) will provide support for operations. This process is illustrated in the figure below:

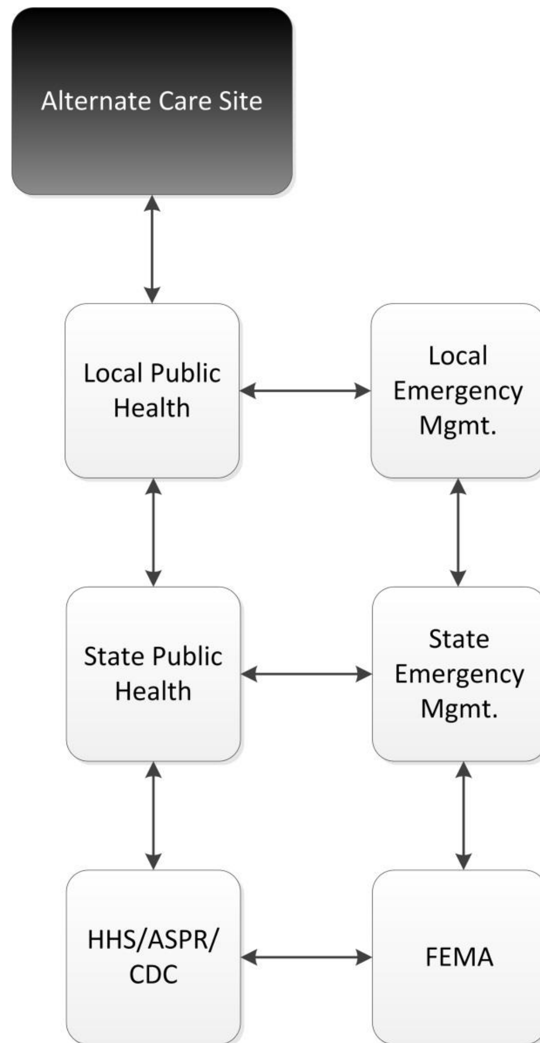
Direction Control and Coordination for Deployment of Federal ACS Assets



Information Collection, Analysis, and Dissemination

During community-based ACS operations, information will be collected at the ACS facility level, distributed to local and regional response entities (public health and emergency management), further distributed to state response entities (public health and emergency management), and then sent on to federal partners. Information will also flow in the opposite direction, from the federal level down to the state, to local/regional partners and finally to the ACS. Information will be analyzed at each step in the process. Information dissemination between response entities will adhere to the process depicted in the figure below:

Information Flow for ACS Operations



Communications

Communication infrastructure must be present for adequate and timely notification of critical personnel. This infrastructure directly influences the ability of public health and medical providers to communicate in the event of a catastrophic disaster. ADHS maintains redundant communications networks and backup systems to support command and control at the ACS. The primary agency will notify necessary partners of activation and provide operational updates for the ACS.

- Types of communications used will be:
    - Telephones,
    - Cell Phones,

- Fax,
- Radios,
- HAM Radios
- Satellite phones,
- AZ Health Alert Network,
- WebEOC, and
- EMResource ©

ADHS personnel have access to 800 MHz radios that can be used to communicate with hospitals throughout much of the state. The systems and frequencies and just-in-time training material can be found on the ADHS Sharepoint site.

In the absence of radios or cell phones, face-to-face communication, runners and the written communication shall be used. Voice amplification systems (e.g., bullhorn, in-house public address system, etc.) should be used if necessary and available.

Administration, Finance, and Logistics

The following table lists some of the logistical considerations for alternate care site operations. This list does not represent an exhaustive list for ACS operators, but rather provides an overview for public health and emergency management agencies involved in ACS support.

Logistical Considerations for ACS Operations

Category	Considerations
Site	Access/permissions, timeline to operational, availability (e.g., schools not always available), size, function, access for those with functional limitations, safety issues, restrooms, water/showers, loading dock, etc.; may include supplemental water, oxygen, power, and other considerations
Traffic Control	Parking and vehicle movement for staff, emergency medical services (EMS), and families
Communications	Including radio, web-based, and public access
Staffing	Medical, administrative, and support (including lab and pharmacy)
Medical Supplies	Durable and disposable (pharmaceuticals, intravenous fluids, dressings, diagnostics, protective equipment, etc.)
Administrative Supplies	Including computers and networks
Personal Care Supplies	Bedding, cots/beds, and personal hygiene supplies
Food Services	Staff and patients

Category	Considerations
Security Services	External and internal accountability for valuables
Transportation	Patients (internal and external) and materials
Check-in Check-out and Badging	Time keeping and badges
Credentialing	Verification system
Registration and Patient Tracking	Patient registration and tracking systems
Medical Records	Record, filing, and archiving/storage
Sanitation	Usual and medical waste
Animal Control/Husbandry	If pets kept on site

Plan Development and Maintenance

Review and maintenance of this plan will be performed on an annual basis. The plan will be evaluated during applicable exercises.

Authorities and References

The summary is intended as a basic reference guide. For a comprehensive listing of Arizona Revised Statutes visit the Arizona State Legislature website http://www.azleg.gov/ArizonaRevisedStatutes.asp

Under **ARS § 26-303**, the Governor:

- During a State of Emergency, shall have complete authority over all state agencies and the right to exercise all police power vested in the state by the constitution and the laws of the state; and may direct all state agencies to utilize and employ state personnel, equipment and facilities for the performance of activities designed to prevent or alleviate damage due to the emergency
- During a State of War Emergency, shall have all authorities as with a State of Emergency; may suspend the provisions of any statute prescribing the procedure for the conduct of state business if the governor determines strict compliance with provisions of any statute would hinder mitigation of the effects of the emergency; may commandeer and utilize any property or personnel deemed necessary in carrying out the responsibilities of the governor and thereafter the state shall pay reasonable compensation
- May confer to the Adjutant General the powers of the Governor prescribed under a State of Emergency

Appendix A: Definition & Acronym List

ACS	Alternte Care Site
ADHS	Arizona Department of Health Services
AFN	Access and Functional Needs
AHCCCS	Arizona Health Care Cost Containment System
ALPHERA	Arizona Local Public Health Emergency Response Association
ARS	Arizona Revised Statute
ASPR	Assistant Secretary for Preparedness and Response
AzTEC	Arizona Tribal Emergency Council
DEMA	(Arizona) Department of Emergency and Miliatry Affairs
EOC	Emergency Operations Center
ESAR-VHP	Emergency System for the Advance Registration of Volunteer Health Professionals
CDC	Centers for Disease Control and Prevention
CBRNE	Chemical Biological Radiological Nuclear and Explosive
CMS	Centers for Medicaid and Medicare Services
EMS	Emergency Medical Services
ERP	Emergency Response Plan
FEMA	Federal Emergency Management Agency
HAI	Healthcare Acquired Infection
HCC	Healthcare Coalition
HEOC	Health Emergency Operations Center
HHS	Health and Human Services
HICS	Hospital Incident Command System
ICS	Incident Command System
HIS	Indian Health Services
JIS	Joint Information System
LEP	Lesser English Proficiency
MCI	Mass Casualty Incident

MHz	Megahertz
NIMS	National Incident Management System
RITN	Radiological Injury Treatment Network
SEOC	State Emergency Operations Center
SMI	Serious Mental Illness

Appendix B: References

1. Federal
    a. Crisis Standards of Care A Systems Framework for Catastrophic Disaster Response – Institute of Medicine (IOM)
    b. National Incident Management System – FEMA
    c. National Response Framework – FEMA
    d. Comprehensive Planning Guide 101 - FEMA
    e. Public Health Preparedness Capabilities: National Standards for State and Local Planning – CDC
    f. Hospital Preparedness Program (HPP) Cooperative Agreement – ASPR
2. State
    a. Arizona State Emergency Response and Recovery Plan – DEMA
    b. Arizona Crisis Standards of Care Plan – ADHS
    c. The Community Alternate Care Site Planning Template – Kansas Department of Health and Environment (KDHE) Bureau of Public Health Preparedness (BPHP)

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