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TO: Van Turner, Chair
Salt Lake City Council

DATE: April 18, 2007

FROM: Lyn Creswell, ~~Chief Administrative Officer~~

SUBJECT: Briefing on Hospital Surge Capacities

STAFF CONTACT: Michael Stever, Emergency Manager, 535-6030

BACKGROUND/DISCUSSION: The Administration will make a presentation to the City Council regarding the surge capacity of Salt Lake City area hospitals. Representatives from IHC, the University of Utah hospitals, the State of Utah, and the Department of Health will participate in the presentation.

Attachments: Utah Department of Health Medical Surge Capacity Plan
Executive Summary, Disaster Plans – University Health Care

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RECYCLED PAPER

Executive Summary
Disaster Plans

University Health Care

In the event a disaster is declared the Utah Department of Health allows all hospitals to surge 20% of their licensed beds.

In the event of a disaster the University Hospital would do the following to care for the sudden influx of patients.

- Activate the hospital command center using the Hospital Incident Command System. The Administrator on Call acts as the Incident Commander.
- Activate telephone call down trees and disaster website to better communicate with our staff.
- Use the Hospital Common channel on the 800 megahertz radio to communicate with other hospitals, the Utah Department of Health, Salt Lake City and Salt Lake County Command Centers. 800 megahertz radios are located in the hospital ED, the Command Center, the Health Science Vice Presidents office and the Huntsman Cancer Hospital. In the event that the 800 megahertz does not work satellite phones as well as HAM radios and GETS cards are available and located in the Command Center.
- Coordination with the Utah Hospital Association Utah Disaster Advisory Council
- Contact Main Campus to alert them of the situation.
- Patients are triaged in the Ambulance Bay; then dependant on their triage category patients would be sent to one of four locations with in the hospital designated areas in the hospital to care for those patients.
- Discharge as many patients as possible, in order to open up beds for patients involved in the event.
- Cancel clinic appointments and pull staff from clinics to help provide care in the main hospital.
- Postpone elective surgeries to open up rooms in the OR to care for those injured.
- Call in additional staff from home if needed then move to 12 hour shifts with all staff working everyday until the disaster is under control.
- Place patients in non traditional patient care areas such as hallways and conference rooms in the event that all beds are filled.
- Set up a volunteer sign in station to credential licensed and non licensed volunteers.
- Call in additional supplies (food, water and medical supplies) from existing vendor agreements as necessary.
- If the number of patient received is exceedingly high, and hospitals are not able to handle any more patients a request would be made to the Utah Department of Health to activate the National Disaster Medical System (NDMS) to transport patients to other areas outside the state not effected by the disaster.

In a situation such as a pandemic influenza the plan outlined above would not meet the needs of the disaster for many reasons. To name a few; the number of people who would become sick and seek medical care greatly exceeds the available resources of all the hospitals in the state. Staff who take care of patients infected with a pandemic influenza risk becoming sick and then possibly taking it home to their families. Additionally, the National Disaster Management System has stated that infectious patients will not be transported across state lines. A pandemic influenza may last for several months so cancelling clinic appointments and elective surgeries is not a feasible solution. Much of the hospital revenue comes from these areas and to cancel for months at a time is not a sustainable business plan.

The University Health Care Pandemic Flu Plan will follow pieces of the disaster plan above but will also include the following elements:

- 5 Phases similar to the Federal Plan will help us to determine what actions should occur when.
- Coordination with the Utah Department of Health and the Salt Lake Valley Health Department.
- Coordination with Hospital Association Utah Disaster Advisory Council
- Identified floor in the hospital as the isolation area
- Identified clinics to function as flu screening clinics
- Shifting of high risk service lines to locations with no infectious patients.
- Employee incentives to come to work such as access to a store for food staples, housing in the event they do not want to risk exposure to their family.
- Altered nurse to patient ratio's
- Reuse of some medical supplies
- Identification of alternate care site
- Equipment for alternate care site
- Partial stockpile of personal protective equipment for staff caring for patients with pandemic influenza.
- Limiting access to the hospital to hospital staff only to prevent transmission of the virus.
- Screening of all persons entering the facility to prevent transmission of the virus.
- Requesting the Utah Department of Health to offer triage guidelines so that all hospitals may provide the same level of care during the height of the pandemic.

Because of the many complicating circumstances surrounding a pandemic influenza this plan alone will not meet all of the medical needs of Salt Lake County.

UTAH DEPARTMENT OF HEALTH

Utah Medical Surge Capacity Plan

DRAFT

January 2007

EXECUTIVE SUMMARY

The Utah Medical Surge Capacity Plan is a guide for the 29 counties, local health departments, medical care facilities and medical personnel within the state of Utah as defined by the Utah Medical Surge Capacity Plan. This plan has the goal of establishing a system that will allow for increasing the number of beds for the triage, treatment and disposition of 500 more patients per 1,000,000 population. Based on the population estimates for 2002 of 2,310,810 , this an increase of 1158 beds within the state of Utah. Another goal is to increase the number of patient care personnel by 125 per 1,000,000 population. Again using the above figures this would be an increase of 289 medical personnel. It has been prepared with the additional goal in mind of assessing the vulnerabilities potentially faced by our citizens and then defining the response mechanism which could be employed by the hospitals and local health departments in a rational response thereto. The scope of this plan encompasses natural, technological and terrorism based emergencies and disasters or combination thereof, which may be reasonably expected to impact the counties.

This plan identifies resources, and outlines mitigation, preparedness, response, and recovery actions, which may be taken by health officials and local responders. This plan does not replace any existing Standard Operating Guidelines (SOG's) within the health department, medical facilities, medical personnel or counties. It has been developed to facilitate the needs of hospital beds, personnel, equipment and supplies, etc. used in the activation of this plan. Because of the nature of detailed SOG's required of each individual department, facility and agency, they are likely to change frequently. It is the responsibility of each individual party within the state of Utah to maintain and review their own SOG's as needed.

This plan is not a plan for individual Health Care Facilities but rather a plan of how each facility in Utah will work together to mitigate, respond to and recover from a disaster type of any origin. This plan is not designed to replace individual, family and Government preparedness plans or actions. This plan is intended for use by region personnel in hospital surge emergencies, conducting drills and exercises.

This plan may be activated at any time by hospitals experiencing a patient surge or the Utah Department of Health when a health emergency arises that would create a surge on hospital capacity so as to overwhelm the resources available.

This plan requires fair and equal treatment to all regardless of race, creed, color, national origin, sex, age, or handicap. As in any emergency where prioritizations must take place, the goal will always be to do the greatest amount of good for the greatest number of people. First priority will always be to save lives.

The Utah Department of Health (UDOH) emphasizes that no guarantee is implied by this plan. Health departments, medical facilities, medical personnel and individual county assets and systems may be damaged, destroyed, or overwhelmed. Each entity can only endeavor to make reasonable efforts to respond based on the situation, information and resources available at the time. The inability of individual entities to carry out their responsibilities due to lack of staff or funding may lower emergency declaration threshold and degrade the services envisioned under this plan. The performance of the assigned tasks and responsibilities will be dependant on appropriations and funding to support the plan. It is therefore recommended that the population in Utah, as defined by this plan, be prepared in the event of any type of disaster.

It will be the intention of the health department, to use the Incident Command System (ICS) as outlined in the National Incident Management System (NIMS).

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I - PURPOSE

The Utah Medical Surge Capacity Plan identifies and outlines the steps that need to be taken to increase the State's current patient bed capability by 1158, with 116 beds being designated as critical care or burn beds. It provides guidelines to be used for the initial care of patients exposed to: explosives, chemical, biological and radiological agents as well as trauma and burn patients.

The plan addresses the needs for caring for the additional 1158 patients including consideration of resources for additional facilities, patient beds, personnel, security, communications, transportation and equipment. It defines medical capabilities within Utah, as defined by this plan, and delineates members of the State Government and other agencies responsible for plan implementation. It also identifies what actions may be taken to prepare for, and reduce the vulnerability of the State's population stemming from natural, technological (man made) disasters and homeland security emergencies.

The plan identifies resources within Utah that may be employed in responding to different and varying emergencies. It facilitates coordination between all agencies involved by providing strategies to prevent or minimize, prepare for, respond to, and recover from emergencies or disasters that threaten life, property and the environment within Utah, as defined by this plan.

II – AUTHORITY

Federal

- Public Law (P.L.) 93-288, Disaster Relief Act of 1974, as amended by P.L. 100-707 ("The Stafford Act"
- Emergency Management and Assistance, 44 U.S. Code 2.1 (Oct. 1, 1980)
- P.L. 81-920, Federal Civil Defense Act of 1950 as amended
- P.L. 99-499, Title III, Emergency Planning and Community Right-to-Know, Oct. 17th, 1986.

State

- UACR R386-702-4
- Utah Code, Title 26; Utah Health Code
- Utah Code, Title 26A; Local Health Authorities

Local

- Health Department Directors
- Health Department Local Ordinances and Policies

1.0 – DIRECTION AND CONTROL

Hospitals will be the primary facilities to activate the Medical Surge Capacity Plan. It may also be activated on the State level by the Director of the Utah Department of Health (UDOH) or his/her designated representative. The State can be reached at the following number: **1-866- DOH-UTAH (364-8824) or 1-866-EPI-UTAH (374-8824)**. If either Director is unavailable, the Director of the Emergency Medical Services will initiate the plan.

1.1 – HOSPITALS

Hospitals will be the primary facilities to provide care in a mass casualty situation. Each hospital will implement its Hospital Incident Command System (HICS) upon activation of this plan and coordinate all activities through or in conjunction with the UDOH ECC. Hospitals will retain individual control of their institutions.

1.2 – LOCAL HEALTH JURISDICTIONS

Local and state health jurisdictions will be responsible for continued monitoring and assessment of casualty care in their jurisdictions. They will provide information and recommendations to the UDOH ECC with respect to responses to anticipated changing conditions during the event.

1.3 – EMERGENCY MANAGEMENT

The UDOH is responsible for implementation of this plan and possesses ultimate authority after the plan has been activated. In the event the incident that activates this plan does not initially affect local emergency management agencies, local agencies including hospitals are encouraged to coordinate their activities through the UDOH ECC.

In order to decrease confusion and enable a unified response, hospitals should not directly contact the State EOC. The UDOH ECC will communicate and coordinate with the State EOC.

1.4 – UDOH REGION EMS CONSULTANTS

The UDOH ECC will provide a region EMS consultant to help facilitate communication between local EMS agencies, hospitals, UDOH ECC and State EOC. They will respond to the local EOC and communicate availability of equipment, supplies and personnel. They will also assist in making transportation arrangements.

The EMS Consultants can be reached at the following number: **1-866- DOH-UTAH (364-8824).** (Please refer to Appendix N for Regional Consultant Map.)

1.5 – UDOH BEMS STRIKE TEAMS

The objective for the BEMS Strike Teams is to assist local agencies and hospitals by making available additional resources such as personnel and equipment that can assist with patient care, triage, treatment, and logistical needs responders during a bioterrorism incident, natural disaster, or medical event that has the potential of overwhelming or depleting local resources. BEMS Strike Teams could also provide assistance to medical examiners, mortuaries, and DMORT(s) during a Mass Fatality Incident.

The BEMS Strike Teams can be reached at the following number: **1-866- DOH-UTAH (364-8824).** (Please refer to Appendix N for Regional Strike Team Map.)

2.0 - ACTIVATION AND SYSTEM RESPONSE

This plan will be activated and followed under the following conditions with respect to alerts and notifications. Due to the nature, place and time of the event, which activates this plan, the timeline is a guidance of what may occur and not an exact account of what will take place.

2.1 – FIRST TWO HOURS

BIOLOGICAL EVENT

In accordance with current protocols, if any patient is suspected of having a condition due to a biological agent, the health care facility will immediately notify the local health department. The local health department will notify UDOH, which in turn will notify the Center for Disease Control (CDC) of the situation. The local and state health department personnel will determine whether immunization, isolation or other actions are necessary and will advise treating physicians of recommended therapy and decontamination actions if warranted. UDOH will notify the Director with the recommendation that this plan be activated in view of the potential for multiple other patients. The UDOH will be responsible for contacting members of the State EOC in order to notify them of this plan's implementation.

ALL HAZARDS EVENT

In other situations producing mass casualties, public safety or other emergency response personnel would initially determine the scope of the event and notify dispatch. Once the local EOC is operational, they will request the level of assistance necessary. The local health department will ascertain preliminary requirements and advise UDOH to contact hospitals in the region affected to implement their HICS and prepare to receive patients in accordance with this plan. Depending on the scope of the disaster, the UDOH ECC may request all hospitals in the state to implement their HICS in preparation for the activation of the Medical Surge Capacity Plan. Hospitals will be required to complete and transmit bed status sheet information to the UDOH ECC. The fax number is: **(801) 538-6808**. The Hospital Status Report (Please see Appendix L) will be updated every 2 hours at a minimum.

2.2 – FIRST TWENTY-FOUR HOURS

Hospitals should prepare to surge bed capacity by 20% of their licensed beds. Reports of numbers and types of patients admitted from hospitals, other medical facilities, local and state health departments, other public safety agencies and other emergency response organizations will be monitored at the UDOH ECC on a continuous basis. It is essential that hospitals relay their status to the UDOH ECC. These reports, along with inputs and recommendations of hospitals and the local health departments will enable the UDOH ECC to determine whether patients should be transported to other facilities in the State. These reports will also be the basis for the UDOH ECC to determine if transferring patients out of state may become necessary. The UDOH ECC will ascertain whether other medical facilities in surrounding states could accept patients and forecast if in-coming patients will be dramatically increased over time. The UDOH ECC will initiate appropriate action with the NDMS and SNS at this time and, as necessary with the State Department of Emergency Services and Homeland Security (DESHS) EOC.

The UDOH ECC will work with the State EOC to coordinate transportation requirements with local health departments, local mass transit, and Emergency Medical Systems (EMS).

In the event of a bioterrorist incident and at the direction of the UDOH ECC, all hospitals and health care facilities in the state of Utah will begin using the provided Screening Form, Home Care Instructions and Frequently Asked Question handouts (See Appendices G, H and I) as needed. The gathering of information will be uniform.

2.3 – FIRST FORTY-EIGHT HOURS

During the first 48 hours it should be possible to refine data and get a more realistic estimate of casualties. The UDOH ECC will coordinate with the state DESHS EOC to prepare for the arrival of NDMS and SNS if they have been requested. The UDOH ECC will also continue to monitor the number and types of patients each hospital is treating. As hospitals begin to approach their 20% surge capacity bed numbers, the UDOH ECC will work with the State EOC to coordinate the transportation of stable patients in hospitals who are at maximum capacity to facilities with open beds in order to allow hospitals' in affected area to continue receiving patients.

2.4 – SUSTAINED RESPONSE FOR BIOLOGICAL INCIDENTS

It is understood that any Biological incident will require an extended response period and all agencies should be prepared to activate their individual emergency response plans. The UDOH ECC will coordinate the delivery of prophylactic antibiotics from state reserves or activate the SNS for hospitals, fire departments, EMS and local health departments in order to preserve the first response service to the public.

Hospitals, fire departments, EMS and health departments will be responsible for distribution of these medications to their staff. Guidelines and information for the public will come from the office of Epidemiology at the UDOH ECC. The location of distribution sites will come from the JIC in coordination with the UDOH ECC and the affected local health departments.

The UDOH ECC will be responsible for coordinating with the State EOC to make requests for federal assistance in regards to staffing issues, equipment and supplies.

3.0 - EMERGENCY COMMUNICATION SYSTEMS

The primary form of communication will be the use of phones, both land line and cellular. These communication systems should be used until they are no longer operational. Radios should be used as the next form of communication. Hospitals can use the 800 MHz and, if needed, VHF radio frequencies. All hospitals in the state are equipped with at least one radio, and random radio checks are being led by the UDOH. The UDOH will be in charge of facilitating communications between facilities. All hospitals should submit requests for supplies and personnel thru the UDOH ECC.

The geography in parts of the Northern Region consists of mountainous terrain with valleys and high desert conditions. With the mountains, direct line of sight communications is often difficult, creating a finite amount of communication resources in certain areas of the region.

In the event of an emergency, there will be an increased demand for communication resources. All hospitals and clinics within the Northern Region are encouraged to work locally and regionally to facilitate needed arrangements for redundant communications using all available communications: phones, radios, HAM radio relay and UNIS.

HAM radios may also be used to facilitate communication; all hospitals should work with their local Amateur Radio Emergency Services (A.R.E.S.) HAM operators to determine how they can best be utilized in the event of an emergency. Most hospitals and clinics in the Northern Region are prepared to provide space and/or equipment in their Command Centers, or in adjacent areas for Ham operator equipment and personnel.

The Utah Notification Information System (UNIS) will allow local and state departments of health to uniformly and simultaneously distribute messages to all hospitals in the affected region or throughout the entire state.

It is important to note that hospitals should plan and practice a combined use of these communication tools. This will enable the UDOH ECC and State EOC to more effectively manage the changing situation. All personnel who will be involved in radio communication should receive basic training in radio communications and discipline.

ORDER IN WHICH BACKUP SYSTEMS SHOULD BE USED

1. Phones (land line and cell)
2. Radio 800 MHz or VHF.
3. HAM Radio Relay
4. UNIS

4.0 – MEDIA/PUBLIC COMMUNICATIONS

BIOLOGICAL EVENT

In the event of a bioterrorism situation, it is recognized that there will be multiple requests from the media for information regarding the agent in question. Hospitals should give information to the press from the provided information (Please see Appendix I and J).

In the event of a large scale incident the State EOC may initiate the JIC. In any situation that a JIC is established and opened, all hospitals should work with the JIC to gather and verify information before speaking to the news media. All hospitals should notify the JIC before any planned news briefing.

Additional information and instruction should come from the State Epidemiologist thru the UDOH ECC and the State EOC or from a press release that has been approved by the Joint Information Center (JIC). Standardization of information coming from all hospitals regarding bioterrorism agents will help decrease the confusion and panic that will accompany such an event.

ALL HAZARDS EVENT

The State EOC will take, at the minimum, two hours from the onset of the incident to become fully staffed. The UDOH ECC will also require some time to become operational. It is rational to expect the media to demand information immediately following or in the middle of any type of Mass Casualty Incident (MCI). During that time it is important that hospitals be prepared to speak to the press.

Hospital Public Information Officers (PIOs) may use pre-scripted messages provided by the UDOH for initial statements to the press (Please see Appendix J). Additional information regarding the situation should come from the State EOC, with hospitals giving updates specific to their hospitals only.

In the event of a large scale incident the State EOC may initiate the JIC. In any situation that a JIC is established and opened, all hospitals should work with the JIC to gather and verify information before speaking to the news media. All hospitals should notify the JIC before any planned news briefing.

4.1 – HOSPITAL PUBLIC INFORMATION OFFICER

Facilities, which have not identified a PIO, should do so. Basic PIO training is available for anyone designated as such through the state division of emergency services and homeland security. The contact number is **801-538-3400**.

Hospitals and clinics that have not contacted responsible media members and media outlets should do so in order to facilitate communication during a disaster situation. Information regarding how to contact and develop strong working relationships with a responsible media representative is discussed in the previously described training.

Queries regarding situations unique to a particular facility should be discussed prior to the response of the query. All additional questions regarding infectious diseases will come to the state epidemiologist thru the UDOH ECC and the JIC.

5.0 – CRITICAL ISSUES

5.1 – HOSPITAL BED CAPACITY

When a disaster occurs which produces mass casualties, elective procedures and patients with non- emergency problems should be discharged. Depending on the extent of the disaster, it may be necessary for the UDOH to contact hospitals throughout the state in preparation to activate their individual Medical Surge Capacity Plans.

SPACE FOR ADDITIONAL BEDS/COTS

Depending on the nature of the event and the projected number of casualties, hospitals should convert any private rooms into multi-bed rooms. It is strongly recommended that hospitals identify other areas that may be suitable for patient care. Additionally, all hospitals have received decontamination tents that may be converted into small patient care areas, by adding cots or beds. They are equipped with a HEPA filter capable of providing either positive or negative-pressured HEPA filtration. In this mode, the shelters could also be utilized to provide temporary isolation for infectious patients.

The UDOH has 8 tractor-trailers called Disaster Response Units (DRUs) that may be deployed to any area at the direction of the UDOH. The trailers are supplied with the necessary linens and 100 cots as well as IV tubing and supplies. These trailers may be delivered to multiple hospitals or to one designated alternate care facility location.

The UDOH also has 51 Environmentally Controlled Unit (ECU) Anterooms that can be deployed anywhere in the state to turn any hospital room or other designated rooms into negative-pressure HEPA filtered isolation areas. These units are pre-deployed throughout the state in cargo trailers. Each trailer contains 10 separate units and there is at least one trailer in each region.

HOSPITAL STAFFING NEEDS

It is recognized that staffing will be an ongoing concern during implementation of this plan. It is strongly recommended that each Hospital have a plan to deal with staff rotation in a disaster. Hospitals should implement this plan at the outset of the disaster. It is strongly recommended that during the initial response to an incident for the first 48-72 hours that all hospitals divide their entire staff into two teams A and B. These teams would rotate every 12 hours. Clearly, this is a short-term solution only, but it will assist with the initial staffing demands of any large MCI.

For additional and long terms staffing needs, the UDOH ECC and State EOC may also consider requesting the National Nurse Response Team (NNRT), which is a specialty Disaster Medical Assistance Team under the National Disaster Medical System (NDMS). An NNRT is comprised of approximately 200 civilian nurses located in each of the ten Department of Homeland Security regions who can be mobilized on short notice.

Hospitals requesting additional manpower should submit these requests to the UDOH ECC. With the arrival of additional manpower, hospitals should follow their individual protocols and plans for registration and tracking of these persons.

5.2 – ISOLATION AND QUARANTINE

In accordance with current protocols, if a patient is suspected of having a condition that is reportable, as directed by the CDC, the reporting facility will notify local health departments.

The local health department will notify UDOH, which in turn will notify the CDC of the situation. The local and State health department personnel will determine whether immunization, isolation or other actions are necessary and will advise treating physicians of recommended therapy and decontamination actions if warranted. UDOH will notify the Director with the recommendation that this plan be activated in view of the potential for multiple other patients.

In the event that isolation and quarantine becomes necessary, local health departments will declare these within their respective jurisdictions. Isolation and quarantine are optimally performed on a voluntary basis, in accordance with instructions of healthcare providers and health officials. Many levels of Government (local, state and federal) have the basic legal authority to compel mandatory isolation and quarantine of individuals and communities when necessary to protect the public's health as stated in Utah Health Code 26A-1-114 (Please see Appendix E).

HOSPITAL SMALLPOX RESPONSE

Each hospital should consider vaccinating a small number of staff members to act as a Smallpox Reaction Team in the event someone with symptoms or findings of smallpox presents to their hospital. Hospitals should also identify a larger number of staff that would volunteer to receive the vaccination immediately after there is a diagnosed case of smallpox in the United States. In the event that hospitals opt not to vaccinate staff, a plan to care for a smallpox patient is still necessary. Currently there is not a designated smallpox hospital in the state; all hospitals must be prepared to care for a patient with a diagnosis of smallpox.

These smallpox reaction teams would be responsible for evaluating any potential smallpox patients and would complement the mass immunization program that would be accomplished by the Department of Health. If a hospital suspects a diagnosis of smallpox, they should IMMEDIATELY contact their Local and State Health Departments by dialing the **1-888-EPI-UTAH (374-8824)** phone number. Hospitals may also follow established protocols for this type of an incident. The UDOH will be responsible for letting all other hospitals in the State know that there is a suspect case of smallpox. This action will allow hospitals to brief staff members in being highly vigilant for additional patients.

5.3 – OVERCROWDING AND DIVERSION

Patient transport will be a major concern during a MCI. It must be recognized that standard ambulance transport for all patients is not a possibility and multi-agency coordination with local transportation agencies will be required to provide transport of casualties to designated hospitals and from hospitals to facilities capable of caring for additional patients.

Hospitals will be responsible for contacting EMS dispatch and the UDOH ECC to let each know they are reaching maximum capacity. **It is important to note that hospitals cannot go to "divert" status during an MCI**. Hospitals may request that already screened or stable patients be transferred to another facility in order to open up more beds and manage the large influx in patient volume. Hospitals **WILL NOT** refuse patients because of volume. It is understood and expected that all hospitals will be initially overwhelmed. In the event of an MCI, hospitals are able to increase bed licensure by 20%. As the event progresses, the UDOH ECC will use the hospital status reports to reallocate supplies and transfer patients to hospitals with available beds.

All hospitals should identify several pick up locations for transfer of patients, and relay this information to local EMS agencies. This location should be different from the drop off for incoming patients. When hospitals request a transfer of patients, they should report this pick up location to the regional EMS coordinator who will report to UDOH ECC.

5.4 – PATIENT FLOW PROCESS

PATIENT DISTRIBUTION

As hospitals reach maximum capacity, the regional EMS coordinator will work with the UDOH ECC to identify hospitals within the state to accept patients. The coordinator will work with hospitals that have reached maximum capacity to schedule transport of patients to the other facilities.

In order to maximize all of the resources the beds in these hospitals provide, it is emphasized that triaging of all patients must be continuous. Hospitals with open beds must be willing to accept patients readily from facilities who are overwhelmed. In the event of an MCI, all hospitals will report their bed and supply status to the UDOH ECC. Coordination of transportation should go through the individual HICS to the UDOH ECC with a request for transportation of patients. The transferring hospital will provide the patients name and primary diagnosis.

Additionally, transferring hospitals must send any diagnostic tests that are obtained. Copies of diagnostic tests include lab results and HARD copies (not the Radiologist report) of any X-Rays or CT scans that were obtained.

The efficacy of this plan will depend on hospitals actively keeping the UDOH ECC informed of their status and ability to accept additional patients. This movement of patients will enable the appropriate use of all available beds.

PATIENT TRACKING

Biological Event

In a biological incident patient tracking needs become quite different. In accordance with state law hospitals must report communicable diseases to local health departments. Local health departments are responsible for performing contact tracing, interviews and gathering information on these patients. In the event of a known wide- spread biological outbreak patients suspected of having the disease should be reported to local health departments. Local health departments will report numbers of patients as well numbers on contact tracing information to the UDOH. The UDOH may not need specific patient information, instead focusing their response on the overall situation, working to predict outbreak patterns and numbers as well as provide supplies and facilitate implementation of the SNS.

All Hazards Event

The transferring hospital will provide the patient's name and primary diagnosis as well as copies of any performed diagnostic tests. In a non-biological event there is no reason for the UDOH ECC to track patient names, the only pertinent information for them is the numbers and categories of patients each hospital is caring for. Tracking of this information can be done on with the Hospital Status Sheets (Please see Appendix L).

5.5 – EQUIPMENT

PERSONAL PROTECTIVE EQUIPMENT (PPE)

It is strongly recommended that all hospitals have staff identified, trained and fit- tested so that they can properly use Personal Protective Equipment (PPE) and accomplish patient decontamination. The potential for decontamination of large numbers of patients would exist in a chemical attack and may be expected by people who have been exposed to a biological agent. All hospitals have received decontamination showers as well as PPE. Hospitals must consider this potential patient demand in their plans.

EQUIPMENT AND SUPPLIES

In order to maximize all resources, it is imperative that all hospitals cooperate with each other by performing mutual exchange of needed equipment and supplies if necessary. Hospitals should use the Equipment and Supply Transfer Sheet (Please see Appendix K) and keep a record of all equipment and supplies that are received and accepted. Tracking movement of supplies and equipment will be necessary to ensure appropriate reimbursement. Hospitals are responsible for providing documentation of the equipment and supplies that they both transfer and receive. Hospitals **MUST** provide the database for reimbursements.

Supplies and equipment that can be requested for transfer should be billable and easily replaceable, such as wound care material, IV fluid and minor equipment such as endo-tracheal tubes and Foley catheters. **Equipment such as IV pumps and primary ventilators should not be requested.**

5.6 – SPECIAL NEEDS POPULATION

Hospitals should follow their established protocols for handling the special needs population which may include: children, elderly, pregnant women, deaf, blind, limited English speaking or other needs not listed.

It is strongly recommended that each hospital conduct yearly training for disaster care of pediatrics, geriatrics and pregnant women. It is also recommended that each hospital have lists and/or means of alternative communications for the deaf or limited English speaking population such as: people who sign for the deaf, special phones (TTY/TTD), interpreters or a language line.

5.7 – ESSENTIAL GOODS AND SERVICES

Each hospital should have policies in place for bringing in essential goods and services during an event that would alter normal routines. This would include plans for food, water, electricity, supplies and emergency needs of patients and staff. It is strongly recommended that a Memorandum of Agreement (MOA) be established prior to an event so as to limit the confusion.

FAMILY ASSISTANCE CENTER

It is strongly recommended that each hospital designate a family care area where employees can bring their children or other family members to be taken care of while they work. Each hospital would provide personnel and resources to manage the family care area, which would allow for the continuity of work by staff. This would help to alleviate the possible shortage of staff due to the emotional distress of caring for a family during an emergency.

MEDICAL WASTE DISPOSAL

Large hospitals have capabilities in place to contain waste runoff during decontamination if necessary. Hospitals must meet current Department of Environmental Quality (DEQ) standard requirements for safe methods of waste disposal. The CDC also offers additional specific instructions regarding the disposal of waste related to caring for a patient with highly infectious diseases. Hospitals should consult the CDC website and follow instructions and recommendations given by the CDC. Hospitals may also contact their local health department who will work with them for safe disposal of any medical waste.

5.8 – PHARMACEUTICALS

The UDOH has purchased several pharmaceutical caches. These caches are integrated into the baseline operating volume of some of the biggest pharmacies in the state. The quick turn over of medications in these pharmacies negates the potential for expiration of the medications. Please refer to the state SNS plan for more specific information.

5.9 – HOSPITAL SECURITY

It is strongly recommended that hospitals develop requirements for lockdown and crowd control procedures. Hospital planning must recognize the potential for the arrival of several hundred injured and non-injured people within a short period of time after an event.

Initial security of the hospital will be provided by hospital security personnel. It is important to recognize that police departments have multiple responsibilities during disasters, and will probably not be able to report to the hospital to provide support or security. Hospitals must work with their hospital security, local law enforcement or, potentially, private security agencies to coordinate their security plan. Coordination must take place prior to an event. Written procedures must be included in the hospital plan, and activation of the procedures should be required as part of hospital practices.

Each hospital should have policies in place for bringing staff into the facility. The problem will arise in getting staff to their individual hospitals so that they may assist in the response to the disaster. Currently, in the event of a disaster, access to critical areas is difficult and may often be restricted.

6.0 – ALTERNATE CARE SITES

Including but not limited to: Community Health Centers, Surgical Centers, Specialty Clinics, Specialty Hospitals, Urgent Care Centers, Medical Clinics and Private Physician Offices and Clinics. Schools, Churches and other non-traditional medical facilities as deemed necessary.

These alternate care sites provide an important resource for the Medical Surge Capacity of the Hospitals and will be listed in the health facility UDOH licensure data base.

1. They have access to decontamination equipment on a cargo trailer that can be utilized and transported in the event a facility needs extra decontamination or isolation capacity. If transportation of equipment is not possible, they will serve as a decontamination station or provide additional space for patient care.

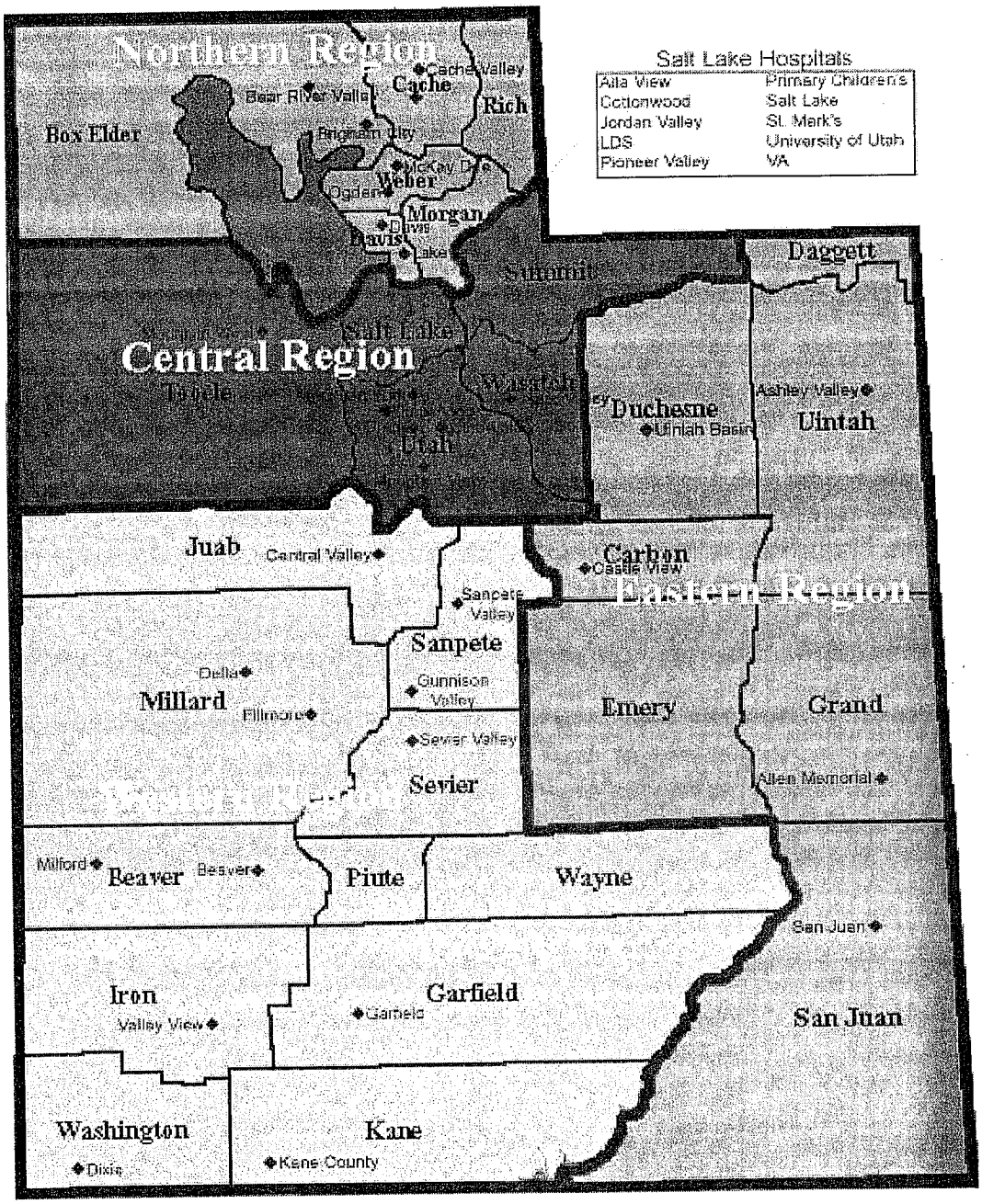
2. They will provide triage and medical assistance to the "worried well" or "walking wounded." They will also provide medical personnel to the specified hospitals or triage areas if needed. This is an important resource whereas several of the clinics have employees that are bilingual.

3. They can provide medical personnel to assist in providing mass immunizations in the event of a disease outbreak or threat of disease outbreak.

DRAFT

7-0 - REGIONAL HOSPITAL OVERVIEW

Hospital Bioterrorism Regions



8.0 - NORTHERN REGION PARTICIPATING HOSPITALS AND/OR CLINICS

There are currently 10 hospitals and/or community health centers that are participating in the Northern Region Medical Surge Capacity Plan. (Please see Appendix N for specific contact information for each facility)

Logan Regional Hospital, Logan, Utah

Cache Valley Specialty Hospital, North Logan, Utah

Bear River Valley Hospital, Tremonton, Utah

Brigham City Community Hospital, Brigham City, Utah

McKay Dee Hospital, Ogden, Utah

Ogden Regional Hospital, South Ogden, Utah

Davis Hospital, Layton, Utah

Lakeview Hospital, Bountiful, Utah

Bear Lake Community Health Center, Garden City, Utah

Midtown Community Health Center, Ogden, Utah

DRAFT

8.1 - EMERGENCY COMMUNICATION SYSTEMS

The primary form of communication will be the use of phones, both land line and cellular. These communication systems should be used until they are no longer operational. Radios should be used as the next form of communication. Hospitals can use the 800 MHz and, if needed, VHF radio frequencies. All hospitals in the state are equipped with at least one radio, and random radio checks are being led by the UDOH. The UDOH will be in charge of facilitating communications between facilities. All hospitals should submit requests for supplies and personnel thru the UDOH ECC.

The geography in parts of the Northern Region consists of mountainous terrain with valleys and high desert conditions. With the mountains, direct line of sight communications is often difficult, creating a finite amount of communication resources in certain areas of the region.

In the event of an emergency, there will be an increased demand for communication resources. All hospitals and clinics within the Northern Region are encouraged to work locally and regionally to facilitate needed arrangements for redundant communications using all available communications: phones, radios, HAM radio relay and UNIS.

HAM radios may also be used to facilitate communication; all hospitals should work with their local Amateur Radio Emergency Services (A.R.E.S.) HAM operators to determine how they can best be utilized in the event of an emergency. Most hospitals and clinics in the Northern Region are prepared to provide space and/or equipment in their Command Centers, or in adjacent areas for Ham operator equipment and personnel.

The Utah Notification Information System (UNIS) will allow local and state departments of health to uniformly and simultaneously distribute messages to all hospitals in the affected region or throughout the entire state.

It is important to note that hospitals should plan and practice a combined use of these communication tools. This will enable the UDOH ECC and State EOC to more effectively manage the changing situation. All personnel who will be involved in radio communication should receive basic training in radio communications and discipline (Please see Appendix L for table of communications availability).

ORDER IN WHICH BACKUP SYSTEMS SHOULD BE USED

1. Phones (land line and cell)
2. Radio 800 MHz or VHF.
3. HAM Radio Relay
4. UNIS

8.2 - EMERGENCY COMMUNICATION SYSTEMS OPERATIONAL WITHIIN THE NORTHERN REGION

HOSPITAL NAME	HEAR/VHF	800 MHZ	CELL PHONES	SATELLITE PHONES	AMATEUR RADIO
Logan Regional Hospital	X	X	X	X	X
CVSH	X	X	X		X
Bear River Valley Hospital	X	X	X		X
Brigham City Community Hospital	X	X	X		X
McKay Dee Hospital	X	X	X	X	X
Ogden Regional Medical Center	X	X	X		X
Davis Hospital		X	X		X
LakeView Hospital		X	X		X
Bear Lake Community Health Center					
Midtown Community Health Center					
Evanston Memorial Hospital	X		X		X
South Davis Community Hospital					

DRAFT

8.3 - MASS CASUALTY ALLOCATION GUIDE

NUMBER OF CASUALTIES	ESTIMATE NUMBER OF URGENT PATIENTS (requiring surgical intervention)	PATIENTS TRANSPORTED TO:	ESTIMATE NUMBER OF NON-URGENT PATIENTS	PATIENTS TRANSPORTED TO:	PROPOSED LEVEL OF CARE
60	12	Closest most appropriate hospital	48	Closest most appropriate hospital	No change in standard level of care. (Cancellation of elective surgeries may not be necessary.)
180	36	Closest most appropriate hospital	144	Hospital Emergency Departments	Cancellation of elective procedures, discharge of stable patients.
300	60	Any Hospital	240	Hospital Emergency Departments, Urgent Care Centers and Clinics	Cancellation of elective procedures, discharge of all stable patients. Use of patient transfer to utilize all available beds in the region.

FIRST TWO HOURS

NUMBER OF CASUALTIES	TYPES OF PATIENTS TRANSPORTED	TRANSPORTATION METHODS
50	Red and Yellow	As per EMS protocol Red and Yellow patients transported by ambulance, Green patients transported by bus. Normal calls managed by use of resources from surrounding counties.
100	Red	As per EMS protocol, Red patients transported by local EMS, additional resources requested from surrounding counties to transport Yellow patients. Green patients transported by bus. Normal calls managed by use of resources from outlying counties
300	Red or Yellow	Transport as many as possible salvageable Red and Yellow patients by ambulance with use of multiple county resources. Green patients transported by bus. Respond to normal calls deemed "emergent" only.

<u>TWO HOURS AFTER EVENT</u> (Transportation of patients from overcrowded hospitals to hospitals with open beds)

NUMBER OF CASUALTIES	TYPES OF PATIENTS TRANSPORTED	TRANSPORTATION METHODS
50	Critical and Stable	All patients transported by ambulance. Normal calls managed by additional help from surrounding counties.
100	Critical and Stable	Critical patients transported by ambulance, stable patients transported by bus (para-transit buses preferably) with staffing coming from surrounding counties. Normal calls managed by use of resources from outlying counties
300	Critical and Stable	Critical patients transported by ambulance as resources and manpower allow from effected county and surrounding counties. Stable patients transported by bus with outlying counties providing staffing. Respond to normal calls deemed "emergent" only.

DRAFT

9.0 - CENTRAL REGION PARTICIPATING HOSPITALS AND/OR CLINICS

There are currently 21 hospitals and/or community health centers that are participating in the Central Region Medical Surge Capacity Plan. (Please see Appendix P for specific contact information for each facility)

Altaview Hospital, Sandy, Utah

American Fork Hospital, American Fork, Utah

Cottonwood Hospital, Murray, Utah

Heber Valley Medical Center, Heber City, Utah

Jordan Valley Hospital, West Jordan, Utah

LDS Hospital, Salt Lake City, Utah

Mountain View Hospital, Payson, Utah

Mountain West Medical Center, Tooele, Utah

Orem Community Hospital, Orem, Utah

Pioneer Valley Hospital, West Valley City, Utah

Primary Children's Medical Center, Salt Lake City, Utah

Salt Lake Regional Medical Center, Salt Lake City, Utah

Shriner's Hospital for Children, Salt Lake City, Utah

St. Mark's Hospital, Salt Lake City, Utah

Timpanogo's Hospital, Orem, Utah

University of Utah Hospital, Salt Lake City, Utah

Utah Valley Regional Medical Center, Provo, Utah

VA Salt Lake City Health Care System, Salt Lake City, Utah

Community Health Centers, Inc., Salt Lake City, Utah

Health Clinic of Utah, Salt Lake City, Utah

Mountainlands Community Health Center, Provo, Utah

DRAFT

9.1 - EMERGENCY COMMUNICATION SYSTEMS

The primary form of communication will be the use of phones, both land line and cellular. These communication systems should be used until they are no longer operational. Radios should be used as the next form of communication. Hospitals can use the 800 MHz and, if needed, VHF radio frequencies. All hospitals in the state are equipped with at least one radio, and random radio checks are being led by the UDOH. The UDOH will be in charge of facilitating communications between facilities. All hospitals should submit requests for supplies and personnel thru the UDOH ECC.

It is recommended that during a medical surge incident, all hospitals in the Central Region should monitor the Hospital Common Channel. This will help in following patient load, hospital needs and available outside assistance. Hospitals are cautioned not to turn down the volume on the radios that are being used for communications. This will hinder communication between hospitals, UDOH, and EMS agencies.

HAM radios may also be used to facilitate communication; all hospitals should work with their local Amateur Radio Emergency Services (A.R.E.S.) HAM operators to determine how they can best be utilized in the event of an emergency. Most hospitals and clinics in the Central Region are prepared to provide space and/or equipment in their Command Centers, or in adjacent areas for Ham operator equipment and personnel.

The Utah Notification Information System (UNIS) will allow local and state departments of health to uniformly and simultaneously distribute messages to all hospitals in the affected region or throughout the entire state.

It is important to note that hospitals should plan and practice a combined use of these communication tools. This will enable the UDOH ECC and State EOC to more effectively manage the changing situation. All personnel who will be involved in radio communication should receive basic training in radio communications and discipline (Please see Appendix L for table of communications availability).

ORDER IN WHICH BACKUP SYSTEMS SHOULD BE USED

1. Phones (land line and cell)
2. Radio 800 MHz or VHF
3. HAM Radio Relay
4. UNIS
5. Satellite Phone

9.2 - EMERGENCY COMMUNICATION SYSTEMS OPERATIONAL WITHIN THE CENTRAL REGION

HOSPITAL NAME	HEAR/VHF	800 MHZ	CELL PHONES	SATELLITE PHONES	AMATEUR RADIO
Alta View Hospital	X	X	X	X	X
American Fork Hospital	X	X	X	X	X
Cottonwood Hospital	X	X	X	X	X
Heber Valley Medical Center	X		X		
Jordan Valley Hospital	X	X	X		X
LDS Hospital	X	X	X	X	X
Mountain View Hospital					
Mountain West Medical Center	X	X	X		
Pioneer Valley Hospital	X	X	X		X
Primary Children's Medical Center	X	X	X		X
Salt Lake Regional Medical Center	X	X	X		X
St. Marks Hospital	X	X	X		X
Timpanogos Hospital	X	X	X		X
University of Utah Hospital	X	X	X	X	X
Utah Valley Regional Medical Center	X	X	X	X	X
VA SLC Health Care	X	X	X	X	X
Mountainlands Community Health Center					
Health Clinic of Utah					

9.3 - MASS CASUALTY ALLOCATION GUIDE

NUMBER OF CASUALTIES	ESTIMATE NUMBER OF URGENT PATIENTS (requiring surgical intervention)	PATIENTS TRANSPORTED TO:	ESTIMATE NUMBER OF NON-URGENT PATIENTS	PATIENTS TRANSPORTED TO:	PROPOSED LEVEL OF CARE
70	14	Closest most appropriate hospital	56	Closest most appropriate hospital	No change in standard level of care. (Cancellation of elective surgeries may not be necessary.)
234	47	Closest most appropriate hospital	187	Hospital Emergency Departments	Cancellation of elective procedures, discharge of stable patients.
703	141	Any Hospital	562	Hospital Emergency Departments, Urgent Care Centers and Clinics	Cancellation of elective procedures, discharge of all stable patients. Use of patient transfer to utilize all available beds in the region.

FIRST TWO HOURS

NUMBER OF CASUALTIES	TYPES OF PATIENTS TRANSPORTED	TRANSPORTATION METHODS
70	Red and Yellow	As per EMS protocol Red and Yellow patients transported by ambulance, Green patients transported by bus. Normal calls managed by use of resources from surrounding counties.
234	Red	As per EMS protocol, Red patients transported by local EMS, additional resources requested from surrounding counties to transport Yellow patients. Green patients transported by bus. Normal calls managed by use of resources from outlying counties
703	Red or Yellow	Transport as many as possible salvageable Red and Yellow patients by ambulance with use of multiple county resources. Green patients transported by bus. Respond to normal calls deemed "emergent" only.

PARCEL INFORMATION

Sidwell Number: 16-23-330-003-0000 **Area:** 0.28

Parcel Address: 2421 S SCENIC DR

PARCEL OWNER INFORMATION

Owner Name: GUPTA, RANJAN K & DEEPA; TRS

Owner address: 2421 S SCENIC DR
SALT LAKE CITY, UT 84109-1480

Owner Phone:

PARCEL LAND USED

SINGLE FAMILY RESIDENCE

PARCEL ZONING

FR-3 -- FOOTHILLS RESIDENTIAL DISTRICT

PARCEL CERTIFIED STRUCTURE ADDRESS

2421 S SCENIC DR

SMALLPOX – FREQUENTLY ASKED QUESTIONS (FAQ)

What is smallpox?
Smallpox is a virus (germ) that causes a high fever and a rash with draining lesions over the whole body. No person in the world has been diagnosed with smallpox since1977. For that reason, vaccination programs were discontinued in all countries including the U.S. in 1980. Adults vaccinated prior to 1980 have no immunity.

Is smallpox spread from person-to-person?
Yes. When the infected person coughs or sneezes the germ is forced out of the mouth into the air. A non-infected person gets the infection by inhaling (breathing) the virus into their l respiratory tract. The infection can also the spread by direct contact with the rash or by contact with contaminated items such as sheets, towels, and clothes.

How will I know if I was exposed to the germ?
You may have been exposed at the location where the germ was intentionally released. The further away you were from the original release site, the less likely it is that you were exposed. You could also be exposed to a person who is infected and you could catch the germ if you had close contact with that person (within 6 feet).

How soon will the symptoms develop (incubation period)?
The symptoms may start within 7-17 days after exposure. Infected persons are not infectious until the rash appears.

What are the symptoms of the infection?
For about 2 - 4 days after the person breathes the infected air, there will be no symptoms. After about 4 days, the infected person will begin to feel very sick with a fever, severe tiredness, headache, backache, stomachache, and vomiting. Over the next several days, the fever may increase and the person may become confused and disoriented. As the fever increases, a rash (raised, discolored spots) may be seen on the face. The rash will then spread to the neck, arms, legs and the soles of the feet and palms of the hands. The rash will progress from fluid-filled vesicles to pus-filled pustules. Scabs will begin to form on the skin about 8-9 days after the onset of the rash. Smallpox is no longer infectious once all the scabs have fallen off the skin.

How is the infection treated?
There is no medicine such as an antibiotic to treat smallpox infection. The doctor may order medicine to control the fever and to keep the person calm (sedative).

How is the infection prevented?
Smallpox vaccine is highly effective in preventing or decreasing the severity of smallpox. If a smallpox outbreak is confirmed, the federal government will provide the vaccine to local health departments for the general public.

How will I know if I need to be vaccinated?
If you were in the location were the germ was originally released or if you were exposed to a person who developed the symptoms (fever and rash) of the infection, you will be offered the vaccination.

How will I know where to go to get the vaccination?
When the vaccine becomes available, the local health department will provide information about the locations of the vaccination sites in your city or county. You should listen to the radio or television for this information.

Do people get sick from the vaccination?
Complications are not common but they occur. An information sheet has been developed that will give you information about how to care for your vaccination and what complications to expect. You will be given this information when you report to the designated vaccination location. You will also be requested to sign a consent form before you receive the vaccine.

What can I do to keep from getting infected?

- In the event that a smallpox outbreak is identified, the most important thing you can do is stay at home. The local health officer may ask you to wear a mask over your nose and mouth if you have to go to the store. Do not go to a hospital emergency room unless you are sick.
- Listen to the local radio or television for special instructions from the local health officer. The local health department may also designate an emergency center or hospital for you to go to if you develop symptoms.

DRAFT

VIRAL HEMORRHAGIC FEVERS (VHF) FREQUENTLY ASKED QUESTIONS (FAQ)

What are viral hemorrhagic fevers?
Viral hemorrhagic fevers are caused by a number of different viruses. These viruses usually cause fevers and bleeding in addition to other symptoms, from severe to mild. They usually occur in parts of Africa and in South America but are very rare in the United States.

Is VHF spread from person-to-person?
Yes. VHF can be spread from person to person by contact with infected blood and other infected body fluids such as urine, feces, vomitus, and by contact with droplets coughed into the air by the infected person.

How soon will symptoms develop (incubation period)?
Normally the symptoms start 5 days or longer after exposure to the germ. Not all persons exposed to the germ will develop symptoms.

What are the symptoms of infection?
The symptoms of VHF generally include high fever, sore muscles and extreme weakness. The eyes may become red and the skin may appear to be red (flushed). In the advanced stages of the infection there may be bleeding from the nose, mouth, bowel or bladder.

How is the infection treated?
There is no medication available to treat VHF infection.

What should I do if I DO NOT have symptoms?
If you do not have any symptoms of the infection, you should continue with your routine daily activities. Please DO NOT go to the hospital emergency room unless you have a fever or other symptoms of the infection.

How can I get more information?

- The local health department will make frequent public announcements. The local health department may also designate an emergency center or hospital for you to go to if you develop symptoms.
- It is important that you listen to the radio or television for more information.

DRAFT

APPENDIX J – PIO PRESCRIPTED MEDIA MESSAGES

INITIAL STATEMENT TO MEDIA
RE: BIOLOGICAL AGENT DISASTER

Biological agents (multiple patients exposed to one of the following diseases: Anthrax, Smallpox, Botulism, Plague, Tularemia, Viral Hemorrhagic Fever and SARS)

Script for all diseases listed above ***except*** Anthrax.

Multiple cases in the valley with NO transmission occurring within the hospital:

The __X__Hospital is currently caring for __X__ patients with the preliminary diagnosis of __X__. The Hospital's number one priorities are caring for those patients affected and protecting the safety of our staff and other patients.
We are working with the Utah Department of Health in order to prevent further transmission of the disease.

Members of the community should listen to all health directives and instructions given by the Utah Department of Health, and the Salt Lake City and State departments of emergency management. They will give you information regarding medication distribution sites and clinic screening locations.

Persons who are concerned about a family member who has been brought to the Hospital with the potential diagnosis of __X__ please call__X__, to obtain information about your loved one.

If you are a regular patient and you have a scheduled clinic appointment or procedure please:
Come in as scheduled
OR
Do not come in at this time. Someone from your doctor's office will call you to re-schedule.
OR
Call your doctor's office before you come in.

We apologize for any inconvenience this may cause you and we appreciate your patience.

If you need immediate medical attention please call 911 or come to the hospital as soon as possible.

We will continue to give you information as we know it. The next media briefing will be at X o'clock , in __X__ location.

Multiple patients in the hospital, multiple patients across the valley and transmission from patient to staff or patient to patient within the hospital.

The __X__Hospital is currently caring for __X__ patients with the preliminary diagnosis of __X__. The hospital has prepared for situations such as this, our number one priorities are caring for those patients affected and protecting the safety of our staff and other patients.
We are working with the Utah Department of Health in order to prevent further transmission of the disease.

Members of the community should listen to all health directives and instructions given by the Utah Department of Health, and State department of emergency management. They will give you information regarding medication distribution sites and clinic screening locations.

In an attempt to protect our patients, our staff and the public, we are currently allowing hospital staff only into the facility. If you are a staff member reporting to work, please report to the__X entrance for a screening exam. No one is permitted into the facility until his or her screening exam has been completed.

Persons who have family members who are patients in the facility should call __X__ to find out about their status.

If you are a regular patient, and you have a scheduled clinic appointment or procedure please:
Do not come in at this time. Someone from your doctor's office will call you to re-schedule.
OR
Call your doctor's office before you come in.

We apologize for any inconvenience this may cause you and we appreciate your patience

If you are in need of immediate medical attention please call 911.

We will continue to give you information as we know it. The next media briefing will be at X o'clock__, in __X location.

DRAFT

INITIAL STATEMENT TO MEDIA
RE: ANTHRAX

The __X__ Hospital is currently caring for ___X___ patients with the preliminary diagnosis of Anthrax. The Hospital has prepared for situations such as this; our number one priority is caring for those patients affected.

We are working with the Utah Department of Health to identify and provide treatment for everyone who was exposed. Remember, Anthrax is not communicable from person to person -- you can't "catch" it from anyone.

Members of the community should listen to all health directives and instructions given by the Utah Department of Health, and the Salt Lake City and State departments of emergency management. They will give you information regarding medication distribution sites and clinic screening locations.

The __X__ Hospital will NOT be administering Cipro for Anthrax prophylaxis on an outpatient basis. Persons concerned that they may have been exposed to Anthrax should report to one of the Strategic National Stockpile distribution areas being given by the Utah Department of Health.

If you are a regular patient and you have a scheduled clinic appointment or procedure please:
Come in as previously scheduled, there is no risk to you.
(OR)
Do not come in at this time. Someone from your doctor's office will call you to re-schedule.
(OR)
Call your doctor's office before you come in.
We apologize for any inconvenience this may cause you and we appreciate your patience.

If you are in need of emergent medical attention please call 911 or come to the hospital immediately.

We will continue to give you information as we know it. The next media briefing will be at X o'clock__, in __X__ alternative location.

DRAFT

INITIAL STATEMENT TO MEDIA
RE: CHEMICAL AGENT DISASTER

Chemical agent (Release from the Toole Army Depot or other chemical incident)

The __X__ Hospital was informed by __X agency__ at __time__ that X incident occurred. We have received _____ patients at this time and have been alerted to expect more.
(Or)
We have not yet received any patients but are prepared to care for them should they be transported here. The hospital has staff that has been trained to care for patients exposed to chemical agents. We do not have any specific information about the incident.

Please listen to all health directives given by the Utah Department of Health, and the Salt Lake City or State departments of emergency management.

Persons who are concerned that a family member may have been brought to University hospital should report to __X location__. If you are looking for a family member please do not come to the hospital; right now we need all our staff to focus on the care of the injured and any influx of family members will impede our efforts to do our job. The hospital will update __X location__ every half hour with the names of any new patients it has received.

If you are a regular patient, and you have a scheduled clinic appointment or procedure please:
Come in as scheduled
OR
Do not come in at this time someone from your doctor's office will call you to re-schedule.
OR
Call your doctor's office before you come in.

We apologize for any inconvenience this may cause you and we appreciate your patience.

If you need immediate medical attention please call 911 or come to the hospital right away.

We will continue to give you information as we know it. The next media briefing will be at __X o'clock__, at the __X (alternative location).__

DRAFT

INITIAL STATEMENT TO MEDIA
RE: GENERIC DISASTER

GENERIC DISASTER (plane crash, train crash, mass casualty)

__X___ Hospital was informed by ____X agency___ at __time__ that X incident occurred.
We have received _____ patients at this time and have been alerted to expect more.
(Or)
We have not yet received any patients but are prepared to care for them should they be transported here. We do not have any additional specific information regarding the incident.

Persons who are concerned that a family member may have been brought to__X____ hospital should report to the _X location. If you are looking for a family member please do not come to the hospital; right now we need all our staff to focus on the care of the injured and any influx of family members will impede our efforts to do our job. The hospital will update the X location every half hour with the names of any new patients it has received.

If you a regular patient and you have a scheduled clinic appointment or procedure please:
Come in as scheduled
OR
Do not come in at this time someone from your doctor's office will call you to re-schedule.
OR
Call your doctor's office before you come in.
We apologize for any inconvenience this may cause you and we appreciate your patience.

If you need immediate medical attention please call 911 or come to the hospital right away.

We will continue to give you information as we know it. The next media briefing will be at _____X_____ o'clock in ___X location___.

DRAFT

APPENDIX K – REIMBURSEMENT FORM

EQUIPMENT & SUPPLY TRANSFER SHEET

DATE: **TIME:**

Transferring HOSPITAL/ CLINIC or GROUP	
CONTACT PERSON (please print name and phone number)	
RECEIVING HOSPITAL	
CONTACT PERSON (please print name and phone number)	
DESCRIPTION and or QUANTITY OF SUPPLIES and EQUIPMENT (please include identification or tracking numbers if any)	**1.**
2.	**3.**
4.	**5.**
SIGNATURE OF TRANSFERRING HOSPTIAL/CLINIC or GROUP	
SIGNATURE OF RECEIVING HOSPITAL	

APPENDIX L – HOSPITAL STATUS SHEET (FAX TO: 801-538-6808)

HOSPITAL STATUS SHEET

HOSPITAL NAME	
CONTACT PERSON	
EOC PHONE #	
EOC FAX #	
EOC E-mail	
TOTAL # OF INPATIENTS	
NUMBER OF POTENTIAL INPATIENT DISCHARGES	
TOTAL # OF AVAILABLE BEDS	ICU: BURN: MED SURG: PEDIATRICS: Negative Pressure: **TOTAL**:
BLOOD (please give unit #'s of each)	O -: A -: B -: AB -: FFP: Cryo: O +: A +: B +: AB +: Platelets: Albumin 25%:
STAFFING REQUEST (please check here to indicate you have no staffing needs at this time) ☐	MD: RN: EMT: CNA: Non-medical personnel:
EQUIPMENT REQUEST (please list)	

APPENDIX M – "CODE RED" UTAH DEPARTMENT OF HEALTH

Code Red is part of the Department's Crisis, Emergency and Risk Communication response capabilities. In an emergency, the Utah Department of Health (UDOH) may receive a very high volume of phone calls from the public. Once normal phone/public inquiry systems are overwhelmed or taxed, the Code Red hotline is activated.

The primary responsibility of Code Red is to respond to calls received on the hotline from the public. Code Red allows UDOH to respond with more operators and with coordinated messaging.

The Code Red hotline is staffed by volunteers who will process calls 24 hours a day as long as needed during a crisis. Hotline operators will answer calls from the public and provide basic information prepared by the Public Information Office and other staff involved in the UDOH Emergency Coordination Center.

Hotline operators receive training on crisis management, cultural competency and other pertinent topics. New operators for Code Red are recruited and trained as needed.

DRAFT

APPENDIX N – REGION RESOURCES

MEDICAL RESERVE CORPS

The Medical Reserve Corps (MRC) is a volunteer team of medical and public health professionals who can contribute their skills and expertise during times of community need. MRC functions as units that are community based and are dedicated to making sure their families, homes and communities are safe from terrorism, crime and disasters of all kinds.

MRC members will be utilized in any event that has the potential to overwhelm local EMS and hospitals. They will have the ability to set up triage centers and will become a focal point for sending appropriate patients to the hospitals. They will also be available to assist in any activation of the SNS, Mass Immunization Clinics, Shelter Needs through the Red Cross and Non-Emergency Public Health Campaigns.

MRC actively recruits active and retired:

- Physicians
- Nurses
- Dentists
- Epidemiologists
- Physician Assistants
- Veterinarians
- Pharmacists
- Physical Therapists
- Counselors
- Educators
- Interpreters
- Microbiologists
- Nutritionists
- Technicians
- Social Workers
- Environmental Specialists
- Industrial Hygienists
- Mental Health Specialists
- Office Managers
- Lay Persons

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CIVIL AIR PATROL

The Civil Air Patrol (CAP) is an Auxiliary of the United States Air Force. They are committed "…to serve America by developing our nation's youth; accomplishing local, state and national missions; and informing our citizen's about the importance of aerospace education." The CAP has three primary missions: Aerospace Education, Cadet Programs and Emergency Services. Under the Emergency Services Division, they:

- Conduct 95% of all inland search and rescue in the US, as tasked by the Air Force Rescue Coordination Center and other agencies
- Performs aerial reconnaissance for homeland security
- Saves an average of 100 lives per year
- Provides disaster-relief support to local, state and national disaster relief organizations
- Transports time-sensitive medical materials, blood products and body tissues
- Provides damage assessment, radiological monitoring, light transport and communications support and low-altitude route surveys for the U.S. Air Force
- Assists federal agencies in the war on drugs
- Conducts orientation flights for Air Force ROTC students
- Maintains its own communication network, the most extensive in the nation

The Utah Wing lies in the Rocky Mountain Region, which consists of 5 states: Utah, Idaho, Montano, Wyoming and Colorado. The Utah Wing has various squadrons located throughout the state. The CAP is able to fly needed supplies or equipment as requested through the State EOC.

The Utah Wing owns 9 fixed wing aircraft. They are typically located in:

- Salt Lake City
- Ogden
- Roosevelt
- Richfield
- St. George
- Moab
- Cedar City

These aircraft may be located anywhere in the state depending on use. There are also 26 member owned aircraft located throughout the State which are available for missions. The standard fee for use of a CAP plane is $66/aircraft hour. May vary slightly depending on the price of fuel.

There is an airport located in every county within the Northern Region.

- Bountiful/SkyPark
- Ogden/Hinckley
- Brigham City
- Logan/Cache
- Morgan
- Evanston/Uinta Co. Burns Field

- Bear Lake County

APPENDIX O - STATE OF UTAH MASS ALLOCATION GUIDE

After an explosive event, it can be expected that 50-80% of casualties will arrive at the closest medical facility within 90 minutes of the event. An "upside-down" pattern can also be expected, where the most severely injured arrive after the less injured, who bypass EMS triage and arrive at the hospital independently.

A predictor (http:www.bt.cdc.gov/masstrauma/predictor.asp) indicates that the total expected casualties after a blast or other explosive event can be roughly predicted as:

Total expected casualties = Number of casualties arriving in the first hour x 2

Two major constraints on treating blast casualties during the first hours after an event are number of staffed operating rooms and number of staffed x-ray machines. Many blast patients will require at least a chest x-ray, and multiple other radiology studies may be necessary. The CDC capacity document referenced above optimistically predicts a procedure can be done every 10 minutes. Capacity for patients requiring x-rays would be:

Patient capacity for those requiring chest x-rays/hour = Number of x-ray machines (fixed and portable) x 6 patients per hour

Significant confusion can be expected during the initial two hours after an explosive event, and the sudden influx of patients will require practiced plans to cope with the situation. Additionally, as more valid estimates of projected casualties are developed, Table 2 can be used as a guide in planning for dispersal of patients throughout Utah. Table 3 can be used as a mass casualty algorithm.

The UDOH will ascertain whether other medical facilities in surrounding states could accept patients and forecast if in-coming patients will be dramatically increased over time. The UDOH is to coordinate transportation requirements with local health departments, local Mass transit, and EMS.

Table 2 - STATE OF UTAH MASS CASUALTY ALLOCATION GUIDE

NUMBER OF CASUALTIES	ESTIMATE NUMBER OF URGENT PATIENTS (requiring surgical intervention)	PATIENTS TRANSPORTED TO:	ESTIMATE NUMBER OF NON-URGENT PATIENTS	PATIENTS TRANSPORTED TO:	PROPOSED LEVEL OF CARE
100	20	Closest most appropriate facility (in accordance with State Law)	80	Local Hospital Emergency Departments	No change in standard level of care. Cancellation of elective procedures may not be necessary
500	100	Closest most appropriate facility (in accordance with State Law)	400	Any Hospital Emergency Departments	Cancellation of elective procedures, discharge of all stable patients.
1000	200	Any Hospital	800	Hospital Emergency Departments, Urgent Care Centers and Clinics	Cancellation of elective procedures, discharge of all stable patients. Use of patient transfer to utilize all available beds in the state.

FIRST TWO HOURS

NUMBER OF CASUALTIES	TYPES OF PATIENTS TRANSPORTED	TRANSPORTATION METHODS
100	Red and Yellow (critical and moderately injured or ill)	As per the MCI plan Red (critical) and Yellow (moderate) patients transported by ambulance, Green (non critical) patients transported by bus. Normal calls managed by use of resources from surrounding counties.
500	Red (critical)	As per MCI plan, Red patients transported by local EMS, additional resources requested from surrounding counties to transport Yellow patients. Green patients transported by bus. Normal calls managed by use of resources from outlying counties
1000	Red or Yellow (critical or moderately injured or ill)	Transport as many as possible salvageable Red and Yellow patients by ambulance with use of multiple county resources. Green patients transported by

		bus. Respond to normal calls deemed "emergent" only.

<u>TWO HOURS AFTER EVENT</u> Transportation of stable inpatients from overcrowded hospitals to hospitals with open bed (most likely inpatient prior to the event)

NUMBER OF CASUALTIES	TYPES OF PATIENTS TRANSPORTED	TRANSPORTATION METHODS
100	Critical and Stable	All patients transported by ambulance. Normal calls managed by additional help from surrounding counties.
500	Critical and Stable	Critical patients transported by ambulance, stable patients transported by bus (para-transit buses preferably) with staffing coming from surrounding counties. Normal calls managed by use of resources from outlying counties
1000	Critical and Stable	Critical patients transported by ambulance as resources and manpower allow from effected county and surrounding counties. Stable patients transported by bus with outlying counties providing staffing. Respond to normal calls deemed "emergent" only.

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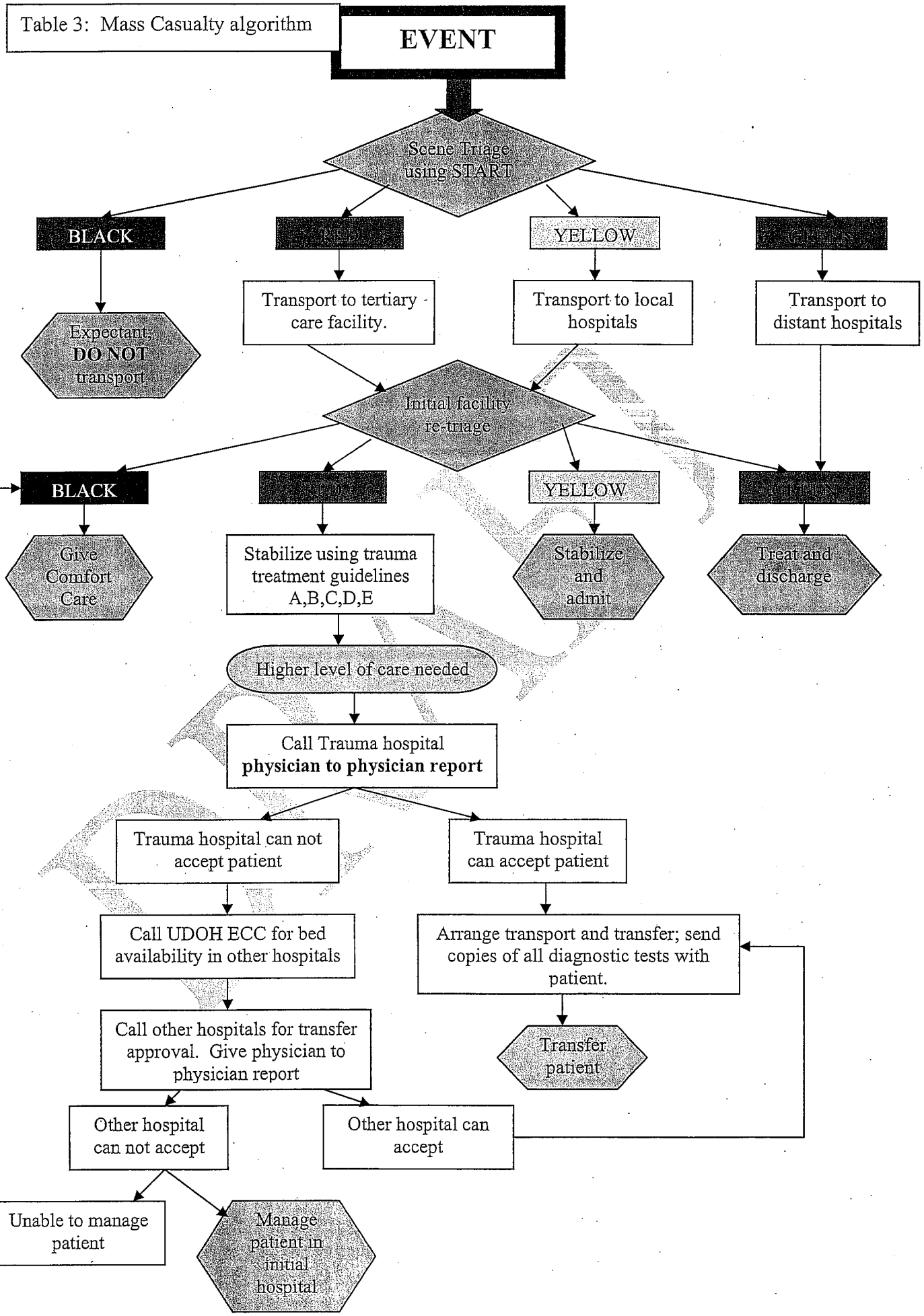
Table 3: Mass Casualty algorithm



APPENDIX P - TRIAGE

Triaging will be required on a continuing basis during a disaster. It will begin at the scene in an explosive or chemical event, continue during transport, occur at the receiving hospital, occur throughout the treatment process, be used in transfer decisions, and continued until the patient recovers or is discharged from care.

It is essential that all involved in evaluation at the scene, patient transport, and treatment use the same standardized triage system. This system must also be practiced through realistic exercises so all who might be involved in triaging during a disaster situation will be able to use the standardized system. The same system must be used throughout the state. Failure to adopt and practice a standardized system will lead to confusion and life-threatening situations.

In accordance with the Utah Mass Casualty Incident Plan, triage of patients should be initiated following the START and JUMP START Triage system.

During any MCI incidents, the severely injured patients with a high probability of survival (Red or Immediate Category patients) would be transported to the closest emergency patient receiving facility appropriate to adequately treat the patient according to the Utah Health Code 26-8a-307 (Please see Appendix D). Excess patients in this Red or Immediate category, will be distributed throughout the state as deemed appropriate by the UDOH ECC and the State EOC.

Patients that require operative intervention that can be delayed without compromise of outcome or loss of life (Yellow or Delayed Category patients) will be initially transported to appropriate facilities where definitive or temporizing care can be provided until the patient could be transported to a larger hospital capable of handling the patient's specific injuries. Patients without serious, life or limb threatening injuries, Green or Minimal Injury category patients, should NOT BE sent to hospitals. These patients should be sent to pre-designated areas where they can be given care at the scene, sent to clinics, same day surgical centers, extended care facilities or home.

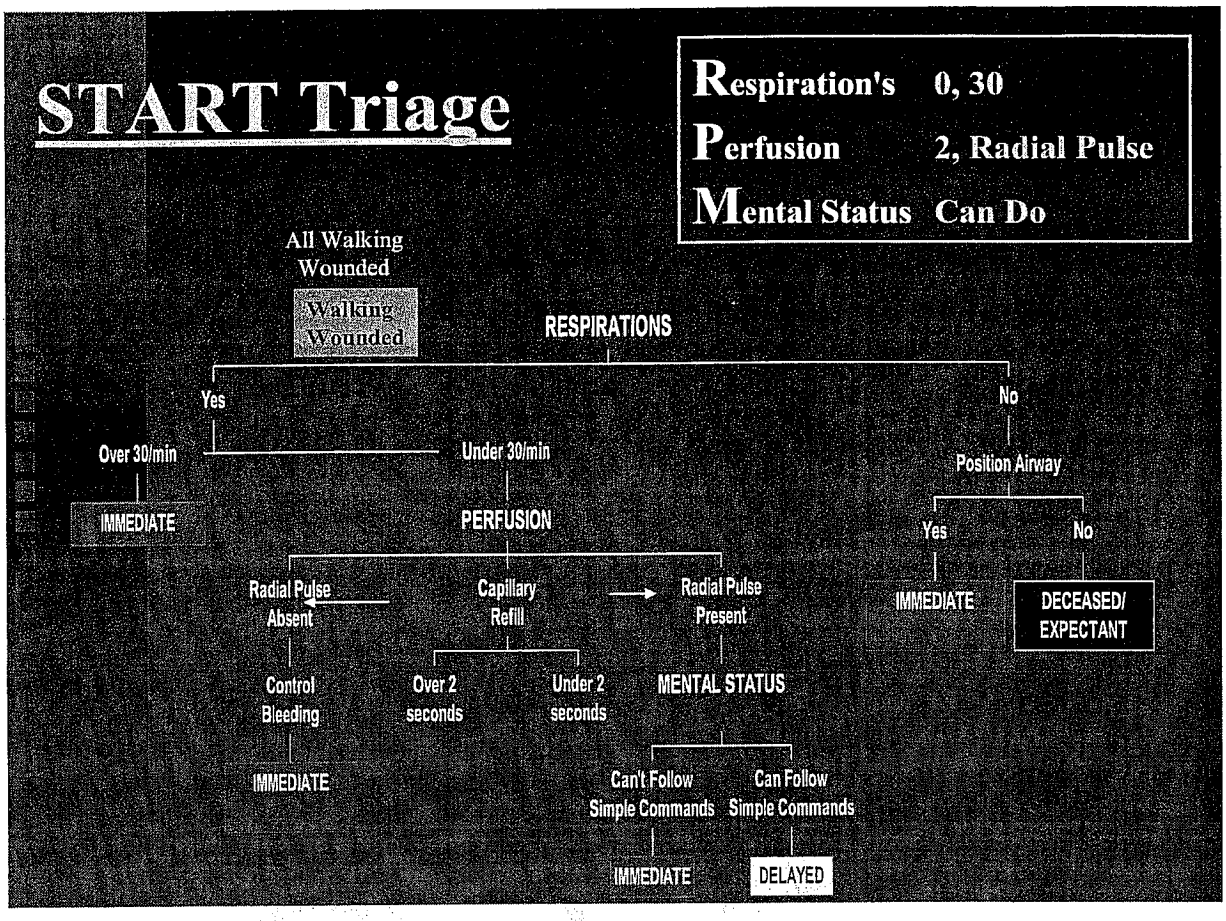
Physicians or Triage Officers at individual hospitals will determine if it is necessary to withdraw or withhold comprehensive care. The number of patients, their conditions and amount of available resources will affect this decision. Hospitals should be able to obtain information on available resources through the UDOH ECC.

START Triage

The START triage system (Simple Triage and Rapid Transport) is a simple method of rapidly assessing and triaging mass casualty patients. It is based upon a rapid assessment of Respiration, Perfusion/Circulation and Mental Status and is a reasonable preliminary tool to sort patients into the Red, Yellow, Green and Black categories outlined below.

The START triage systems uses the following color coded system whereby victims are

Red:	Immediate
Yellow:	Delayed
Green:	Minimal treatment (the walking wounded)
Black:	Deceased or expectant management



HOSPITAL TRIAGE

As previously mentioned triage will be required on a continuous basis during a disaster. On arrival patients should be triaged again to ensure they are in the appropriate triage category. An explanation of each color-coded category with examples is listed below.

RED - IMMEDIATE

Includes severely injured patients with high probability of survival. These patients need procedures of moderately short duration to prevent death

Examples:

- Airway or breathing difficulties
- Shock
- Uncontrolled or suspected severe bleeding
- Unstable chest and abdominal wounds
- Sucking chest wounds
- Pneumothorax
- Maxillofacial wounds with actual or potential airway compromise

Internal hemorrhage unresponsive to volume replacement
Deteriorating CNS injuries
Incomplete amputations
White phosphorous burns
Inaccessible vascular injury with limb ischemia
Second or third degree burns of 15 – 40%
Crush or burn injuries with suspected compartment syndrome
Serious medical problems such as poisoning, complicated diabetes, cardiac emergencies

YELLOW - DELAYED

Includes patients that require operative intervention that may be delayed without compromise of outcome or loss of life. **Temporizing measures include IV fluids, antibiotics, pain management, catheterization, gastric decompression and splinting of long bone fractures.**

Examples:
Hemodynamically stable patients with abdominal injuries
Soft tissue wounds requiring extensive debridement
Maxillofacial injuries without airway compromise
Vascular injuries with adequate distal circulation
Genitourinary disruptions
Fractures requiring debridement and fixation without circulatory compromise
Eye and stable CNS injuries
Patients requiring time consuming surgery
Back injuries with or without spinal cord compromise

GREEN – MINIMAL

Includes patients without serious injuries to major organs, vascular structures or nerves. These are the walking wounded that can provide self-care or be cared for by family or minimally trained personnel.

Examples:
Superficial wounds and abrasions
Burns less than 15% of TBSA except in special care areas (face, hands, genitalia)
Upper extremity fractures
Sprains
Radiation injuries
Blast injuries without obvious problems
Psychiatric disturbances

BLACK – EXPECTANT OR DECEASED

Includes patients that are dead, unlikely to survive even in a level I trauma center and patients that would require time and or resources that would allow other salvageable patients to deteriorate or die. These patients should be separated from other patients, be kept comfortable
and be attended to by competent sympathetic personnel. These patients should receive operation only when other operative cases have been completed and if supplies are not limited.

Examples:

- Cardiac arrest
- Severe brain injury (GCS $\leq$ 5 or visible brain matter)
- Multi-cavity penetrating wounds
- Massive soft tissue injury or loss
- Burns > 70% of TBS

jumpSTART Triage

The jumpSTART triage system (Simple Triage and Rapid Transport) is a simple method of rapidly assessing and triaging pediatric patients ages 1-8. It is based upon a rapid assessment of Respiration, Perfusion/Circulation and Mental Status and is reasonable preliminary tool to sort patients into the Red, Yellow, Green and Black categories outlined below.

The jumpSTART triage system uses the following color-coded system whereby victims are categorized in the following manner:

Red: Immediate
Yellow: Delayed
Green: Minimal treatment (the walking wounded)
Black: Deceased or expectant management

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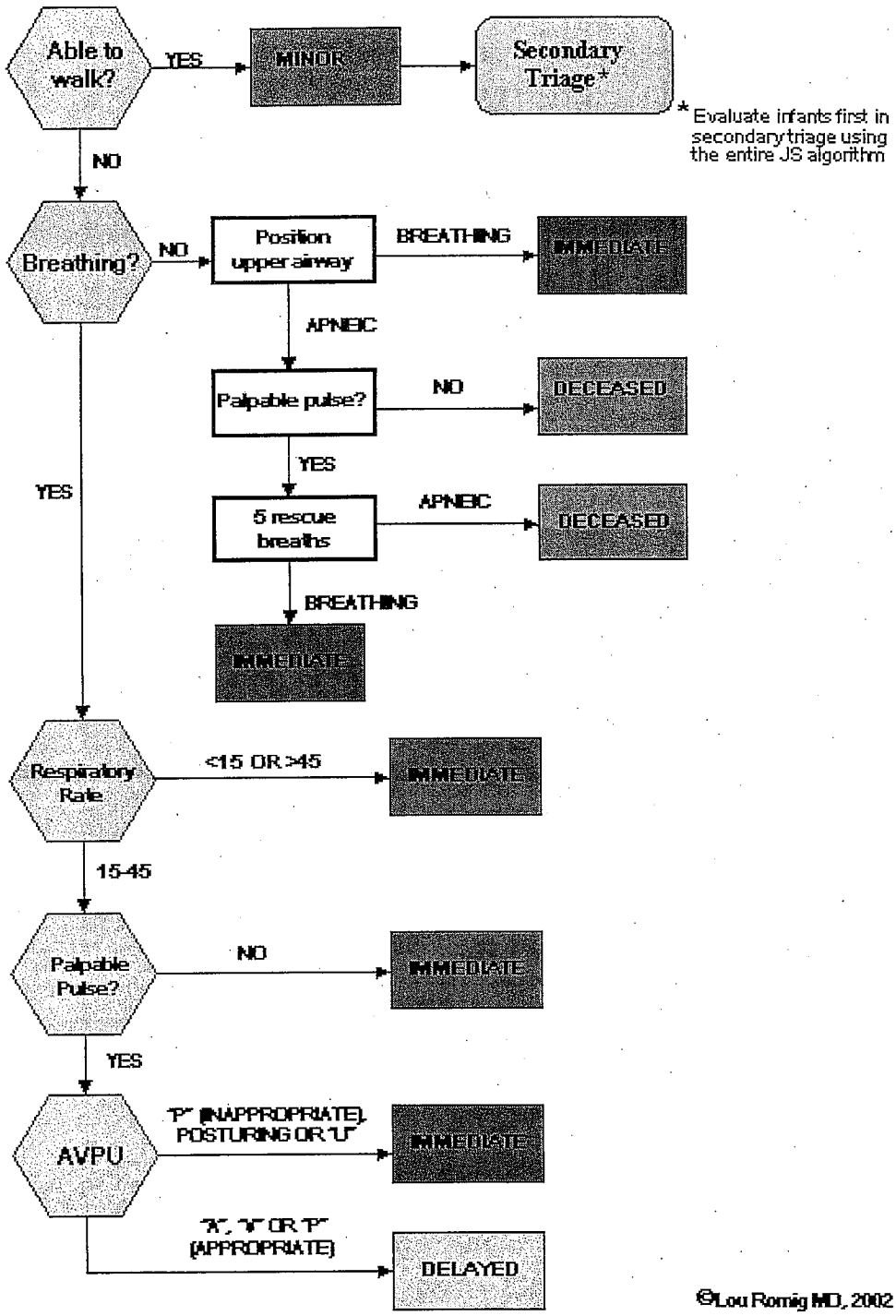
JumpSTART Pediatric MCI Triage©



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APPENDIX F: BIOLOGICAL AND ALL HAZARDS EVENT PROTOCOL

Local Health Departments

Biological Event

The UDOH serves as the contact point for activation of the Strategic National Stockpile (SNS) UDOH members will be responsible for obtaining this resource if requested by local health departments. Upon arrival of the stockpile the implementation of mass immunizations and mass administration of prophylaxis medication will be coordinated and managed by the local health departments. Each local health department is responsible for their area. The UDOH is also responsible for contacting and requesting the use of resources available through the National Disaster Medical Systems (NDMS) at the request of local health departments. However, the local health departments are responsible for coordination and dispersal of those resources on arrival.

Isolation and Quarantine

Local health departments may initiate quarantine within their jurisdiction at the recommendation of their epidemiologist. The UDOH would initiate any required quarantine actions for multiple jurisdictions at the recommendation of the State Epidemiologist or designee from the Bureau of Epidemiology in the UDOH ECC.

All Hazards Event

Local Health departments should function in a supportive role during any incident working with local EOC's to assist with locating and obtaining any needed resources. In the event local health departments become overwhelmed with requests for resources, they may turn to the UDOH ECC for assistance.

DIRECTION AND CONTROL

BIOLOGICAL EVENT

During a biological event, Command and Control for all hospitals, EMS and transportation agencies lie with the individual entities. However, patient tracking is an integral portion of any biological response. In the event of a biological incident, local health departments are responsible for all patient tracking and contact tracing in their jurisdictions. If the incident crosses health districts, in an effort to unify the response the incident will be managed by the UDOH ECC with the local health departments coordinating their efforts through the UDOH ECC.

ALL HAZARDS EVENT

In all incidents except biological incidents, the UDOH ECC will act in a supportive role. All hospitals, EMS and transportation agencies will be responsible for Command and Control of their entities and request help from the UDOH ECC when they become overwhelmed.

APPENDIX G – SCREENING FORM

GENERAL SCREENING FORM

Assigned ID Number:_____ Place of Treatment:_____

Last Name:_____ First Name:_____

Today's Date:_____ Date of Birth:_____ Age:_____ Sex:_____

Street Address:_____ Apt. #:_____

City:_____ State:_____ Zip:_____

Telephone Number:_____ Alternate Number:_____

Occupation:_____ Place of Employment:_____

Work Address:_____

City:_____ State:_____ Zip_____

Work Phone Number:_____ Date Symptoms Started:_____

Allergies:_____

Past History: **IN THE PAST 6 WEEKS HAVE YOU:**

Traveled to other USA Cities or Towns? Please List:	**YES**	**NO**
Traveled to a Foreign Country? Please List:	**YES**	**NO**
Stayed outdoors or camped outside? Please List:	**YES**	**NO**
Had any insect bites? Please List:	**YES**	**NO**
Do you have lesions or sores from bites or others? Please List:	**YES**	**NO**
Have you had contact with sick animals? Please List:	**YES**	**NO**

Please list current medications:

Assigned ID Number:_____ Place of Treatment:_____

Last Name:_____ First Name:_____

IN THE PAST 6 WEEKS HAVE YOU HAD ANY OF THE FOLLOWING SYMPTOMS?

Fever (range: to)	YES	NO	Shivers/Shakes	YES	NO
Nausea/Vomiting	YES	NO	Coughing up Blood	YES	NO
Vomiting Blood	YES	NO	Red or Painful Bumps on Skin	YES	NO
Stomach Pain	YES	NO	Swollen Glands	YES	NO
Headache	YES	NO	Shortness of Breath	YES	NO
Excessive Fatigue	YES	NO	Confusion or Disorientation	YES	NO
Excessive Sweating	YES	NO	Lump in Groin, Armpit or Neck	YES	NO
Dry Cough	YES	NO	Pain in Groin, Armpit or Neck	YES	NO
Trouble Swallowing	YES	NO	Persistent Cough	YES	NO
Sore Throat	YES	NO	Change in Mental Status	YES	NO
Itchy Skin	YES	NO	Sore Mouth	YES	NO
Black Scabs on Skin	YES	NO	Bumps in Mouth	YES	NO
Pain or Tightness in Chest	YES	NO	Rash on Face, Arms or Legs	YES	NO
Difficulty Breathing	YES	NO	Lower Back Pain	YES	NO
Sore Muscles	YES	NO	Trouble Walking	YES	NO
Pain in Neck	YES	NO	Excessive Weakness	YES	NO
Bloody Diarrhea	YES	NO	Pain in Eyes	YES	NO
Droopy Eyelids	YES	NO	Colored Eyes (red or yellow)	YES	NO
Double Vision	YES	NO	Loss of Vision	YES	NO
Blurred Vision	YES	NO	Light Hurts Eyes	YES	NO
Dry Mouth	YES	NO	Red Spots on Skin	YES	NO
Constipation	YES	NO	Swelling of Legs, Hands or Fingers	YES	NO
Diarrhea	YES	NO	Reduced or Excessive Urination	YES	NO
Loss of Appetite	YES	NO	Bleeding from: Nose, Mouth, Rectum or Bladder	YES	NO
Feeling Cold All Over	YES	NO	Seizures	YES	NO

Are any of these symptoms normal for you? Please List:

PHYSICAL ASSESSMENT:

Temperature:_____ Blood Pressure:_____ Respirations:_____

Pulse Rate:_____ O2 Sat:_____ Skin Condition:_____

Patient Triage Category: _____Red_____Yellow_____Green_____Black

Patient Sent To:_____ **Patient Sent By**:_____

APPENDIX H – HOME CARE INSTRUCTIONS

ANTHRAX – HOME CARE INSTRUCTIONS

In the event of an intentional release of the germ that causes anthrax, many people may require hospitalization within a few days. Hospitals may become overcrowded and it may become necessary for many sick people to be cared for in their home by relatives or friends. The following information may be helpful in providing care to sick persons at home.

- Wash your hands with soap and water before you eat or drink, after using the bathroom and after contact with the sick person. If soap and water are not readily available, use an alcohol-based hand sanitizer.
- Wear disposable gloves (vinyl or latex) when you have contact with the sick person's blood and other body fluids (urine, feces, vomit, wound drainage, mucous or saliva). Wash your hands after removing the gloves. If gloves are not available, wash your hands with soap and water after contact with the sick person's blood and other body fluids.
- Wash the sick person's hands after using the bathroom, before eating or drinking and after contact with pets. If soap and water are not immediately available, use an alcohol-based hand sanitizer.
- If an antibiotic is recommended, give it exactly as prescribed by the doctor or nurse. If an allergic reaction develops, seek medical advice immediately.
- Take the person's temperature at least twice a day. If the temperature goes above 100° F give Tylenol® (if not allergic) or other medicine such as Motrin® or Advil®. Follow the instructions on the package insert. If the temperature is not controlled by the medicine, call your health care provider (doctor or nurse) or take the person to the nearest designated emergency center or hospital.
- If the person is having trouble breathing, go immediately to the nearest designated emergency center or hospital.
- Give the person plenty of fluids such as water or juice. Allow the person to eat solid food as tolerated.
- Change the sick person's clothes and bed linens frequently especially if soiled with blood or other body fluids.
- Wash soiled clothes and bed linens in warm water using any commercial laundry product; use a clothes dryer set onto a warm or hot cycle, or, let clothes dry in the sun.
- Disinfect the bathroom and kitchen with a disinfectant such as Lysol® every day or when surfaces become soiled with blood or other body fluids.
- As a caregiver, you must take care of yourself. Get plenty of rest, drink fluids frequently, and eat a healthy diet. Even if you are not taking an antibiotic, take your temperature in the morning and afternoon for 3 weeks. If you develop a fever above 100° F or if have shortness or breath, seek medical attention immediately.

BOTULISM—HOME CARE INSTRUCIONS

In the event of an intentional release of the toxin that causes botulism, many people require hospitalization. If you or any member of our family has any of the following symptoms, seek medical attention immediately or go to the nearest hospital emergency room:

- Blurred vision
- Double vision
- Trouble swallowing food or liquids
- Dry mouth
- Trouble speaking
- Trouble breathing

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TULAREMIA- HOME CARE INSTRUCTIONS

In the event of an intentional release of the bacteria that cause tularemia, many people may require hospitalization with in a few days. Hospitals may become overcrowded and it may become necessary for many sick people to be cared for in their home by relatives or friends. The following information may be helpful in providing care to sick persons at home.

- Wash your hands with soap and water before you eat or drink, after using the bathroom, and after contact with the sick person. If soap and water are not readily available, use an alcohol-based hand sanitizer.
- Wear disposable gloves (vinyl or latex) when you have contact with the sick person's blood and other body fluids (urine, feces, vomit, wound drainage, mucous or saliva). Wash your hands after removing the gloves. If gloves are not available, wash your hands thoroughly with soap and water after contact with the sick person's blood and body fluids.
- Wash the sick person's hands after using the bathroom, before eating or drinking, and after contact with pets. If soap and water are not readily available, use an alcohol-based hand sanitizer.
- If an antibiotic is recommended, give it exactly as prescribed by the doctor or nurse. If an allergic reaction develops, seek medical advice immediately.
- Take the person's temperature at least twice a day. If the temperature goes above 100.4 F give anti fever medications such as Tylenol, Motrin or Advil. Follow the instructions on the package insert. If the temperature is not controlled by the medicine, call your health care provider (doctor or nurse) or take the person to the nearest designated emergency center or hospital.
- Give the person plenty of fluids such as water or juice. Allow the person to eat solid food as tolerated.
- If the person is having trouble breathing, go immediately to the nearest designated emergency center or hospital.
- Change the sick person's clothes and bed linens frequently especially if soiled with blood or other bodily fluids.
- Wash soiled clothes and bed linens in warm water using any commercial laundry product; use a clothes dryer set onto a warm or hot cycle, or, let clothes dry in the sun.
- Disinfect the bathroom and kitchen with a disinfectant such as Lysol every day or when surfaces become soiled with blood or other bodily fluids.
- As a caregiver, you must take care of yourself. Get plenty of rest, drink fluids frequently and eat a healthy die. Even if you are not taking an antibiotic, take your temperature in the morning and afternoon for 3 weeks. If you develop a fever above 100.4 F or if you have flu-like symptoms, seek medial attention immediately.

PLAGUE—HOME CARE INSTRUCTIONS

In the event of an intentional release of the bacterial that causes plague, many people may require hospitalization within a few days. Hospitals may soon become overcrowded and it may become necessary for many sick people to be cared for in their home by relatives or friends. The following information may be helpful in providing care to sick persons at home.

- Listen closely to the local radio or television for special instructions.
- Advise friends and relatives not to visit until the sick person is feeling better.
- Wash your hands with soap and water before you eat or drink, after using the bathroom and after contact with the sick person. If soap and water are not readily available, use an alcohol-based hand sanitizer.
- Wash the sick person's hands after using the bathroom, before eating or drinking and after contact with pets. If soap and water are not readily available, use an alcohol-based hand sanitizer.
- Wear disposable gloves (latex or vinyl) when you have contact with the sick person's blood and other body fluids (urine, feces, vomit, wound drainage, mucosa or saliva). Wash your hands after removing the gloves. If gloves are not available, wash your hands thoroughly with soap and water after contact with the sick person's blood or body fluids.
- If the person is having trouble breathing, go immediately to the nearest designated emergency center or hospital.
- If an antibiotic is recommended, give it exactly as prescribed by the health care provider (doctor or nurse). If an allergic reaction develops, seek medical advice immediately.
- Take the person's temperature at least twice a day. If the temperature goes above 100.4 F, give an anti fever medication such as Tylenol (if not allergic), Motrin or Advil. Follow the instructions on the package insert. If the temperature is not controlled by the medicine, call your health care provider (doctor or nurse) or take the person to the nearest designated emergency center or hospital.
- Give the person plenty of fluids such as water or juice. Allow the person to eat solid food as tolerated.
- Change the sick person's clothes and bed linens frequently especially if soiled with blood or other body fluids.
- Wash soiled clothes and bed linens in warm water using any commercial laundry product, use a clothes dryer set onto a warm or hot cycle, or, let clothes dry in the sun..
- Disinfect the bathroom and kitchen with a disinfectant such as Lysol every day or when surfaces become soiled with blood or other body fluids.
- As a caregiver, you must take care of yourself. Get plenty of rest, drink fluids frequently and eat a healthy diet. If you are taking an antibiotic, take your temperature in the morning and afternoon for 3 weeks. If you develop a fever above 100.4 F or if you have flu-like symptoms see a doctor or nurse immediately.

SMALLPOX- HOME CARE INSTRUCTIONS

In the event of an intentional release of the germ that causes smallpox, many people may require hospitalization within a few days. Hospitals may become overcrowded and it may become necessary for many sick people to be cared for in their home by relatives or friends. The following information may be helpful in providing care to sick persons at home.

- Listen closely to the local radio or television for special instructions.
- Advise friends and relatives NOT to visit.
- Wear a mask over your nose and mouth when you are within 6 feet of the infected person.
- Wash your hands with soap and water before you eat or drink, after using the bathroom and after contact with the sick person. If soap and water are not readily available, use an alcohol-based hand sanitizer. Wash the sick person's hands after using the bathroom, before eating or drinking, and after contact with pets. If soap and water are not readily available, use an alcohol-based hand sanitizer.
- Wear disposable gloves (vinyl or latex) when you have contact with the sick person's skin, blood, and other body fluids (urine, feces, vomit, drainage, mucous or saliva). Wash your hands after removing the gloves. If gloves are not available, wash your hands thoroughly with soap and water after contact with the sick person's blood, urine, feces, vomit, wound drainage, mucous or saliva.
- If the person is having trouble breathing, go immediately to the nearest designated emergency center or hospital.
- Take the persons temperature at least twice a day. If the temperature goes above 100 degrees F, give Tylenol (if not allergic) or other medicine such as Motrin or Advil. Follow the instructions on the package insert. If the temperature is not controlled by the medicine, call your health care provider (doctor or nurse) or take the person to the nearest designated emergency center or hospital.
- Give the person plenty of fluids such as water or juice. Allow the person to eat solid food as tolerated.
- Change the sick person's clothes and bed linens frequently especially if soiled with blood or other body fluids.
- Wash soiled clothes and bed linens in warm water using any commercial laundry product; use a clothes dryer set onto a warm or hot cycle, or, let clothes dry in the sun..
- Disinfect the bathroom and kitchen with a disinfectant such as Lysol every day or when surfaces become soiled with blood or other body fluids.
- As a caregiver, you must take care of yourself. Get plenty of rest, drink fluids frequently, and eat a healthy diet. Take your temperature in the morning and afternoon for 3 weeks. If you develop a fever above 100 degrees F or if you have flu-like symptoms see a doctor or nurse immediately.

VIRAL HEMORRHAGIC FEVERS (VHF) – HOME CARE INSTRUCTIONS

In the event of an intentional release of the germ that causes a viral hemorrhagic fever, many people may require hospitalization within a few days. Hospitals may soon become overwhelmed and unable to care for every person who seeks treatment. It may become necessary for many sick people to be cared for in their home by relatives or friends. The following information may be helpful in providing care to sick persons at home.

- Listen closely to the local radio or television for special instructions from the local health department.
- Advise friends and relatives not to visit.
- Wear a mask when you are in close contact with an infected person who is coughing or bleeding from any site.
- Wear disposable gloves (vinyl or latex) when you have contact with the infected person's blood and other body fluids (urine, feces, vomit, drainage, mucous or saliva). Place the gloves in a waste receptacle after each use. Do not wash or reuse gloves. If disposable gloves are not available, wash your hands thoroughly with soap and water after contact with the infected person's blood or body fluids. If soap and water are not readily available, use an alcohol-based hand sanitizer.
- Wear a plastic apron or gown to protect clothes from becoming soiled with blood or other body
- Wash your hands with soap and water before you eat or drink, after using the bathroom and after contact with the sick person. If soap and water are not readily available, use an alcohol-based hand sanitizer.
- Wash the sick person's hands after using the bathroom, before eating or drinking and after contact with pets. If soap and water are not readily available, use an alcohol-based hand sanitizer.
- If the person is having trouble breathing, go immediately to the nearest designated emergency center or hospital.
- Take the person's temperature at least twice a day. If the temperature goes above 100°F, give Tylenol ® (if not allergic). Do not give the person aspirin or ibuprofen (Motrin). Follow the instructions on the package insert. If the temperature is not controlled by the medicine, call your health care provider (doctor or nurse) or take the person to the nearest designated emergency center or hospital.
- Give the person plenty of fluids such as water or juice. Allow the person to eat solid food as tolerated.
- Change the sick person's clothes and bed linens frequently especially if soiled with blood or other body fluids. Wear gloves and gowns if the linen is soiled with blood and body fluids.
- Wash soiled clothes and bed linens in hot water using any commercial laundry product; use a clothes dryer set onto a warm or hot cycle, or, let clothes dry in the sun.
- Disinfect the bathroom and kitchen with a disinfectant such as Lysol ® every day and when any surface becomes soiled with blood or other body fluids
- As a caregiver, you must take care of yourself. Get plenty of rest, drink fluids frequently and eat a healthy diet. Take your temperature in the morning and afternoon for 3 weeks.

If you develop a fever above 100°F or if you begin to bleed from the mouth, bladder or bowel see a doctor or nurse immediately.

DRAFT

APPENDIX I – FREQUENTLY ASKED QUESTIONS (FAQ)

ANTHRAX – FREQUENTLY ASKED QUESTIONS (FAQ)

What is anthrax?
Anthrax is caused by bacteria that may intentionally be released into the air (bioterrorism) and breathed (inhaled) into people's lungs causing severe respiratory distress. The bacteria can also get into non-intact skin or open sores. Rarely, the bacteria enter the body though contaminated, uncooked food and cause stomachache, vomiting and diarrhea.

Is anthrax spread from person to person?
The infection is NOT spread from person to person.

How will I know if I was exposed to anthrax?
It will depend on how the anthrax is released, where it was released, and where you were in relation to the release site. The further away you were from the release site the less likely it will be that you were exposed.

How soon will symptoms develop (incubation period)?
Symptoms may start from 1-6 days after exposure to the anthrax bacteria. Because the bacteria can survive for a long time in the environment, symptoms may not start for up to 60 or more days after the bacteria were released into the air.

What are the symptoms of infection?
If the anthrax bacteria invades your lungs, you will have a fever, possibly a non-productive cough, and severe shortness of breath. If the skin is contaminated, an itchy, black spot with swelling may appear. If the bacteria are eaten, you may develop a stomachache, vomiting, and diarrhea that may be bloody.

How is the infection treated?
If you have the infection, your health care provider (doctor or nurse) will give you an antibiotic.

How is the infection prevented?
If the local health department determines that you were exposed to the germ, you will be offered an antibiotic. Even if you take the antibiotic, you may develop the infection. If you develop symptoms such as fever or shortness of breath while you are taking the antibiotic, you should seek medical attention immediately or go to the nearest hospital emergency room.

How long should I take the antibiotic?
You may have to take the antibiotic for a long time. The local health department will make frequent announcements to give you the most current information.

What should I do if I DO NOT have symptoms?
If you do not have symptoms of the infection, you should continue with your routine daily activities. Please DO NOT go to the hospital emergency room unless you have a fever or you develop shortness of breath.

How can I get more information?

- The local health department will make frequent public announcements about who should receive the antibiotic, how to take the antibiotic, and where you can obtain the antibiotic. The local health department may also designate an emergency center or hospital for you to go to if you develop symptoms.
- It is important that you listen to the radio or television for more information.

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BOTULISM—FREQUENTLY ASKED QUESTIONS

What is botulism?
The bacteria that cause botulism release a powerful toxin that causes the muscles to become paralyzed. The bacteria are normally found in the soil and in ocean or lake-water sediment or silt. Most people get botulism from eating (ingesting) improperly cooked or preserved food. Airborne botulism does not occur naturally. However, if the toxin is intentionally released into the air it could be absorbed into the skin and lungs and cause the same symptoms as ingested botulism.

Is botulism spread from person to person?
Neither the bacteria nor the poisonous toxin released by the bacteria are spread from person to person.

How will I know if I was exposed to the toxin that causes botulism?
It will depend on how the toxin was released, where it was released, and where you were in relation to the release site. The toxin could be released into the air or in food or water.

How soon will symptoms of botulism develop (incubation period)?
Normally the symptoms start within 12-36 hours but the incubation period may be as short as 6 hours or as long as 10 days depending on how the toxin was released.

What are the symptoms of botulism?
The early symptoms include blurred vision, double vision, and dry mouth. As the toxin spreads in the body, the symptoms become more intense and include sore throat, trouble speaking and swallowing, droopy eyelids, muscle weakness, and trouble breathing.

How is botulism treated?
It may become necessary to put a tube in your throat that is attached to a breathing machine (ventilator) to help you breath. You may be paralyzed and require hospitalization for a long time. As time passes, most persons with botulism recover full use of their muscles.

How is botulism prevented?
The local health department will provide you with information about food and water contamination. If the toxin is released into the air, the local health department may tell you to stay inside and close all the windows and doors for a short time.

What should I do if I have symptoms of botulism?
If you have any symptoms such as difficulty eating or drinking, blurred or double vision, dry mouth or difficulty breathing you should seek medical treatment immediately or go to the nearest emergency room. If you do not have any symptoms, you should continue with your routine daily activities. Please do not go to the hospital emergency room unless you are feeling sick.

How can I get more information?

- The local health department will make frequent public announcements. The local health department may also designate an emergency center or hospital for you to go to if you develop symptoms.
- It is important that you listen to the radio or television for more information.

DRAFT

TULAREMIA- FREQUENTLY ASKED QUESTIONS

What is tularemia?
The bacteria that cause tularemia are normally transmitted (spread) to humans by contact with dead, infected animals (rabbits, squirrels and birds), by flea and tick bites and by inhaling (breathing) dust or soil that has been contaminated by infected animals. The infection can also be transmitted by drinking contaminated water or by eating undercooked meat. If the bacteria were intentionally released into the air it could be inhaled (breathing) into your lungs and cause an infection such as pneumonia.

Is tularemia spread from person to person?
The infection is NOT spread from person to person.

How will I know if I was exposed to the bacteria?
It will depend on how the bacteria were released, where the bacterial were released, and where you were in relation to the release site. The further away you were from the release site the less likely it will be that you were exposed.

How soon will symptoms develop (incubation period)?
Normally the symptoms start 3-5 days after exposure to the bacteria, but the incubation period may be as short as 1 day or as long as 21 days depending on how close you were to the site where the bacterial were released into the air. Not all persons exposed to the bacteria will develop symptoms.

What are the symptoms of infection?
The symptoms of pneumonia are generally flu-like and may include a sudden onset of fever, chills, headache, tiredness, sore muscles, loss of appetite, cough, and chest pain. You may also develop vomiting, stomach pain, and watery diarrhea. Although rare, you may develop a sore throat with painful, swollen glands or an ulcer on your face, neck or arms with painful, swollen glands.

How is the infection treated?
If you have symptoms of the infection, your health care provider (doctor or nurse) will give you an antibiotic.

How is the infection prevented?
If you have symptoms of the infection, your health care provider (doctor or nurse) will give you an antibiotic. If any of the following symptoms develop while you are taking the antibiotic, you should see your health care provider (doctor or nurse) immediately.

How long should I take the antibiotic?
It is important that you take the antibiotic exactly as directed. The dose and number of treatment days will differ depending on the antibiotic prescribed. If you develop side effects (reaction) to the antibiotic, call your health care provider (doctor or nurse) immediately. Do not give your antibiotic to another person.

What should I do if I do not have symptoms?
If you do not have any symptoms of the infection, you should continue with your routine daily activities. Please do not go to the hospital emergency room unless you have a fever or other symptoms of the infection.

How can I get more information?

- The local health department will make frequent public announcements about who should receive an antibiotic, how to take the antibiotic, and where you can obtain the antibiotic. The local health department may also designate an emergency center or hospital for you to go to if you develop symptoms.
- It is important that you listen to the radio or television for more information.

DRAFT

PLAGUE-FREQUENTLY ASKED QUESTIONS

What is plague?
The bacteria that cause plague are normally transmitted (spread) to humans by infected fleas. If the bacteria were intentionally released into the air they could be inhaled (breathed) into your lungs and cause a severe infection such as pneumonia.

Is plague spread from person to person?
The infection is spread from person to person by close contact (within 3 feet) with the infected person who coughs the bacteria from the lungs into the air.

How will I know if I was exposed to the bacteria?
That will depend on how the bacterial were released into the air, where the bacteria were released, and where you were relative to the release site. The further away you were from the release site, the less likely it will be that you were exposed. If you have close contact with an infected person (within 3 feet), the local health department may determine that you have been exposed.

How soon will symptoms develop (incubation period)?
The symptoms may start within 1-6 days after you breathe the bacteria into your lungs.

What are the symptoms of infection?
The symptoms include sudden onset of high fever, chills, headache, extreme fatigue, muscle aches and a cough that may be bloody.

How is the infection treated?
If you have the infection, your health care provider (doctor or nurse) will give you an antibiotic.

How is the infection prevented?
If the local health department determines that you were exposed to the bacteria, you will be offered an antibiotic. Even if you take the antibiotic, you may develop the infection. If you develop symptoms of the infection such as fever or bloody cough while you are taking the antibiotic, you should go to the nearest emergency service center or hospital immediately.

How long should I take the antibiotic?
It is extremely important that you take the antibiotic exactly as directed. The dose and the number of treatment days will differ depending on the antibiotic prescribed. If you develop side effects (reaction) to the antibiotic, call your health care provider (doctor or nurse) immediately. Do not give your antibiotic to another person.

What should I do if I develop symptoms of infection while I am taking the antibiotic?
Take you temperature daily. If you have a fever of greater that 100.4 F or if you develop flu-like symptoms (cough, fatigue, muscle aches) or a headache, go immediately to the nearest emergency medical service or hospital.

What should I do if I do not have symptoms?

If you do not have symptoms of the infection, you should continue with your routine daily activities. Please do not go to the hospital emergency room unless you are feeling sick. The local health officer may suggest that you wear a mask over your nose and mouth if you have to go to public places.

How can I get more information?

- The local health department will make frequent public announcements about who should receive an antibiotic, how to take the antibiotic, and where you can obtain the antibiotic. . The local health department may also designate an emergency center or hospital for you to go to if you develop symptoms.
- It is important that you listen to the radio or television for more information.

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TWO HOURS AFTER EVENT

(Transportation of patients from overcrowded hospitals to hospitals with open beds)

NUMBER OF CASUALTIES	TYPES OF PATIENTS TRANSPORTED	TRANSPORTATION METHODS
70	Critical and Stable	All patients transported by ambulance. Normal calls managed by additional help from surrounding counties.
234	Critical and Stable	Critical patients transported by ambulance, stable patients transported by bus (para-transit buses preferably) with staffing coming from surrounding counties. Normal calls managed by use of resources from outlying counties
703	Critical and Stable	Critical patients transported by ambulance as resources and manpower allow from effected county and surrounding counties. Stable patients transported by bus with outlying counties providing staffing. Respond to normal calls deemed "emergent" only.

DRAFT

10.0 - EASTERN REGION PARTICIPATING HOSPITALS AND/OR CLINICS

There are currently 11 hospitals and/or community health centers that are participating in the Eastern Region Medical Surge Capacity Plan. (Please see Appendix P for specific contact information for each facility)

Allen Memorial Hospital, Moab, Utah

Ashley Valley Hospital, Vernal, Utah

Castleview Hospital, Price, Utah

Green River Medical Center, Green River, Utah

San Juan Hospital, Monticello, Utah

Uintah Basin Medical Center, Roosevelt, Utah

Blanding Family Practice, Blanding, Utah

Carbon Medical Services Association, East Carbon, Utah

Montezuma Creek Community Health Center, Montezuma Creek, Utah

Monument Valley Community Health Center, Monument Valley, Utah

Navajo Mountain Community Health Center, Navajo Mountain, Utah

DRAFT

10.1 - EMERGENCY COMMUNICATION SYSTEMS

The primary form of communication will be the use of phones, both land line and cellular. These communication systems should be used until they are no longer operational.

Radios should be used as the next form of communication. All hospitals in the state are equipped with at least one radio, and random radio checks are being led by the UDOH. The UDOH will be in charge of facilitating communications between facilities. All hospitals should submit requests for supplies and personnel thru the UDOH ECC.

The geography of the Eastern Region consists of mountainous terrain with valleys and high desert conditions. With the mountains, direct line of sight communications is often difficult, creating a finite amount of communication resources.

In the event of an emergency, there will be an increased demand for communication resources. All hospitals and clinics within the Eastern Region are encouraged to work locally and regionally to facilitate needed arrangements for redundant communications using all available communications: phones, HAM radio relay and UNIS.

HAM radios may also be used as a secondary form of communication to facilitate needed radio communication; all hospitals should work with their local Amateur Radio Emergency Services (A.R.E.S.) HAM operators to determine how they can best be utilized in the event of an emergency. Most hospitals and clinics in the Eastern Region are prepared to provide space and/or equipment in their Command Centers, or in adjacent areas for Ham operator equipment and personnel.

The Utah Notification Information System (UNIS) will allow local and state departments of health to uniformly and simultaneously distribute messages to all hospitals in the affected region or throughout the entire state.

It is important to note that hospitals should plan and practice a combined use of these communication tools. This will enable the UDOH ECC and State EOC to more effectively manage the changing situation. All personnel who will be involved in radio communication should receive basic training in radio communications and discipline (Please see Appendix L for table of communications availability).

ORDER IN WHICH BACKUP SYSTEMS SHOULD BE USED

1. Phones (land line and cell)
2. Radios (on a limited local basis)
3. HAM Radio Relay
4. UNIS

10.2 - EMERGENCY COMMUNICATION SYSTEMS OPERATIONAL WITHIIN THE EASTERN REGION

HOSPITAL NAME	HEAR/VHF/UHF	CELL PHONES	SATELLITE PHONES	AMATEUR RADIO
Allen Memorial Hospital	X	X		X
Ashley Valley Medical Center	X	X		
Castleview Hospital	X	X		X
Green River Medical Center	X	X		
San Juan Hospital	X	X		X
Uintah Basin Medical Center	X	X		X
Blanding Family Practice	X	X		
Carbon Medical Services Association	X	X		
Montezuma Creek Community Health Center	X	X		

DRAFT

10.3 - MASS CASUALTY ALLOCATION GUIDE

NUMBER OF CASUALTIES	ESTIMATE NUMBER OF URGENT PATIENTS (requiring surgical intervention)	PATIENTS TRANSPORTED TO:	ESTIMATE NUMBER OF NON-URGENT PATIENTS	PATIENTS TRANSPORTED TO:	PROPOSED LEVEL OF CARE
9	2	Closest most appropriate hospital	7	Closest most appropriate hospital	No change in standard level of care. (Cancellation of elective surgeries may not be necessary.)
27	5	Closest most appropriate hospital	22	Hospital Emergency Departments	Cancellation of elective procedures, discharge of stable patients.
45	9	Any Hospital	36	Hospital Emergency Departments, Urgent Care Centers and Clinics	Cancellation of elective procedures, discharge of all stable patients. Use of patient transfer to utilize all available beds in the region.

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FIRST TWO HOURS

NUMBER OF CASUALTIES	TYPES OF PATIENTS TRANSPORTED	TRANSPORTATION METHODS
9	Red and Yellow	As per EMS protocol Red and Yellow patients transported by ambulance, Green patients transported by bus. Normal calls managed by use of resources from surrounding counties.
27	Red	As per EMS protocol, Red patients transported by local EMS, additional resources requested from surrounding counties to transport Yellow patients. Green patients transported by bus. Normal calls managed by use of resources from outlying counties
45	Red or Yellow	Transport as many as possible salvageable Red and Yellow patients by ambulance with use of multiple county resources. Green patients transported by bus. Respond to normal calls deemed "emergent" only.

<u>TWO HOURS AFTER EVENT</u> (Transportation of patients from overcrowded hospitals to hospitals with open beds)

NUMBER OF CASUALTIES	TYPES OF PATIENTS TRANSPORTED	TRANSPORTATION METHODS
9	Critical and Stable	All patients transported by ambulance. Normal calls managed by additional help from surrounding counties.
27	Critical and Stable	Critical patients transported by ambulance, stable patients transported by bus (para-transit buses preferably) with staffing coming from surrounding counties. Normal calls managed by use of resources from outlying counties
45	Critical and Stable	Critical patients transported by ambulance as resources and manpower allow from effected county and surrounding counties. Stable patients transported by bus with outlying counties providing staffing. Respond to normal calls deemed "emergent" only.

DRAFT

11.0 - WESTERN REGION PARTICIPATING HOSPITALS AND/OR CLINICS

There are currently 14 hospitals and/or community health centers that are participating in the Western Region Medical Surge Capacity Plan. (Please see Appendix P for specific contact information for each facility)

Beaver Valley Hospital, Beaver, Utah

Central Valley Medical Center, Nephi, Utah

Delta Community Medical Center, Delta, Utah

Dixie Regional Medical Center, St. George, Utah

Fillmore Community Medical Center, Fillmore, Utah

Garfield Memorial Hospital, Panguitch, Utah

Gunnison Valley Hospital, Gunnison, Utah

Kane County Hospital, Kanab, Utah

Milford Valley Memorial Hospital, Milford, Utah

Sanpete Valley Hospital, Mt. Pleasant, Utah

Sevier Valley Hospital, Richfield, Utah

Valley View Medical Center, Cedar City, Utah

Enterprise Valley Medical Clinic, Enterprise, Utah

Wayne Community Health Center, Bicknell, Utah

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11.1 - EMERGENCY COMMUNICATION SYSTEMS

The primary form of communication will be the use of phones, both land line and cellular. These communication systems should be used until they are no longer operational.

Radios should be used as the next form of communication. All hospitals in the state are equipped with at least one radio, and random radio checks are being led by the UDOH. The UDOH will be in charge of facilitating communications between facilities. All hospitals should submit requests for supplies and personnel thru the UDOH ECC.

The geography of the Western Region consists of mountainous terrain with valleys and high desert conditions. With the mountains, direct line of sight communications is often difficult, creating a finite amount of communication resources.

In the event of an emergency, there will be an increased demand for communication resources. All hospitals and clinics within the Western Region are encouraged to work locally and regionally to facilitate needed arrangements for redundant communications using all available communications: phones, HAM radio relay and UNIS.

HAM radios may also be used as a secondary form of communication to facilitate needed radio communication; all hospitals should work with their local Amateur Radio Emergency Services (A.R.E.S.) HAM operators to determine how they can best be utilized in the event of an emergency. Most hospitals and clinics in the Western Region are prepared to provide space and/or equipment in their Command Centers, or in adjacent areas for Ham operator equipment and personnel.

The Utah Notification Information System (UNIS) will allow local and state departments of health to uniformly and simultaneously distribute messages to all hospitals in the affected region or throughout the entire state.

It is important to note that hospitals should plan and practice a combined use of these communication tools. This will enable the UDOH ECC and State EOC to more effectively manage the changing situation. All personnel who will be involved in radio communication should receive basic training in radio communications and discipline (Please see Appendix L for table of communications availability).

ORDER IN WHICH BACKUP SYSTEMS SHOULD BE USED

1. Phones (land line and cell)
2. Radios (on a limited local basis)
3. HAM Radio Relay
4. UNIS

11.2 - EMERGENCY COMMUNICATION SYSTEMS OPERATIONAL WITHIIN THE WESTERN REGION

HOSPITAL NAME	HEAR/VHF/UHF	CELL PHONES	SATELLITE PHONES	AMATEUR RADIO
Beaver Valley Hospital	X	X		
Central Valley Medical Center	X	X		X
Delta Community Medical Center	X	X		
Dixie Regional Medical Center	X	X		X
Fillmore Community Medical Center	X	X		
Garfield Memorial Hospital	X	X		X
Gunnison Valley Hospital	X	X		
Kane County Hospital	X	X		X
Milford Valley Memorial Hospital	X	X		
Sanpete Valley Hospital	X	X		
Sevier Valley Hospital	X	X		
Valley View Medical Center	X	X		X
Enterprise Valley Medical Center		X		
Southwest Utah Community Health Center	X	X		
Wayne County Community Health Center		X		

11.3 - MASS CASUALTY ALLOCATION GUIDE

NUMBER OF CASUALTIES	ESTIMATE NUMBER OF URGENT PATIENTS (requiring surgical intervention)	PATIENTS TRANSPORTED TO:	ESTIMATE NUMBER OF NON-URGENT PATIENTS	PATIENTS TRANSPORTED TO:	PROPOSED LEVEL OF CARE
22	5	Closest most appropriate hospital	17	Closest most appropriate hospital	No change in standard level of care. (Cancellation of elective surgeries may not be necessary.)
44	9	Closest most appropriate hospital	35	Hospital Emergency Departments	Cancellation of elective procedures, discharge of stable patients.
110	22	Any Hospital	88	Hospital Emergency Departments, Urgent Care Centers and Clinics	Cancellation of elective procedures, discharge of all stable patients. Use of patient transfer to utilize all available beds in the region.

FIRST TWO HOURS

NUMBER OF CASUALTIES	TYPES OF PATIENTS TRANSPORTED	TRANSPORTATION METHODS
22	Red and Yellow	As per EMS protocol Red and Yellow patients transported by ambulance, Green patients transported by bus. Normal calls managed by use of resources from surrounding counties.
44	Red	As per EMS protocol, Red patients transported by local EMS, additional resources requested from surrounding counties to transport Yellow patients. Green patients transported by bus. Normal calls managed by use of resources from outlying counties
110	Red or Yellow	Transport as many as possible salvageable Red and Yellow patients by ambulance with use of multiple county resources. Green patients transported by bus. Respond to normal calls deemed "emergent" only.

TWO HOURS AFTER EVENT

(Transportation of patients from overcrowded hospitals to hospitals with open beds)

NUMBER OF CASUALTIES	TYPES OF PATIENTS TRANSPORTED	TRANSPORTATION METHODS
22	Critical and Stable	All patients transported by ambulance. Normal calls managed by additional help from surrounding counties.
44	Critical and Stable	Critical patients transported by ambulance, stable patients transported by bus (para-transit buses preferably) with staffing coming from surrounding counties. Normal calls managed by use of resources from outlying counties
110	Critical and Stable	Critical patients transported by ambulance as resources and manpower allow from effected county and surrounding counties. Stable patients transported by bus with outlying counties providing staffing. Respond to normal calls deemed "emergent" only.

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APPENDIX A: RECORD OF CHANGES

The Utah Department of Health (UDOH) Hospital Bioterrorism Preparedness Program will ensure that the necessary changes and revisions to the plan are prepared, coordinated, published and distributed.

The plan will undergo revision whenever:

- Any other condition occurs that causes conditions to change.
- It fails during an emergency.
- Exercises, drills reveal deficiencies or "shortfall(s)."
- Local Government structure changes.
- Community situations change.
- State requirements change.

The UDOH Hospital Bioterrorism Preparedness Program will maintain a list of individuals and organizations which have controlled copies of the plan. Only those with controlled copies will automatically be provided updates and revisions. Plan holders are expected to post and record these changes. Revised copies will be dated and marked to show where changes have been made.

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RECORD OF CHANGES

Date of Change	Page(s) Affected	Nature of Change	Changes Made by (Signature)

APPENDIX B: DISTRIBUTION LIST

These are not controlled distribution copies of the Medical Surge Capacity Plan. The individuals listed below will not be provided with any updates or revisions unless done so by the person or facility distributing the document.

Date	Distributed By:	Distributed To:	Signature of Acknowledgement

APPENDIX C: GLOSSARY OF TERMS

A

ART -- Assessment and Response Team
The Secretary of Health and Department of Health's Senior Management Team. The team assesses the severity of emergencies and manages the Department of Health's overall response plan.

ARES -- Amateur Radio Emergency Services

B

Bioterrorism -- The intentional use of microorganisms, or toxins, derived from living organisms, to produce death or disease in humans, animals, or plants.

BT -- Bioterrorism

Board of Health -- The membership includes people who are experienced in matters of health and sanitation, elected officials, local health officers, and citizen consumers of health care. The board provides a forum for the development of public health policy and has rulemaking authority to protect public health, improve health status, and promote and assess the quality, cost, and accessibility of health care throughout the state.

BRAC -- Bioterrorism Response Advisory Committee
Committee consisting of Department of Health partners and stakeholders that advise the Department of Health on the creation of its plan for bioterrorism preparedness and response.

C

Category "A" Agents -- The possible biological terrorism agents having the greatest potential for adverse public health impact with mass casualties. The Category "A" agents are:

1. **Smallpox**
2. **Anthrax**
3. **Plague**
4. **Botulism**
5. **Tularemia**
6. **Viral hemorrhagic fevers (e.g. Ebola and Lassa viruses)**

CD -- Communicable Disease

CDC -- Centers for Disease Control and Prevention
A branch of the federal Department of Health and Human Services.

CEMP -- Comprehensive Emergency Management Plan

The overarching jurisdictional emergency plan at the state level and at most local jurisdictions.

Cooperative agreements -- Federal grants for bioterrorism preparedness and response from the Centers for Disease Control and Prevention and the Health Resources and Services Administration.

Critical agents -- The biological and chemical agents likely to be used in weapons of mass destruction and other bioterrorist attacks. Current lists may be found on the Centers for Disease Control and Prevention Web site:

D

DEQ – Department of Environmental Quality

Disaster -- A large emergency event that is beyond the community's ability to address within its own and mutual aid resources.

DOJ -- Department of Justice

DSHS -- Department of Social and Health Services

E

EAS -- Emergency Alert System

ECC -- Emergency Coordination Center

EDI -- Electronic Data Interchange

EDTH -- Department of Health Electronic Data Transfer Hub

Emergency management -- A systematic program of activities that governments and their partners undertake before, during and after a disaster to save lives, prevent injury, and to protect property and the natural environment. Emergency management activities include:
Mitigation: eliminating hazards or reducing their potential impact
Preparedness: planning, training, and exercising for disastrous events
Response: taking action when a disaster occurs to save lives, prevent injuries, and prevent or limit property damage
Recovery: restoring normalcy after the disaster
These activities are not the sole responsibility of the designated emergency management agency. Virtually all agencies have a role, but most particularly law enforcement, fire services, public works, and public health.

EMA -- Emergency Management Agency (local)

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Emergency -- A set of circumstances which demand immediate action to protect life, preserve public safety, health and essential services, or protect property and the environment.

EMS -- Emergency Medical Services

EMTALA -- Emergency Medical Treatment and Active Labor Act

EOC -- Emergency Operations Center
The facility from which a jurisdiction or agency coordinates its response to major emergencies/disasters - there may be a state EOC, county EOC, city EOC and/or agency EOC.

ERC -- Emergency Response Coordinator
Person authorized to direct implementation of an agency's emergency response plan.

ESF -- Emergency Support Function
A portion of a comprehensive emergency management plan (federal, state, or local) that describes activities related to a single function.

Epidemiologist -- A professional skilled in disease investigation. Epidemiologists design and conduct epidemiological studies, analyze data to detect patterns and trends in disease, establish and maintain surveillance systems, monitor health status and evaluate the performance and cost effectiveness of public health programs.

F

FEMA -- Federal Emergency Management Agency

First responders and First Receivers -- Local fire, law enforcement, HAZMAT, emergency medical services, emergency management personnel, designated volunteers and hospital emergency room personnel.

Focus areas -- Categories of emergency preparedness activities states must address in their Cooperative Agreements for Public Health Preparedness and Response for Bioterrorism. Focus areas cover the following topics:

Focus Area A: Preparedness planning and readiness assessment
Focus Area B: Disease detection and reporting
Focus Area C: Laboratory readiness
Focus Area E: Electronic information sharing
Focus Area F: Public health communications
Focus Area G: Education and training

FRP -- Federal Response Plan -- The overarching emergency management plan of the US government

H

Health alerts -- Urgent messages from the CDC to health officials requiring immediate action or attention. The CDC also issues health advisories containing less urgent information about a specific health incident or response that may or may not require immediate action, and health updates, which do not require action.

HEICS -- Hospital Emergency Incident Command System

HHS -- US Department of Health and Human Services

HIPPA -- Health Information Privacy Policy Act

HRSA -- Health Resources and Services Administration
A branch of the federal Department of Health and Human Services. HRSA administers the funding and implementation of Utah's Cooperative Agreement for Bioterrorism Hospital Preparedness.

HSQA -- Health Systems Quality Assurance.

I

ICS -- Incident Command System
The direction and control scheme used by first response and other agencies to manage emergencies.

Isolation -- The separation and restriction of movement or activities of ill infected persons who have a contagious disease, for the purpose of preventing transmission to others.

J

JIC -- Joint Information Center
A central point of contact for all news media near the scene of a large-scale disaster. The center is staffed by public information officials who represent all participating federal, state, and local agencies to provide information to the media in a coordinated and consistent manner.

L

Laboratory levels (A,B,C,D) -- A system for classifying laboratories by their capabilities. Classifications are:

A: routine clinical testing. Includes independent clinical labs and those at universities and community hospitals
B: more specialized capabilities. Includes many state and local public health laboratories
C: More sophisticated public health labs and reference labs such as those run by CDC.
D. Possessing sophisticated containment equipment and expertise to deal with the most dangerous, virulent pathogens and include only CDC and Department of Defense labs,

the FBI, and the U.S. Army Medical Research Institute of Infectious Diseases.

LEPC -- Local Emergency Planning Committee

LERC -- Local Emergency Response Coordinator

L-LERC -- Local Lead Emergency Response Coordinator

LHJ -- Local Health Jurisdiction

LIMS -- Laboratory Information Management System
LIMS connect the analytical instruments in the lab to one or more workstations or personal computers. A full-featured LIMS will forward data from lab instruments to a PC, organize it into meaningful information, and arrange it in required report formats.

LRN --Laboratory Response Network
A national partnership of public health laboratories designed to coordinate and share resources for an effective response during a health emergency.

M

MCI -- Mass Casualty Incident

MOA -- Memorandum of Agreement

MOU -- Memorandum of Understanding

MMRS -- Metropolitan Medical Response System
A program of the US Health and Human Services Office of Emergency Preparedness intended to increase cities' ability to respond to a terrorist attack by coordinating the efforts of local law enforcement, fire, HAZMAT, EMS, hospital, public health and other personnel.

N

NACCHO -- National Association of City and County Health Officials

NCID -- National Center for Infectious Diseases
A branch of the Centers for Disease Control and Prevention.

NDMS -- National Disaster Medical System

NEDSS -- National Electronic Disease Surveillance System
A Centers for Disease Control and Prevention initiative that promotes the use of data and information system standards to improve disease surveillance systems at federal, state and local levels.

NIH -- National Institutes of Health.
A branch of the federal Department of Health and Human Services. The NIH encourages and oversees medical and behavioral research.

NIMS -- National Incident Management System
A comprehensive, first-ever standardized incident management response system developed by Homeland Security at the request of the President.

NNRT -- National Nurse Response Team

Notifiable conditions -- Incidences of communicable disease, traumatic injury, cancer or other health condition that a state requires health care providers to report to a central collecting agency.

O

OCR -- Official Code Registry

OER -- Office of Emergency Response
Division of the US Department of Health and Human Services.

OPHP -- Office of Public Health Preparedness
Office within the U.S. Office of Health and Human Services that provides coordination between the CDC and HRSA Cooperative Agreements.

OSHA -- Occupational Safety and Health Administration

P

Pathogen -- Any agent or organism that can cause disease.

PHTN -- Public Health Training Network
The Centers for Disease Control and Prevention's distance learning system that uses instructional media ranging from print-based to videotape and multimedia to meet the training needs of the public health workforce nationwide.

PIO -- Public Information Officer

PPE -- Personal Protective Equipment

Push package -- A delivery of medical supplies and pharmaceuticals sent from the strategic national stockpile to a state undergoing an emergency within 12 hours of federal approval of a request by the state's Governor.

Q

Quarantine -- The separation and restriction of movement or activities of persons who are not ill but who are believed to have been exposed to infection, for the purpose of preventing transmission of diseases.

S

SNS -- Strategic National Stockpile
A cache of drugs, vaccines, and supplies that can be deployed to areas struck by disasters, including bioterrorism.

Surge capacity -- The ability of institutions such as clinics, hospitals, or public health laboratories to respond to sharply increased demand for their services during a public health emergency.

Surveillance -- The systematic ongoing collection, collation, and analysis of data and the timely dissemination of information to those who need to know so that action can be taken. Surveillance is the essential feature of epidemiological practice.

T

TOPOFF -- Top Officials
A full-scale preparedness exercise sponsored jointly by the Departments of Justice and State.

TBSA -- Total Body Surface Area

U

UDOH -- Utah Department of Health

UDOH ECC -- Utah Department of Health Emergency Coordination Center

UDOT -- Utah Department of Transportation

UTA -- Utah Transit Authority

DRAFT

APPENDIX D: THE NATURE OF THE THREAT

Terrorism, natural disasters and accidents have the potential to produce large numbers of casualties requiring urgent care. The "unknown" aspects of many terrorism agents can be expected to add to care requirements as the "worried well" and panicked arrive at medical treatment facilities demanding treatment. The following threat situations must be considered in planning for proper response to mass casualty situations.

TERRORISM

Throughout the 1990's, domestic and international terrorism in the United States rose to become the single most influential hazard on emergency preparedness. Terrorism is defined by the Department of Justice as: "A violent act or an act dangerous to human life, in violation of the criminal laws of the United States or any segment thereof, in furtherance of political or social objectives."

While individual definitions of terrorism may vary slightly, all sources agree that a terrorist incident will almost always comprise two elements: Criminal Activity, and Technological Hazard(s). In short, terrorists are willing to use violence to create fear in order to achieve objective(s). This means that not only the target, but also more importantly the motivation, defines an act of terrorism.

The FBI recognizes two categories of terrorism: Domestic terrorism, and International Terrorism.

- Domestic Terrorism – Involves groups or individuals whose terrorist activities are directed at elements of our government without foreign direction. The Oklahoma City bombing is an example of domestic terrorism.
- International Terrorism – Involves groups or individuals whose terrorist activities are foreign-based and/or directed by countries or groups outside the United States or whose activities transcend national boundaries. The World Trade Center bombing is an example of international terrorism.

A terrorist threat in Northern Utah is defined as: "The threat of a violent act which would be dangerous to human life to intimidate or coerce a government, the civilian population or any segment thereof, in furtherance of political or social objectives, which is received directly from the terrorist, or through credible intelligence. The threat need not be specific. (Refer to the Northern Utah Regional Homeland Security Plan)

The four categories of terrorism of particular concern are:

1. EXPLOSIVES

The overwhelming majority of terrorist events have involved explosive devices. On March 16, 2004 CDC issued the following advisory: "Based on recent events in Spain, Pakistan and London, clinicians, hospitals, and public health agencies should ensure that they are prepared to respond to mass trauma related to terrorist bombings." An explosive event may produce large numbers of seriously injured personnel, whether the cause was terrorism or an accident. The total number of patients requiring urgent care can typically be ascertained relatively rapidly, and this factor aids in allocating resources.

2. CHEMICAL AGENTS: The major categories of chemical agents are:

1. Nerve Agents, e.g. tabun, sarin, soman, VX

2. Cyanide, e.g. hydrogen cyanide, cyanogens chloride
3. Pulmonary Intoxicants, e.g. phosgene, chlorine
4. Vesicants, e.g. mustard, lewisite
5. Riot Control Agents, e.g. pepper spray, mace
6. Incapacitating Agents, e.g. BZ
7. Miscellaneous, e.g. ammonia

Typically, the effects of chemical agents are manifested within minutes to hours, and an attack should be recognized promptly. It is essential that first responders wear appropriate personal protective equipment if a chemical agent is suspected so that they themselves do not become casualties. Numbers may range from only a few to many. In the Tokyo sarin gas event, over 5,000 people came to emergency departments. The impact of the "worried well" is illustrated by the fact that 74% of those seeking care had no physical findings.

3. BIOLOGICAL AGENTS

A covert biological event will most likely be ecognized by skilled primary care providers who are able to determine that the situation is not a naturally occurring disease outbreak. As Dr. Gerberding, CDC Director, noted in January 2003, "The most important part of our surveillance systems is the astute physician." Initial numbers of patients may be quite small, followed by increases in numbers if the disease is transmissible. Conversely, if large numbers were exposed during an attack, the initial manifestation may be large numbers of patients seeking care.

A particularly unfortunate aspect of a biological attack is the fact that one does not have to actually release an agent to say that multiple people have been exposed. The resultant large numbers of "worried well" could rapidly overwhelm health care facilities. The six "Category A" conditions of particular terrorism concern to CDC are anthrax, botulism, plague, smallpox, tularemia and the viral hemorrhagic fevers.

4. RADIOACTIVE AGENTS AND NUCLEAR BOMBS

The dispersal of radioactive material would likely be with an explosive device, the "dirty bomb". However, it is also possible to "seed" an area covertly, with the situation recognized only when people with skin burns or other manifestations arrive at treatment facilities. An attack on a nuclear power plant could conceivably result in release of large amounts of radioactive material that could spread for hundreds of miles, as almost happened at Three Mile Island. Treatment of those exposed to a "dirty bomb" is not particularly complicated. However, if a nuclear power plant was attacked or if one of the former Soviet Union's small nuclear weapons that are not accounted for were used, those near the event could receive sufficient radiation exposure (over 50 rads) to experience the acute radiation syndrome. Depending on the amount of radiation absorbed, major treatment resources may be required. Large numbers of patients could be expected from any explosive scenario.

OTHER ASPECTS OF TERRORISM

Many terrorists are becoming increasingly sophisticated, and the significance of an event will depend in part on whether the terrorists involved are more "professional" or are more amateur. Professionals can be expected to target multiple sites, as was seen on 9/11, and they may use more than one category of agents. They could also target decision-makers who would be responsible for initiating and controlling responses. Due to the crucial role of major medical

facilities in responding to a terrorist event, it is reasonable to expect that these activities could also be attacked. Similarly, major transportation arteries may be destroyed as might power and water plants.

NATURAL DISASTERS

Natural disasters may evolve slowly over time, as is the situation with some floods and even hurricanes. However, they may occur suddenly, as with earthquakes, mudslides, wild fires, and tornadoes. Numbers of casualties may range from only a few to very large numbers. Those planning a response to natural disasters must consider the need to respond during weather conditions that may involve extreme heat, extreme cold, heavy rains, and high wind situations. Depending on the situation, power and water supplies may be compromised, adding to difficulties in responding.

ACCIDENTS

With the multiple rail, airline, and highway transportation activities in Utah, accidents involving one or more of these areas are a significant possibility. A bus, train, or airplane accident could produce multiple casualties with little or no warning. An accident involving hazardous materials, such as an overturned train car containing chlorine, could require evacuation of large areas as well as treatment of immediate casualties and those who only later developed symptoms. Many major medical facilities have aeromedical helicopter landing sites at the hospital or near by. The most hazardous part of any aircraft flight is landing and take-off. The probability of a helicopter accident is very low, but such a tragic event could seriously compromise the ability of the affected facility to continue normal activities.

EPIDEMIC

An epidemic, which is a sudden increase of a disease that occurs suddenly in numbers that clearly exceed what would normally be expected, applies to any disease, injury or other health-related event occurring in an outbreak. The CDC has listed several diseases, which have the potential to become an epidemic. They have been listed as a "high priority" and include: small pox, monkey pox, SARS, plague, west nile virus, anthrax, botulism, tularemia and viral hemorrhagic fevers.

An epidemic within the state of Utah would cause varying degrees of both personal and economic stress. Many diseases have the potential of causing wide spread illness or even loss of life. Even if a disease does not cause loss of life, it still may have the potential to incapacitate people to the point where they can not perform their daily functions, like going to work or school.

Local health departments, hospitals and doctors have been working together to decrease the incidence of disease. Vaccinations are an important key to reducing the spread of disease both prior to an event and after the event has begun. Another area that is used to reduce the spread of disease is good epidemiological surveillance of disease. The sooner the disease is detected, the sooner the health community can begin taking counter measures to mitigate the problem. This is the case for both naturally occurring diseases and diseases that could be released in a bioterrorist attack.

APPENDIX E: HIPPA/OSHA REGULATIONS

EMTALA

EMTALA requires certain standards of care for emergency care in hospitals and other treatment facilities. The Health and Human Services Secretary's Advisory Committee on Regulatory Reform has adopted the following modifications that relate to disaster situations and have received Full Advisory Committee on Regulatory Reform adoption of the following:

1. Use of community based EMS protocols, including established 911 protocols, is not a violation of EMTALA.

2. In the event of a disaster or conventional attack involving multiple casualties and where hospitals have an established disaster plan, EMTALA does not apply.

3. In the event of bioterrorism, or the threat of bioterrorism, EMTALA does not apply to those hospitals directly affected and where hospitals follow a community based, regional or CDC directed protocol (especially for highly contagious outbreaks like smallpox), EMTALA does not apply.

(Source: http://www.cms.hhs.gov/faca/ppac/emtalast.asp?)

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164.510(a)(3)(i)

(3) Emergency Circumstances.

(i) If the opportunity to object to uses or disclosures required by paragraph (a)(2) of this section cannot practicably be provided because of the individual's incapacity or an emergency treatment circumstance, a covered health care provider may use or disclose some or all of the protected health information permitted by paragraph (a)(1) of this section for the facilities directory, if such disclosure is:

164.510(a)(3)(i)(b)

(b) in the individual's best interest as determined by the covered health care provider, in the exercise of professional judgment.

164.510(b)(1)

(b)Standard: uses and disclosures for involvement in the individual's care and notification purposes.

(1) Permitted uses and disclosures:

164.510(b)(3)

(3) Limited uses and disclosures when the individual is not present. If the individual is not present, or the opportunity to agree or object to the use or disclosure cannot practicably be provided because of the individual's incapacity or an emergency circumstance, the covered entity may, in the exercise of professional judgment, determine whether the disclosures is in the best interests of the individual and, if so, disclose only the protected health information that is directly relevant to the person's involvement with the individual's health care. A covered entity

may use professional judgment and its experience with common practice to make reasonable inferences of the individual's best interest in allowing a person to act on behalf of the individual to pick up filled prescriptions, medical supplies, X-rays, or other similar forms of protected health information.

164.510(b)(4)
(4) Use and disclosures for disaster relief purposes. A covered entity may use or disclose protected health information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating with such entities the uses or disclosures permitted by paragraph (b)(1)(ii) of this section. The requirements in paragraphs (b)(2) and (3) of this section apply to such uses and disclosures to the extent that the covered entity, in the exercise of professional judgment determines that the requirements do not interfere with the ability to respond to the emergency circumstances.

PATIENT DESTINATION
Utah Health Code: 26-8a-307
(1) If an individual being transported by a ground or air ambulance is in critical or unstable condition, the ground or air ambulance shall transport the patient to the trauma center or closest emergency patient receiving facility appropriate to adequately treat the patient.
(2) If the patient's condition is not critical or unstable as determined by medical control, the ground or air ambulance may transport the patient to the:

(a) hospital, emergency patient receiving facility, or other medical provider chosen by the patient and approved by medical control as appropriate for the patient's condition and needs; or

(b) nearest hospital, emergency patient receiving facility, or other medical provider approved by medical control as appropriate for the patient's condition and needs if the patient expresses no preference

ISOLATION AND QUARANTINE POWERS AND DUTIES OF DEPARTMENTS
Utah Health Code 26A-1-114:
(1)(b) establish, maintain and enforce isolation and quarantine, and exercise physical control over property and over individuals as the local health department finds necessary for the protection of the public health.