

REGIONAL MEDICAL EVACUATION AND PATIENT TRACKING *MUTUAL AID PLAN (MAP)*

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**Sponsored by:
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Regional Medical Evacuation and Patient Tracking *Mutual Aid Plan (MAP)*

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RESOURCE REQUIREMENTS – TO AVOID EVACUATION

Individual Facility in Need of Resources

Disaster Struck Facility:

1. Call 911 (or non-emergency number), notifying appropriate local emergency responders of the situation
2. Implement internal disaster notification. Establish internal disaster plan and Command Center - **required** if requesting assistance
3. Notify Public Health Duty Officer (206-296-4606)
4. Assign a Liaison Officer to communicate with Health & Medical (HM) Area Command re: supply, staffing, equipment and resource needs
5. Assigns a Liaison Officer to report to the local EOC to assist in resource coordination and communications (if applicable)
6. Continue to follow your facility's internal Emergency Management / Emergency Operations Plan

Health & Medical (HM) Area Command:

1. Activated by the Public Health Duty Officer
2. Verifies the local Emergency Manager / Municipality is aware of the incident
3. Notifies the Washington State DoH for the Disaster Struck Facility(ies), if necessary
4. If necessary, request a State Mission number through the City of Seattle / County Office of Emergency Management
5. Confirms WATrac used to alert King County healthcare facilities and critical partners

Medical Needs

Non-medical Needs

HM AREA COMMAND

Work through the HM Area Command for all medical needs. This includes staff, supplies, pharmaceuticals, medical equipment, Strategic National Stockpile (SNS) requests, and blood distribution

- HM Area Command will work with other organizations via phone, fax, e-mail and WATrac to identify available resources

LOCAL EMERGENCY OPERATIONS CENTER (EOC)

Work through the local EOC for all non-medical needs. This includes generators, HVAC units, transportation (i.e. Buses), etc.

- In the event local EOC is unavailable to assist the facility, work through the King County ECC
- If additional assistance is needed, inform the HM Area Command of the situation and seek resource support

NEED SUPPLIES AND EQUIPMENT

1. Call your facility's suppliers
2. Work with the HM Area Command to secure suppliers or staff listed in the Mutual Aid Plan (MAP) from Vendors
3. Work with the local Emergency Operations Center (EOC) to address other supplies and equipment requests
4. See supply and equipment availability from member facilities within your MAP

NOTES:

1. Fax request form to supplier to use as identification at police roadblocks (access may still be denied)
2. Communicate with EOC to inform them of supplier access needs
3. Consider security needs, as necessary, for transportation of pharmaceutical and supplies

NEED TRANSPORTATION FOR INCOMING SUPPLIES:

1. Work with the local EOC to secure transportation resources
2. If the local area is overwhelmed by the complexity or magnitude of the disaster, all requests will be coordinated through the HM Area Command. HM Area Command will in turn work with the appropriate EOC to coordinate resources.
 - a. Transportation help may be secured from facilities within your Mutual Aid Plan (MAP) for box trucks or other transportation vehicles that may be available
 - b. Request may be filled from outside of King County based on the magnitude of the incident

NEED STAFF

1. Call your facility's staffing personnel vendors (i.e. Nurse relief teams, staffing agencies)
2. Work with the HM Area Command to secure staff listed in the Mutual Aid Plan (MAP) from other member facilities via the Medical Reserve Corp (MRC)
3. Work with the local EOC to address non-medical staff (i.e. damage assessment team, food service support, etc.)

NOTES:

1. Fax request form to other facilities to use as identification for staff at police roadblocks. If from another healthcare facility, ensure they have their facility ID and one other form of acceptable identification (access may still be denied.)
2. Communicate with EOC to inform them of staff access needs

Legend

EOC – Emergency Operations Center
EMS – Emergency Medical Services
HM Area Command – Health and Medical Area Command
KC ECC – King County Emergency Coordination Center
MAP – Mutual Aid Plan
NDMS – National Disaster Medical System

REGIONAL ACTIONS: Phase I – III Evacuation

DISASTER OCCURS FORCING EVACUATION – PATIENT LIFE SAFETY IS PRIORITY

ACTIVATION / NOTIFICATION

Disaster Struck Facility:

1. Call 911, notifying appropriate local emergency responders and private ambulance / transportation groups under contract
2. Implement internal disaster notification. Establish internal disaster plan and Command Center - **required** if requesting assistance
3. Notify Hospital Control (HC) to prepare for Patient Evacuation
Harborview ED phone: 206-744-4074; ED Charge Nurse phone: 206-744-4025; or 800 MHz on hospital common channel
Back up - Overlake ED: 425-462-5100
4. Assigns a Liaison Officer to communicate with HC & Health & Medical (HM) Area Command re: patient placement and transportation needs
5. Assigns a Liaison Officer to report to the local EOC to assist in resource coordination and communications (if applicable)
6. Continue to follow your facility's internal Emergency Management / Emergency Operations Plan

Hospital Control (HC):

- Notify Public Health Duty Officer (206-296-4606)

Health & Medical (HM) Area Command:

1. Activated by the Public Health Duty Officer
2. Verifies the local Emergency Manager / Municipality is aware of the incident
3. Notifies the Washington State DoH for the Evacuating Facility[ies]
4. Requests a State Mission number through the City of Seattle / County Office of Emergency Management
5. Confirms WATrac used to alert King County healthcare facilities and critical partners

TRANSPORTATION FOR EVACUEES

1. Fire / EMS provide on-site transportation for patients (primary responsibility will focus around private ambulance / transport groups)
2. HC and HM Area Command coordinate patient placement

If additional non-EMS transportation resources are needed and requests escalate above the capacity of local EOC:

1. Evacuating Facility notifies HM Area Command
2. HM Area Command requests assistance from KC ECC to mobilize transit agencies and private transportation contractors who are members of the Regional Disaster Plan
3. HM Area Command requests assistance from State EOC via KC ECC
4. State assistance may trigger activation of mutual aid between adjacent states (Emergency Management Assistance Compact) or federal assets

EVACUATION ACTIONS

Disaster Struck Facility:

- Establishes Unified Command with local / on-site Emergency Response Agencies
- Implements census reduction (on-site patient reduction) / discharge plan to minimize number of patient transfers
- Send Patient Medical Record/Chart and tracking forms (and staff, as necessary)
- Track patients and staff with Patient Evacuation Tracking Form
- Evaluate the necessity of transferring controlled substances with patients
- Disaster Struck Facility notifies each patient's responsible party and physician (utilizing **Regional Call Center** if facility is overwhelmed)

Hospital Control:

- Coordinates patient movement to Patient Accepting Facilities including the number and type of patients being sent (see Patient Transportation)
- **Slow evacuation:** Distributes patients based on bed availability
- **Fast evacuation:** Distributes patients based on pre-planned range for number and type of patients for accepting facilities

HM Area Command:

- Considers activation of Medical Needs Shelter for patients qualified for discharge
- Activate **Regional Call Center** if Disaster Struck Facility is overwhelmed
- Assures notification of other healthcare facilities in the region
- Alerts the State of Washington DOH or State EOC to notify facilities outside King County

Legend

EOC – Emergency Operations Center

EMS – Emergency Medical Services

HC – Hospital Control

HM Area Command - Health & Medical Area Command

KC ECC – King County Emergency Coordination Center

MAP – Mutual Aid Plan

MULTIPLE FACILITY EVACUATION

HM Area Command (utilizing Hospital Control):

- Assign patients to Patient Accepting Facilities
- Establish Area Command to ensure that EOCs and the KC ECC are coordinating to provide resources and guidance to Fire Responder Agencies and Disaster Struck Facilities
- Consider activation of an Alternate Care Facility (ACF)

ACTIVATION PHASES I – III

Phase I: First 2 – 4 hours for current Open Staffed Beds / Census Reduction

Phase II: Up to 24 hours using full Surge Capacity Plan with Staffed Beds

Phase III: Up to 24 hours for overflow areas where staff and equipment from other facilities are required to ensure continuity of care. Long-term care (skilled nursing) facilities may be considered in Phase III for lower acuity patients.

PATIENT ACCEPTING FACILITY

1. Activate internal plans to receive evacuated patients
 - a. Identify patient intake areas and communicate to Hospital Control
 - b. Consider initiating Surge Capacity Plan
 - c. Consider initiating Census Reduction Plan
2. Assume provision of all staff and equipment required for evacuated patients until Disaster Struck Facility's staff and equipment arrive
3. Notify Disaster Struck Facility **or Regional Call Center** when patients have been received
4. Admit the patient and assign an attending physician
5. Start a new Medical Record / Chart for the patient and clearly delineate the end point in the existing Medical Record / Chart

REGIONAL ACTIONS – Phase IV – VI Evacuation

Phase I – III Incapable of Handling Patient Volume in Region 6

REGIONAL EVACUATION:

Health & Medical Area Command (HM Area Command):

1. In coordination with KC ECC and/or the Seattle EOC will be in communication with Washington State DoH and State EOC
2. Advise appropriate agencies if Statewide Mobilization of Fire Resources should be activated across Washington for additional EMS units and emergency staff
3. Follow activation protocol for appropriate Federal Agencies (i.e. NDMS) to provide resource coordination for regional evacuation

Hospital Control

1. Continue to coordinate patient movement until outside area First Responder Agencies assume command

Phase IV Activation: Regional Beds/EMAC

PRIORITY EVACUATION REGIONS (see Patient Placement):

1. Region 5
2. Region 1
3. Region 2
4. Region 3
5. Greater Portland, OR area
6. Region 9

Phase V Activation: Alternate Care Facilities

ALTERNATE CARE FACILITIES (ACF)

Activated through HM Area Command:

- Estimated time for ACF to be at a level ready to receive patients: 12 – 24 hours
- Assumption: includes staff from Disaster Struck Facility being transported to ACF with the patient (coordinated through the Volunteer Management System – VMS)
- Transportation of Supplies, Pharmaceuticals and Equipment: responsibility of the HM Area Command working with the appropriate EOC or KC ECC

Phase VI Activation: Federal Resources

Department of Health & Human Services (DHHS) – Activation upon Federal Disaster Declaration

DHHS works with the *State EOC* to coordinate initial response, then with *HM Area Command* for two objectives:

- Priority 1: Insert teams and resource to support the ability to sustain patient care in the Region
- Priority 2 (if Priority 1 fails or conditions prevent its success): Utilize the NDMS Activation and Request Protocol to secure federal assets for regional evacuation
 - Federal contracts for ground and air transport
 - Federal medical facilities

If air evacuation protocols are utilized, pick-up points would be at Sea-Tac, Boeing Field and Paine Field

Legend

EOC – Emergency Operations Center
EMAC – Emergency Management Assistance Compact
EMS – Emergency Medical Services
HM Area Command – Health and Medical Area Command
KC ECC – King County Emergency Coordination Center
MAP – Mutual Aid Plan
NDMS – National Disaster Medical System

SECTION 2: OVERVIEW

Local Mutual Aid Plans (MAP) are important so nearby facilities can assist a member Disaster Struck Facility by accepting evacuated patients or helping with needed supplies and equipment.

In the past decade disasters such as the 1998 Northeast Ice Storm, 2001 Nisqually Earthquake, Tropical Storm Allison's assault on Houston, Texas in 2001, the Florida hurricanes of 2004, Hurricane Katrina in August 2005 and the California Wildfires of 2007 have resulted in such widespread damage that Mutual Aid Plans must be established to institute a pre-planned methodology for regional disaster planning.

PLAN OBJECTIVE:

Voluntary agreement among individual plan members to provide help for each other at the time of a disaster.

PLAN SCOPE:

1. To place and support care of patients evacuated from a Disaster Struck Facility.
2. To provide supplies as needed to a Disaster Struck Facility.
3. To assist with transportation of evacuated patients.
4. To provide Alternate Care Facilities and transportation for evacuated patients or to provide supplies from member facilities geographically removed from the region-wide disaster area.

MEMORANDUM OF UNDERSTANDING:

The Memorandum of Understanding (MOU) in Section 3 is the Agreement among King County Hospitals that commits the healthcare facilities to voluntarily provide support to accept evacuated patients and/or provide assistance to member hospitals with needed supplies, equipment, staffing and transportation.

RESPONSIBILITIES OF PLAN MEMBERS:

Note: Refer to the Memorandum of Understanding in Section 3 for additional details

Following is a list of responsibilities of all plan members:

- Number of Patients Accepted: All members are expected to provide a range for the amount of patients they will accept and insert this information into the Hospital Patient Capacity chart; assuming 100% occupancy. Type of patient is those your facility is qualified to care for.
- Members are expected to attend the annual meeting and sign recommitment forms, as needed.
- Members are expected to participate in all regional drills.
- Members must notify all participants and the Task Force (or its evolution into a Steering Committee) of any changes throughout the year, which may include: changes in administration personnel and phone numbers, temporary changes which affect the number of patients the Patient Accepting Facility can accommodate due to construction/renovation.
- Members are required to use the plan-specified *Patient Evacuation Tracking Form*. If evacuating, the Patient Record/Chart is sent with the patient unless the speed of the evacuation forces the facility out to the sidewalk; then the *Patient Evacuation Tracking Form* will be utilized for each patient prior to transport.
- Members are required to have activated their internal disaster plan and Command Center in order to request support from the plan.

It is further understood that this plan is instituted in conjunction with any additional requirements that may be identified by the Washington State Department of Health, which maintains ultimate regulatory authority over licensed facilities and works with additional state and local agencies to assist and support facilities in times of crisis.

1. This plan covers different levels of care. Due to this, the concept is that facilities should evacuate to like-to-like levels of care or up a level of care. During an evacuation, the following evacuation protocols should be instituted (example only as other levels of care are present within Member facilities):
 - a. **Behavioral Health** evacuates to other behavioral health facilities or to the behavioral health units of another hospital.
 - b. **Transitional Care Units (TCU)** evacuates to other TCUs or higher level of care. If additional bed availability is necessary, TCU patients may be able to evacuate to area Nursing Homes with appropriate staff support from the Disaster Struck Facility.
 - c. **Medical Acute Care** patients evacuate to other Acute Care facilities.
 - d. If it is required to evacuate to a healthcare facility that does not provide the equivalent level of care, staff from the Disaster Struck Facility should attempt to relocate to the Patient Accepting Facility or teams from other healthcare facilities should be appropriately redeployed as necessary. This typically will require Waivers from the Washington Department of Health or the appropriate federal agency.

2. This plan complements the Regional Disaster Plan, the Region 6 Hospital Emergency Response Plan and the current operational strengths of Hospital Control, Public Health Seattle & King County and the King County Healthcare Coalition, utilizing the Health & Medical Area Command to coordinate command.
3. It is the intent of this plan to evolve over time and be an inclusive plan. This incorporates reviewing opportunities to partner with and include other Regions in Washington (Region 1 – 5 and 7 – 9), adjacent states and British Columbia into future planning to ensure that the boundaries between states and countries do not obstruct the ability to manage regional evacuations and resources or assets in a disaster.
4. Payment for supplies, equipment, staffing, transportation and patient care will be coordinated between the Borrower or Disaster Struck Facility and the Lender or Patient Accepting Facility. While the majority of situations are a straightforward calculation of resources and assets utilized and the timeframe for which they were utilized, below are a few examples of situations that may require additional dialogue:
 - a. If an Open Heart surgical patient is involved in the evacuation, the facilities are paid under a Surgical DRG. If the surgery has taken place on Day 1 of the patients stay and the evacuation takes place on Day 3 and the patient remains at the Patient Accepting Facility until Day 6, the revenue split would NOT be 50% for each hospital due to length of stay. The appropriate consideration is provided to the hospital that performed the surgery with a proportionately higher share of the payment. In the absence of supporting documentation due to damage or destruction, a logical process is used to determine this amount based on expected service delivery at both Member Hospitals and hospitals outside of the region.
 - b. If non-traditional Open Space is used for the delivery of care, an Emergency Waiver will be requested from the Department of Health and/or the Federal Payer programs for the hospital to exceed its licensed bed capacity and the payment for the patient is consistent with the model listed in “a” above.

5. In disaster response planning, Member Hospitals should not rely solely on this Regional Medical Evacuation and Patient Tracking Mutual Aid Plan. After an earthquake or other substantial regional/state-wide disaster, the hospitals may not receive support from vendors, first responder agencies and/or emergency management based on the severity of the disaster and prioritization of infrastructure resources. Prioritization criteria for which any given hospital receives resources is incident specific with an emphasis on the impact to the community or region based on a hospital being unable to sustain operations.

Therefore, this plan does not replace the requirement for healthcare facilities to have in place:

- *Internal Incident Command Systems (ICS) that are compliant with the National Incident Management System (NIMS)*
- *Full building evacuation plans to safely transport the patients to the sidewalk*
- *Communications plan*
- *Influx of patients/Mass Casualty Incident plan*
- *Isolation/rationing plans when supplies, equipment, staffing or other resources will not allow a facility to stand alone for a 96 hour period or greater.*

6. Since regional evacuation assets are vulnerable to natural and technological disaster events, they may be overwhelmed in a disaster requiring the activation of this plan. The King County Health Care Coalition, Public Health of Seattle & King County, King County Government departments, cities and special purpose districts can only attempt to make every reasonable effort to support this plan based on the situation, information, and resources available at the time of the disaster.

SECTION 3:

REGIONAL MEDICAL EVACUATION AND PATIENT TRACKING

Mutual Aid Plan (MAP)

MEMORANDUM OF UNDERSTANDING (MOU)

Introduction and Background

As in other parts of the nation, members of this plan are susceptible to disasters that could exceed the resources of any individual healthcare entity. A disaster could result in the need for partial or complete evacuation of a single member hospital or multiple facilities in a geographic region or a member hospital experiencing a disaster may require staff, supplies or equipment in order to avert the need to evacuate.

The mutual aid support concept is well established and is considered “standard of care” in most emergency response disciplines. The purpose of this mutual aid support agreement is to aid facilities in their internal Emergency Operations Plan (EOP) by authorizing resources distribution to the Disaster Struck Facility and the pre-established acceptance protocol for evacuated patients from a Disaster Struck Facility or multiple facilities in King County.

This Mutual Aid Plan (MAP) is made and entered into by certain public and private organizations to enable them to provide Emergency Assistance to each other during times of disaster.

WHEREAS, the Subscribing Organizations have expressed a mutual interest in the establishment of a MAP to facilitate and encourage Emergency Assistance among participants; and

WHEREAS, in the event of an emergency, a Subscribing Organization who has executed this MAP may need Emergency Assistance in the form of supplemental personnel, equipment, materials or other support; and

WHEREAS, the proximity of the Subscribing Organizations to each other enables them to provide Emergency Assistance to each other in disaster situations.

WHEREAS, each Subscribing Organization may own and maintain equipment, stock materials and employ trained personnel for a variety of services and is willing, under certain conditions, to lend its supplies, equipment and staff to other Subscribing Organizations in the event of an emergency; and

WHEREAS, in the event of a hospital evacuation, a Subscribing Organization may be in a position to receive single or multiple patients from the Disaster Struck Facility in a timely manner.

NOW THEREFORE, in consideration of the mutual covenants and agreements

hereinafter set forth, the undersigned Subscribing Organization agrees as follows:

Article I – APPLICABILITY.

This MAP is available for execution to all Subscribing Organizations, in geographic King County. Execution of this MAP by a Subscribing Organization occurs when a Subscribing Organization signs an identical version of this MAP.

Article II – DEFINITIONS.

- A. 'Alternate Care Facility' references a location that is not currently providing healthcare services and will be converted to enable the provision of healthcare services to support, at a minimum, inpatient and/or outpatient care required after a declared catastrophic emergency. These specific sites are not part of the expansion of an existing healthcare facility (i.e., extensions of general acute care hospitals, clinics, or long term care facilities), but rather are designated under the authority of the local government.
- B. 'Assistance Costs' means any direct material costs, equipment rental fees, fuel, and the fully loaded labor costs that are incurred by the Lender or Patient Accepting Facility in providing any requested assets or services (see Article XII for additional clarity.)
- C. 'Borrower' means a Subscribing Organization who has adopted, signed and subscribes to this MAP and has made a request for Emergency Assistance and has received commitment(s) to deliver Emergency Assistance pursuant to the terms of this MAP Agreement.
- D. 'Census Reduction Plan' means an internal strategy utilized by a hospital to open up existing acute care beds in order to receive additional patients. This plan would include approaches to provide either early discharge to patients or increase physician, nursing, administrative and support staffing to speed up patients that would be discharged on that given day.
- E. 'Command Center' means location from which the Hospitals Incident Command oversees all incident operations. It is established in a facility during an emergency and is the facility's primary point of administrative authority and decision-making. This term references what individual facilities may call their internal Emergency Operations Center, Incident Command Center or other name for internal Command.
- F. 'Disaster' includes, but is not limited to, a human-caused or natural event or circumstance within the area of operation of any participating Subscribing Organization causing or threatening loss of life, damage to the environment, injury to person or property, human suffering or financial loss, such as: fire, explosion, flood, severe weather, drought, earthquake, volcanic activity, spills or releases of hazardous materials, contamination, utility or transportation emergencies, disease, infestation, civil disturbance, riots, act of terrorism or sabotage; said event being or is likely to be beyond the capacity of the affected Subscribing Organization(s), in terms of personnel, equipment and facilities,

thereby requiring Emergency Assistance. The 'Disaster' may affect an individual facility or several health care facilities at or about the same time. Since the community is also affected, local vendors could be caught in the same disaster incident. This disaster could overwhelm the regional response in its ability to place numerous evacuated patients or provide needed supplies and transportation resources.

- G. 'Disaster Struck Facility' is a facility directly affected by the disaster (for internal or external disasters – i.e. loss of water, flood). Transportation, staff, equipment or supplies may be requested, or the evacuation and transportation of patients may be required.
- H. 'Emergency Assistance' means employees, services, equipment, materials, or supplies offered during an Emergency by the Lender or Patient Accepting Facility and accepted by the Borrower or Disaster Struck Facility to assist in maintaining or restoring normal services when such service has been disrupted by acts of the elements, equipment malfunctions, accidents, terrorism/sabotage and other occurrences where Emergency Assistance from other Subscribing Organizations is necessary or advisable, as determined by the requesting Subscribing Organization.
- I. 'Emergency Contacts' are the persons, in a line of succession, listed on the Emergency Contact Information Form to be submitted to the Zone Emergency Planning Committee by each Subscribing Organization. The list includes names, addresses, and 24-hour phone numbers of the Emergency contact points of each Subscribing Organization. The people listed as Emergency Contacts have (or can quickly get) the authority of the Subscribing Organization to commit available equipment, services, and personnel for the organization. Note: The phone number of a dispatch office staffed 24 hours a day that is capable of contacting the Emergency contact point(s) is acceptable.
- J. 'Emergency Management Agencies' refers to city, county, state and federal emergency management agencies that have responsibility for disaster mitigation, preparedness, response and recovery phases. These agencies own and staff Emergency Operations Centers (EOCs) and Emergency Coordination Centers (ECCs) that will provide non-medical resources, if available, to evacuating hospitals.
- K. 'Emergency Support Function #8 (ESF 8)' is the Health, Medical and Mortuary response services support function for King County, state government, or federal level that provides for the organization, mobilization, and coordination of health and medical services in an imminently threatening health emergency or during other disasters that require the involvement of or activation of ESF 8.
- L. 'First Responder Agencies' refers to local fire, EMS and police; typically accessed through 911 or a non-emergency direct line.
- M. 'Health & Medical Area Command (HM Area Command)' is an incident management group used to coordinate emergency response efforts across all jurisdictions in King County, and among multiple healthcare agencies vying for

the same resources. Health, medical and mortuary response agencies across King County will utilize the Incident Command System, and specifically Area Command, to manage information, resources and decisions during disasters. The health, medical and mortuary response are led by the ESF 8 Area Commander, who reports to the Local Health Officer.

- N. 'Lender' means a Subscribing Organization who has signed this MAP and has agreed to deliver Emergency Assistance to another Subscribing Organization pursuant to the terms and conditions of this MAP.
- O. 'Liaison Officer' means a staff member of a healthcare facility that knows the facility, its Administration & Incident Command System. This is the primary facility contact position for the Liaison Officers and other Incident Command positions for the local, regional, state and federal first responder and emergency response agencies.
- P. 'Medical Reserve Corp (MRC)' has the mission to improve the health and safety of communities across the country by organizing and utilizing public health, medical and other volunteers to respond to local, regional and statewide medical emergencies.
- Q. 'Medical Shelter' is shelter operations for patients that have no acute medical conditions but require some medical surveillance and/or special assistance beyond what is available in a traditional/dormitory shelter.
- R. 'Member Hospital' means a Subscribing Organization that has the ability to receive patients or voluntarily provide support with staff, supplies and equipment during the disaster.
- S. 'Mutual Aid Plan (MAP)' means this Agreement.
- T. 'National Disaster Medical System (NDMS)' is a federally coordinated system that augments the Nation's medical response capability. The overall purpose of the NDMS is to establish a single integrated National medical response capability for assisting State and local authorities in dealing with the medical impacts of major peacetime disasters and to provide support to the military and the Department of Veterans Affairs medical systems in caring for casualties evacuated back to the U.S. from overseas armed conventional conflicts.
- U. 'Patient Accepting Facility' is a healthcare facility that receives patients evacuated from a Disaster Struck Facility.
- V. 'Subscribing Organization' means the executive governing authority of any public or private organization in, or bordering King County, WA, that chooses to subscribe to and sign onto the MAP.
- W. 'Surge Capacity Plan' means an internal strategy utilized by a hospital to open up existing acute care beds, open licensed beds that are not typically staffed, open non-traditional areas of the hospital for patient care and potentially open up an alternate care facility to support a mass influx of patients over a short duration or

extended period of time. This plan might include a Census Reduction Plan, cohorting of patients, utilization of recovery areas for patient overflow or intensive care units and other strategies employed that are specific to each individual hospital.

Article III – PARTICIPATION.

A disaster almost always involves the local first responder agencies, local emergency management agency, Public Health Seattle & King County and other local, county, and state regulatory and emergency response agencies. The disaster may be an “external” or “internal” event for facilities and in order to activate the MAP **assumes** that:

- **Each Disaster Struck Facility’s internal emergency management and operations plans have been fully implemented**
- **The Disaster Struck Facility’s Command Center is activated**
- **In the event of an evacuation, the Disaster Struck Facility has implemented their census reduction plan/discharge plan to minimize the number of evacuation patients.**

It is agreed, acknowledged, and understood that participation in this MAP is purely voluntary and at the sole discretion of the requested Lender for staff, supplies and equipment or the requested Patient Accepting Facility to receive evacuated patients. All Subscribing Organizations are encouraged to provide full support to the MAP, but no Subscribing Organization shall be liable to another Subscribing Organization for, or be considered to be in breach of or default under this MAP on account of any delay in or failure to perform any obligation under this MAP. Additionally, there are areas where advance information and participation is expected under this plan:

1. Modifications: Ensure that Public Health Seattle & King County has the Organization’s most current Emergency Contacts. Should any changes occur during the plan year that preclude your facility from participating, it is required that Public Health Seattle & King County is notified.
2. Member Hospitals: Each designates a representative to attend the Mutual Aid Plan meetings and to **coordinate the mutual aid initiatives** with the individual facility’s emergency operations plans. Members also commit to participating in exercises and drills to test the plan and knowledge of it.
3. Patient Accepting Facility: Projected Patient Surge Capacity: Every Member Hospital will agree to processes that they will undertake to:
 - a. Increase to their maximum capacity to receive and provide care for patients, and
 - b. Communicate this information through the Health & Medical Area Command at the time of the disaster.
4. Implementation of the MAP: During a disaster, only the authorized Emergency Contacts (or designee) or Command Center at each Member Hospital, Hospital Control, Public Health Duty Officer, and the HM Area Command has the authority to **request or offer assistance** through the MAP. If any other agency or individuals attempt to request or offer assistance to the MAP, they may make this

request via their local Emergency Operations Center or the King County Emergency Coordination Center with communications channeled back through the HM Area Command.

If the disaster is widespread and the Mutual Aid Plan is no longer effective between Member Hospitals due to the severity of the disaster, the authorized Subscribing Organizations may communicate with the HM Area Command to secure support or institute appropriate steps for activation of Alternate Care Facilities. In addition, HM Area Command may contact, through the City of Seattle EOC or County ECC, the State EOC to initiate protocols for mobilization of any State assets, the Department of Health & Human Services (DHHS) resources and the NDMS response plan. In the event the HM Area Command, the City of Seattle EOC or the County ECC are unavailable due to the scope of the disaster the member hospital should communicate directly with the Washington State EOC.

5. **Communications:** The Disaster Struck Facility is responsible for **informing local First Responder Agencies** and Hospital Control (which in turn communicates with the Public Health Duty Officer – HM Area Command) of its situation and defining needs that cannot be accommodated by the facility itself. The Emergency Contact (or designee) at the Disaster Struck Facility is responsible for authorizing the evacuation of patients.

In a situation where the Disaster Struck Facility only requires resources, they are responsible for requesting support from local EOCs for non-medical resources and the Public Health Duty Officer for medical resources (who in turn communicates with HM Area Command).

Communications between facilities for formally requesting and volunteering assistance should therefore occur through the facility Emergency Contacts (or designee) and centralized through HM Area Command. This communication often begins through the Liaison Officer of the Disaster Struck Facility's Command Center.

6. **Patient Care Responsibility:** Once admitted, the patient is under the care of the Patient Accepting Facility's admitting physician until discharged, transferred, or reassigned. The Disaster Struck Facility is responsible for transferring of extraordinary drugs or other special patient needs (e.g. equipment, blood products) if possible. At the end of the disaster, patients may be returned (at their request) and must be accepted at the Disaster Struck Facility. The following conditions immediately eliminate the potential for a transfer:
 - a. The patient is discharged to home or alternate level of care (rehabilitation hospital, skilled nursing facility, assisted living facility)
 - b. The patient/family/responsible party refuses transfer
 - c. The attending physician deems the patient unstable for transport.

Article IV – ROLE OF EMERGENCY CONTACT FOR SUBSCRIBING ORGANIZATIONS.

Subscribing Organizations agree that their Emergency Contacts or their designee can

serve as representatives of the Subscribing Organizations in any meeting to work out the language or implementation issues of this Memorandum of Understanding.

The Emergency Contacts from a Subscribing Organization shall:

- A. Act as a single point of contact for information about the availability of resources when other Subscribing Organizations seek assistance.
- B. Take the initiative to obtain and communicate decisions and discussion items of the meeting.
- C. Maintain a hard-copy manual containing the MAP including a list of Subscribing Organizations who have executed this MAP.

Article V – TERM AND TERMINATION.

- A. This MAP is effective upon execution by two or more Subscribing Organizations.
- B. A Subscribing Organization opting to terminate its participation in this MAP, shall provide written termination notification to the Preparedness Director at Public Health Seattle & King County, 401 Fifth Avenue, Suite 1300, Seattle, WA 98104 or by Fax at (206)296-0629. Notice of termination becomes effective upon receipt by Public Health Seattle & King County who shall, in turn, notify all Subscribing Organizations. Any terminating Subscribing Organization shall remain liable for all obligations incurred during its period of participation, until the obligation is satisfied.

Article VI – PAYMENT FOR SERVICES AND ASSISTANCE.

- A. Borrower shall pay to the Lender all valid and invoiced Assistance Costs within 60 days of receipt of the Lender's invoice, for all of the Emergency Assistance services provided by the Lender. In the event the Lender provides supplies or parts, the Lender shall have the option to accept payment of cash or in kind for the supplies or parts provided.
- B. Reimbursement for Patient Care: The Disaster Struck Facility and the Patient Accepting Facility acknowledge that there will be payment issues to be addressed between the facilities and that revenue will be divided based on the amount and type of care provided. The facilities agree to:
 - a. Attempt to work out the division of payment amicably amongst themselves and incorporate into the discussions, as necessary, the Washington State Department of Health and the appropriate payer (private, state or federal.) The payment for the patient care services may include the cost of equipment, staff, materials and supplies to provide that care.
 - b. If the dispute requires Mediation or Arbitration, see Article XIV Section E.
 - c. If the dispute escalates to require Litigation, see Article XIV Section F.

Article VII - INDEPENDENT CONTRACTOR.

Lender shall be and operate as an independent contractor of Borrower in the performance of any Emergency Assistance. Employees of Lender shall at all times while performing Emergency Assistance continue to be employees of Lender and shall not be deemed employees of Borrower for any purpose. Wages, hours, and other terms and conditions of employment of Lender shall remain applicable to all of its employees who perform Emergency Assistance. Lender shall be solely responsible for payment of its employees' wages, any required payroll taxes and any benefits or other compensation. Borrower shall not be responsible for paying any wages, benefits, taxes, or other compensation directly to the Lender's employees, but shall reimburse Lender for same when invoiced by Lender. The costs associated with borrowed personnel are subject to the reimbursement process outlined in Article XII. In no event shall Lender or its officers, employees, agents, or representatives be authorized (or represent that they are authorized) to make any representation, enter into any agreement, waive any right or incur any obligation in the name of, on behalf of or as agent for Borrower under or by virtue of this MAP.

Article VIII – REQUESTS FOR EMERGENCY ASSISTANCE.

Requests for Emergency Assistance shall be directed to the designated Emergency Contact(s) on the contact list provided by the Subscribing Organizations. These requests will be managed by HM Area Command. EOCs and ECCs will provide non-medical resources, if available. Those resources will be paid for by the organization submitting the request for emergency assistance. The extent to which the Lender provides any Emergency Assistance shall be at the Lender's sole discretion. In the event the emergency impacts a large geographical area that activates either Federal or State emergency laws, this Agreement shall remain in effect until or unless this Agreement conflicts with such Federal and State laws.

Article IX - GENERAL NATURE OF EMERGENCY ASSISTANCE (Equipment, supplies and personnel).

Emergency Assistance is in the form of resources, such as equipment, supplies, and personnel or the direct provision of services. The execution of the MAP shall not create any duty to respond on the part of any Subscribing Organization hereto. A Subscribing Organization shall not be held liable for failing to provide Emergency Assistance. A Subscribing Organization has the absolute discretion to decline to provide any requested Emergency Assistance and to withdraw resources it has provided at any time without incurring any liability. Resources are "borrowed" with reimbursement and terms of exchange varying with the type of resource as defined in Articles X through XII. The Subscribing Organizations recognize that time is critical during an emergency and diligent efforts are made to respond to a request for resources as rapidly as possible, including any notification(s) that requested resources are not available.

Article X – LOANS OF EQUIPMENT.

Use of equipment, such as construction equipment, road barricades, vehicles, and tools, shall be at the Lender's current equipment rate, or if no written rates have been established, at the hourly operating costs set forth in an **industry standard publication**

as selected by the Regional Disaster Planning Task Force, or as mutually agreed between Borrower and Lender. Equipment and tool loans are subject to the following conditions:

- A. At the option of the Lender, loaned equipment may be loaned with an operator. See Article XII for terms and conditions applicable to use of borrowed personnel.
- B. Loaned equipment shall be returned to the Lender upon release by the Borrower, or immediately upon the Borrower's receipt of an oral or written notice from the Lender for the return of the equipment. When notified to return equipment to a Lender, the Borrower shall make every effort to return the equipment to the Lender's possession within 24 hours following notification.
- C. Borrower shall, at its own expense, supply all fuel, lubrication and maintenance for loaned equipment. The Borrower takes proper precaution in its operation, storage and maintenance of Lender's equipment. Equipment shall be used only by properly trained and supervised operators. Borrower takes responsibility to assure users are properly trained in the use of any equipment or supplies. Lender shall endeavor to provide equipment in good working order. All equipment is provided "as is", with no representations or warranties as to its fitness for particular purpose.
- D. Lender's cost related to the transportation, handling, and loading/unloading of equipment shall be chargeable to the Borrower. Lender shall provide copies of invoices for such charges where provided by outside sources and shall provide hourly accounting of charges for Lender's employees who perform such services.
- E. Without prejudice to a Lender's right to indemnification under Article XIV herein, in the event loaned equipment is lost or damaged while being dispatched to Borrower, or while in the custody and use of the Borrower, or while being returned to the Lender, Borrower shall reimburse the Lender for the reasonable cost of repairing said damaged equipment. If the equipment cannot be repaired within a time period indicated by the Lender, then Borrower shall reimburse Lender for the cost of replacing such equipment with equipment, which is of equal condition and capability. Any determinations of what constitutes "equal condition and capability" shall be at the discretion of the Lender. If Lender must lease or rent a piece of equipment while the Lender's equipment is being repaired or replaced, Borrower shall reimburse Lender for such costs. Borrower shall have the right of subrogation for all claims against persons other than parties to this MAP who may be responsible in whole or in part for damage to the equipment. Borrower shall not be liable for damage caused by the sole negligence of Lender's operator(s).
- F. A noted exception in A – E above is where the Borrower is acting as a Patient Receiving Facility and the Lender is the Disaster Struck Facility.

Determination on reimbursement may be modified as DRG distributed revenue generated by the use of equipment from the Disaster Struck Facility to support the ability to provide patient care to the patients of the Disaster Struck Facility. See Article VI.

Article XI – EXCHANGE OF MATERIALS AND SUPPLIES.

Borrower shall reimburse Lender in kind or at Lender's actual replacement cost, plus handling charges, for use of partially consumed or non-returnable materials and supplies, as mutually agreed between Borrower and Lender. Other reusable materials and supplies which are returned to Lender in clean, damage-free condition shall not be charged to the Borrower and no rental fee is charged. Lender shall determine whether items returned are "clean and damage-free" and items shall be treated as partially consumed or non-returnable materials and supplies if item is found to be damaged.

In the event where the Borrower is acting as a Patient Receiving Facility and the Lender is the Disaster Struck Facility, determination on reimbursement may be modified as DRG distributed revenue generated by the use of materials and supplies on the patients from the Disaster Struck Facility. See Article VI.

Article XII – LOANS OF PERSONNEL.

Lender may, at its option, make such employees as are willing to participate available to Borrower at Borrower's expense equal to Lender's full cost, including employee's salary or hourly wages, call back or overtime costs, benefits and overhead, and consistent with Lender's personnel union contracts, if any, or other conditions of employment. Costs to feed and house loaned personnel, if necessary, shall be chargeable to and paid by the Borrower. The Borrower is responsible for assuring such arrangements as may be necessary to provide for the safety, housing, meals, and transportation to and from job sites/housing sites (if necessary) for loaned personnel. The Subscribing Organizations' Emergency Contacts or their designees shall develop planning details associated with being a Borrower or Lender under the terms of this MAP Agreement. Lender personnel providing Emergency Assistance shall be under the operational control of the command structure of the Borrower. Lender shall not be liable for cessation or slowdown of work if Lender's employees decline or are reluctant to perform any assigned tasks if said employees judge such task to be unsafe. A request for loaned personnel to direct the activities of others during a particular response operation does not relieve the Borrower of any responsibility or create any liability on the part of the Lender for decisions and/or consequences of the response operation. Loaned personnel may refuse to direct the activities of others without creating any liability on the part of the Lender. Any valid licenses issued to Lender personnel by Lender or Lender's state, relating to the skills required for the emergency work, may be recognized by the Borrower during the period of emergency and for purposes related to the emergency (interstate actions would require appropriate approvals by the State of Washington.) When notified to return personnel to a Lender, the Borrower shall make every effort to return the personnel to the Lender's possession immediately after notification.

In the event where the Borrower is acting as a Patient Receiving Facility and the Lender is the Disaster Struck Facility, determination on reimbursement may be modified as

DRG distributed revenue generated by the use of personnel to support patient care for the patients from the Disaster Struck Facility. See Article VI.

Article XIII - RECORD KEEPING AND DOCUMENTATION.

Time sheets and/or daily logs showing hours worked and equipment and materials used or provided by the Lender are recorded on a shift-by-shift basis by the Lender and/or the loaned employee(s) and provided to the Borrower as needed. If no personnel are loaned, the Lender provides shipping records for materials and equipment, and the Borrower is responsible for any required documentation of use of material and equipment for state or federal reimbursement. The documentation is presented to the Administration/Finance Section of the Incident Command System or appropriate financial officers and materials management personnel when the Incident Command System has been demobilized. All necessary information will be provided to the Borrower to support reimbursement efforts. Under all circumstances, the Borrower remains responsible for ensuring that the amount and quality of all documentation is adequate to enable disaster reimbursement.

Patient Care Related Documentation: The Subscribing Organizations are required to use the *Patient Evacuation Tracking Form*. The Active Patient Record/Chart (including Medical Administration Record) is sent with the patient. Also, the *Patient / Medical Record & Equipment Tracking Sheet* should be used to support tracking the patients between facilities.

NOTE: Many facilities are moving towards or have achieved electronic medical records. If electronic medical records are currently in place, it is critical that a strong effort be made to provide a clear and concise Patient Evacuation Tracking Form in the event that access to the computers are limited. The facility should attempt to batch print the records, if possible, on each evacuating unit. Additionally, if the facility was unable to print the appropriate sections of the records prior to evacuation, it should be reviewed if the electronic medical record can be accessed from an off-site location and be printed out from that location to support patient care.

Article XIV - INDEMNIFICATION AND LIMITATION OF LIABILITY.

- A. INDEMNIFICATION. Except as provided in section B., to the fullest extent permitted by applicable law, the Borrower and Disaster Struck Facility releases and shall indemnify, hold harmless and defend each Lender, Patient Accepting Facility and City/County Emergency Management Agencies, their officers, employees and agents from and against any and all costs, including costs of defense, claims, judgments or awards of damages asserted or arising directly or indirectly from, on account of, or in connection with providing Emergency Assistance, resources or patient care to/for the Borrower and Disaster Struck Facility, whether arising before, during or after performance of the Emergency Assistance or patient care and whether suffered by any of the Subscribing Organizations or any other person or entity. The Borrower, Disaster Struck Facility, city and county emergency management agencies agree that their obligation under this section extends to any claim, demand and/or cause of action brought by or on behalf of any of its employees, or

agents. For this purpose, the Borrower and Disaster Struck Facility and emergency management agencies, by mutual negotiation, hereby waives, as respects any indemnitee only, any immunity that is otherwise available against such claims under the Industrial Insurance provisions of Title 51 RCW of the State of Washington and similar laws of other states.

- B. **ACTIVITIES IN BAD FAITH, NEGLIGENCE OR BEYOND SCOPE.** Any Subscribing Organizations shall not be required under this MAP Agreement to indemnify, hold harmless and defend any other Subscribing Organization from any claim, loss, harm, liability, damage, cost or expense caused by or resulting from the activities or negligence of any Subscribing Organizations officers, employees, or agents acting in bad faith or performing activities beyond the scope of their duties.
- C. **LIABILITY FOR PARTICIPATION.** In the event of any liability, claim, demand, action or proceeding, of whatever kind or nature arising out of rendering of Emergency Assistance through this MAP Agreement, the Borrower and Disaster Struck Facility agrees, to indemnify, hold harmless, and defend, to the fullest extent of the law, each signatory to this MAP Agreement, whose only involvement in the transaction or occurrence which is the subject of such claim, action, demand, or other proceeding, is the execution and approval of this MAP Agreement.
 - i. The Patient Accepting Facility assumes the legal responsibility for transferred patients upon arrival into the Patient Accepting Facility.
- D. **DELAY/FAILURE TO RESPOND.** No Subscribing Organization shall be liable to another Subscribing Organization for, or be considered to be in breach of or default under this MAP Agreement on account of any delay in or failure to perform any obligation under this MAP Agreement, except to make payment as specified in this MAP Agreement.
- E. **MEDIATION AND ARBITRATION.** If a dispute arises out of or relates to this Contract, or the breach thereof, and if said dispute cannot be settled through direct discussions, the parties agree to first endeavor to settle the dispute in an amicable manner by mediation. Thereafter, any unresolved controversy or claim arising out of or relating to this Agreement, or breach thereof, may be settled by arbitration, if they agree to do so, and judgment upon the award rendered by the arbitrator may be entered in any court having jurisdiction thereof. The parties to this Contract may seek to resolve disputes pursuant to mediation or arbitration, but are not required to do so.
- F. **SUBSCRIBING ORGANIZATION LITIGATION PROCEDURES.** Each Subscribing Organization seeking to be released, indemnified, held harmless or defended under this Article with respect to any claim shall promptly notify the Borrower and Disaster Struck Facility of such claim and shall not settle such claim without the prior consent of Borrower and Disaster Struck Facility, which consent shall not be unreasonably withheld. Such Subscribing Organization shall have the right to participate

in the defense of said claim to the extent of its own interest. Subscribing Organization's personnel shall cooperate and participate in legal proceedings if so requested by the Borrower and Disaster Struck Facility, and/or required by a court of competent jurisdiction.

Article XV – SUBROGATION.

- A. **BORROWER'S WAIVER.** Borrower expressly waives any rights of subrogation against the Lender, which it may have on account of, or in connection with, the Lender providing Emergency Assistance to the Borrower under this MAP Agreement.

- B. **LENDER'S RESERVATION AND WAIVER.** Lender expressly reserves its right to subrogation against the Borrower to the extent the Lender incurs any self-insured, self-insured retention or deductible loss. The Lender expressly waives its rights to subrogation for all insured losses only to the extent the Lender's insurance policies, then in force, permit such waiver.

Article XVI – WORKER'S COMPENSATION AND EMPLOYEE CLAIMS.

Lender's employees, officers or agents, made available to Borrower, shall remain the general employee, officer or agents of Lender while engaged in carrying out duties, functions or activities pursuant to this MAP Agreement, and each Subscribing Organization shall remain fully responsible as employer for all taxes, assessments, fees, premiums, wages, withholdings, workers' compensation and other direct and indirect compensation, benefits, and related obligations with respect to its own employees. Likewise, each Subscribing Organization shall provide worker's compensation in compliance with statutory requirements of the state of residency.

Article XVII – MODIFICATIONS.

No provision of this MAP Agreement may be modified, altered, or rescinded by any individual Subscribing Organization without two-thirds affirmative concurrence of the Subscribing Organizations. Public Health Seattle & King County is the coordinating body for facilitating modifications of this MAP Agreement. Modifications to this MAP Agreement must be in writing and becomes effective upon approval of the modification by a two-thirds affirmative vote of the Subscribing Organizations. Modifications must be signed by an authorized representative of each Subscribing Organization.

Article XVIII – NON-EXCLUSIVENESS AND PRIOR AGREEMENTS.

This Agreement shall not supercede any existing mutual aid agreement or agreements between two or more Subscribing Organizations, and as to assistance requested by a party to such mutual agreement within the scope of the mutual aid agreement, such assistance shall be governed by the terms of the mutual aid agreement and not by this MAP Agreement.

Article XIX – GOVERNMENTAL AUTHORITY.

This Agreement is subject to laws, rules, regulations, orders, and other requirements, now or hereafter in effect, of all governmental authorities having jurisdiction over the emergencies covered by this MAP Agreement, the Subscribing Organization or either of them.

Article XX – NO DEDICATION OF FACILITIES.

No undertaking by one Subscribing Organization to the other Subscribing Organizations under any provision of this MAP Agreement shall constitute a dedication of the facilities or assets of such Subscribing Organization, or any portion thereof, to the public or to the other Subscribing Organization. Nothing in this MAP Agreement shall be construed to give a Subscribing Organization any right of ownership, possession, use or control of the facilities or assets of the other Subscribing Organization.

Article XXI – NO PARTNERSHIP.

This MAP Agreement shall not be interpreted or construed to create an association, joint venture or partnership among the Subscribing Organizations or to impose any partnership obligation or liability upon any Subscribing Organization. Further, no Subscribing Organization shall have any undertaking for or on behalf of, or to act as or be an agent or representative of, or to otherwise bind any other Subscribing Organization.

Article XXII – NO THIRD PARTY BENEFICIARY.

Nothing in this MAP Agreement shall be construed to create any rights in or duties to any Third Party, nor any liability to or standard of care with reference to any Third Party. This Agreement shall not confer any right, or remedy upon any person other than the Subscribing Organizations. This MAP Agreement shall not release or discharge any obligation or liability of any Third Party to any Subscribing Organizations.

Article XXIII – ENTIRE AGREEMENT.

This Agreement constitutes the entire agreement amongst the Subscribing Organizations.

Article XXIV – SUCCESSORS AND ASSIGNS.

This MAP Agreement is not transferable or assignable, in whole or in part, and any Subscribing Organization may terminate its participation in this MAP Agreement subject to Article V.

Article XXV – GOVERNING LAW.

This MAP Agreement shall be interpreted, construed, and enforced in accordance with the laws of Washington State.

Article XXVI – VENUE.

Any action which may arise out of this MAP Agreement shall be brought in Washington State and King County.

Article XXVII – TORT CLAIMS.

It is not the intention of this MAP Agreement to remove from any of the Subscribing Organizations any protection provided by any applicable Tort Claims Act. However, between Borrower and Lender or Disaster Struck Facility and Patient Accepting Facility, the Borrower and Disaster Struck Facility retains full liability to the Lender and Patient Accepting Facility for any claims brought against the Lender and Patient Accepting Facility as described in other provisions of this agreement.

Article XXVIII – WAIVER OF RIGHTS.

Any waiver at any time by any Subscribing Organizations of its rights with respect to a default under this MAP Agreement, or with respect to any other matter arising in connection with this Agreement, shall not constitute or be deemed a waiver with respect to any subsequent default or other matter arising in connection with this Agreement. Any delay short of the statutory period of limitations, in asserting or enforcing any right, shall not constitute or be deemed a waiver.

Article XXIX – INVALID PROVISION.

The invalidity or unenforceability of any provisions hereof, and this MAP Agreement shall be construed in all respects as if such invalid or unenforceable provisions were omitted.

Article XXX – NOTICES.

Any notice, demand, information, report, or item otherwise required, authorized, or provided for in this MAP Agreement shall be conveyed and facilitated by the Public Health Seattle & King County, 401 Fifth Avenue, Suite 1300, Seattle, WA 98104, Phone at (206) 296-4600 or by Fax at (206) 296-0629. Such notices, given in writing, and shall be deemed properly given if (i) delivered personally, (ii) transmitted and received by telephone facsimile device and confirmed by telephone, or (iii) sent by United States Mail, postage prepaid.

Article XXXI – PUBLIC RELATIONS.

Each Member Hospital is responsible for developing and coordinating with other Member Hospitals and Subscribing Organizations for the media response to the disaster in coordination with first responder agencies and through Public Information Officers (PIO). If a Joint Information Center (JIC) at the city/town/county/state level is operations and/or ESF 8 is activated, this should be a combined response from all parties.

**REGIONAL MEDICAL EVACUATION AND PATIENT TRACKING
MUTUAL AID PLAN (MAP) Signatory Documentation Sheet**

IN WHITNESS WHEREOF, the subscribing Organization hereto has caused this
Regional Medical Evacuation and Patient Tracking Mutual Aid Plan to be
executed by duly authorized representatives as of the date of their signature:

ORGANIZATION: _____

BUSINESS ADDRESS: _____

PHONE: _____

AUTHORIZED SIGNATURE(s):

PRINTED NAME: _____

POSITION TITLE: _____

SIGNATURE: _____

DATE: _____

PRINTED NAME: _____

POSITION TITLE: _____

SIGNATURE: _____

DATE: _____

PRINTED NAME: _____

POSITION TITLE: _____

SIGNATURE: _____

DATE: _____

**The document will be reconfirmed annually or as needed and will be
maintained at Public Health Seattle & King County offices.**

If you would like to join as a new plan member, please have your agency, organization, or tribal signatory authority sign and return the "Signatory Documentation Sheet." For organizational adoption of the MAP, sign and mail one (1) originally signed sheet back to:

**Public Health – Seattle & King County
C/O The King County Healthcare Coalition
401 5th Ave., Suite 1300
Seattle, WA. 98104
FAX: 206-296-0166**

SECTION 4: PATIENT PLACEMENT / CAPACITY

If a disaster forces a hospital(s) to fully or partially evacuate, other facilities within the plan receive and care for the **evacuated patients**. It is the intent of this plan to be able to absorb within the region the evacuation of the single largest medical center, with the potential exception certain high risk high acuity patients or special care patients.

For all communications, see *PLAN COMMUNICATIONS*, in Section V, for activation protocols.

Phase I Evacuation

Disaster Struck Facility:

To minimize the number of patients transferred to other hospitals:

1. Activate census reduction plans as time permits
2. Identify those patients who could be discharged whereby the patients would either be discharged home, if the responsible party is able to pick them up, or the region may work to redirect those patients to a Medical Needs Shelter until discharge arrangements can be completed.

Patient Accepting Facilities:

To create the capacity in the hospitals, each facility has outlined a process for opening beds along with outlining the type of patients they would accept (and are qualified to care for) into staffed beds in a 2-4 hour period (this is initial capacity and extends up to the 12 hour period). **Space** for these patients is created by:

1. Activation of its census reduction plan
2. Implementing emergency bed opening plan

Phase II Evacuation

If additional space is needed within existing staffed beds:

Member Hospitals would utilize their Surge Capacity Plan to open more staffed beds in a 12-24 hour period; beds that are usually unavailable for inpatient care. This does not include the creation of patient care areas in Open Space not designated for patient care on a daily basis.

Phase III Evacuation (may happen concurrently with Phase II for some Member Hospitals)

Some hospitals have indicated overflow areas. Staff and equipment will be needed for these areas as they may be non-traditional care areas within the hospital. If Phase III is activated, this would require an Emergency Waiver to be issued by the Washington State Department of Health (via communication with the Health & Medical Area Command).

NOTE: The Disaster Struck Facility would provide clinical staff and equipment with patients (i.e. surgical teams for open ORs; ICU teams for higher acuity patients; Emergency Department teams for management of an open holding area.) It is important to take into account that privileges may differ from Member facilities and appropriate questions should be asked of responding staff (i.e. Respiratory Techs may have different privileges from one hospital to another.)

Long-term Care (skilled nursing) facilities may be activated to absorb patients into unoccupied beds or areas where patients can be safely cared for in open spaces such as lounges and activity rooms as decided by physician and nursing leadership from the Disaster Struck Facility and as approved by the Washington State Department of Health. There are more than 6,700 long-term care beds in 68 facilities in King County.

Phase I – III Incapable of Handling Patient Volume

If Phases I – III are incapable of handling the patient placement and transportation requirements due to the magnitude of the incident, actions would concurrently be taking place to activate Phases IV – VI. All communications are centralized through an Area Command with Health & Medical Area Command (HM Area Command) coordinating all functions of the healthcare evacuation, exclusive of Scene Incident Command.

Phase IV Evacuation – Adjacent Regions

Distribution to other Counties and adjoining planning regions is utilized when the resources of the hospitals within King County have been overwhelmed. A disaster of this magnitude also includes preliminary activation of Phase V and Phase VI resources.

- Region 5 (Pierce County/Tacoma): Approximately 1,194 hospital bed capacity in 5 hospitals and 2,407 long-term care bed capacity in 21 facilities
- Region 1: Approximately 1,122 hospital bed capacity in 9 hospitals and 3,311 long-term care bed capacity in 37 facilities
- Region 2 (Kitsap County area/Bremerton): Approximately 306 hospital bed capacity in 2 hospitals and 1,002 long-term care bed capacity in 10 facilities
- Region 3 (Thurston County area/Olympia): Approximately 434 hospital bed capacity in 2 hospitals and 677 long-term care bed capacity in 7 facilities
- Greater Portland, OR area: Approximately 2,908 hospital bed capacity in 12 hospitals and 4,339 long-term care bed capacity in 45 facilities.
- Region 9 (Spokane): Approximately 1,207 hospital bed capacity in 4 hospitals and 1,763 long-term care bed capacity in 19 facilities
- British Columbia: Review Pacific NW Emergency Mgmt Arrangement (PNEMA) and WA/BC Public Health MOU to initiate through State EMD.

AirLift NorthWest is utilized to manage the air evacuation element of the patients under the coordination of Hospital Control.

Phase V Evacuation – Alternate Care Facilities

Alternate Care Facilities (in Region) are activated if the path of travel outside of the region to other healthcare facilities is impacted by the disaster. It takes approximately 12 – 24 hours to stand up an Alternate Care Facility with the assumption that staff would be moved with the patients. This expands patient capacity by 400 – 450 beds. Any transportation of supplies, pharmaceuticals and equipment are the responsibility of the HM Area Command in coordination with the appropriate EOC.

The Volunteer Management System (VMS) will manage the set-up, activation, operations and demobilization of the Alternate Care Facility. In the event that the staff from the VMS, along with the staff from the Disaster Struck Facility, are unable to provide the full resources necessary to support the Alternate Care Facility, staff may be requested from other hospitals inside King County and outside the area to provide additional staffing support. Additionally, Federal resources will be requested (see Phase VI – Priority 1) to supplement or provide full staffing for an Alternate Care Facility.

Transportation of supplies, pharmaceuticals and equipment shall be the responsibility of the HM Area Command working with the appropriate EOC or King County ECC.

Phase VI Evacuation – Department of Health & Human Services Mobilization (activation upon Federal Disaster Declaration)

Phase VI activation indicates an extended disaster with the inability to manage the volume of patient care within King County and surrounding regions or the fact that King County is isolated from other regions.

The State EOC will formally request the intervention and specific resources from the Department of Health & Human Services (DHHS) and resources will be coordinated with the State EOC, via the Emergency Management Division. Following the initial authorization and activation, direct communication will be established with the HM Area Command for two objectives:

- Priority 1 (avoid full regional evacuation): Insert teams to support the ability to sustain patient care in the Region. This is most likely activated during Phase III – V to support special care needs and to work diligently to utilize all resources possible to avoid mass patient movement. These teams may be used to fully staff or supplement Alternate Care Facility staff.
- Priority 2 (if Priority 1 fails or conditions prevent its success): Utilize specialized federal support including the National Disaster Medical System (NDMS) Activation and Request Protocol to secure federal assets. Examples of these assets include:
 - Federal contracts for ground (ambulance groups) and air transport
 - Federal medical facilities

NDMS works with the hospitals and HM Area Command to assist with evacuation out of the area when all local and state assets are insufficient to perform this

function. NDMS institutes pick-up points at Sea-Tac, Boeing Field and Paine Field (McChord AFB for out of region movement.)

Please refer to the following:

- **Hospital Patient Capacity chart (see Attachment C and WATrac)**

TRANSFER / EVACUATION OF PATIENTS

1. Communication of request: The request for the transfer of patients initially can be made verbally through the Incident Commander or Liaison Officer. The request, however, should be followed up with a written communication, if possible, prior to the actual transferring of any patients. The Disaster Struck Facility identifies to Hospital Control (who in turn communicates with the Patient Accepting Facility[ies]) the following information:
 - a. Number of patients needed to be transferred to the Patient Accepting Facility
 - b. General nature of their illness or condition
 - c. Type of specialized services required, (i.e. ICU bed, burn bed, trauma care, hemodialysis, dementia).

Refer to the WATrac for the Hospital Patient Capacity List (see also Attachment C) for each facility and the Region.

2. Documentation: The Disaster Struck Facility is responsible for providing the Patient Accepting Facility with the patient's complete available medical records, all paper-based documentation, insurance information and other patient information necessary for the care of the transferred patient. As time and resources permit, electronic records are printed for transportation with the patient or electronically transmitted/accessed at the Patient Accepting Hospital. Both the Disaster Struck Facility and the Patient Accepting Facility are responsible for tracking the destination of all evacuated patient (Refer to *Patient / Medical Record & Equipment Tracking Sheet* and the *Patient Evacuation Tracking Form*.) This includes all intra-hospital patient movement.

Considering the nature of the disaster, HIPAA regulations will be followed, as applicable, unless relaxed by Federal Authorities.

3. Transporting of Patients: The Disaster Struck Facility is responsible for initial coordination with Hospital Control, who in turn coordinates with EMS and other transportation resources (private and public) in the early stages of the disaster ('early stages' is defined based on the available resources at the time of the incident – estimates may be 30 minutes to 2 hours during normal business hours and 1 – 4 hours during off hours/weekends/ holidays). As the incident escalates and resources stand up, coordination of the incident remains with the Unified Incident Command (EMS/Fire/PD) and resources are coordinated by the Health & Medical Area Command (HM Area Command) via Hospital Control with local EOCs coordinating non-medical resources, if available.

The following information should be provided (see *Page 4.8 for the Charge Nurse criteria for Categorization of Patients for transport*):

- a. Total requiring Critical Care Transport (i.e. Ventilator, NICU)
- b. Total requiring Isolation for Infectious Disease
- c. Total requiring bariatric transport (Non-ambulatory and >400lbs)
- d. Total requiring ALS Transport
- e. Total requiring BLS Transport
- f. Total Wheelchair Van/Bus Patients - Transfer to another healthcare facility (Note if alternate level of care is possible and which level required – i.e. Skilled Nursing)
- g. Total for Standard Ground Transport – Transfer to another healthcare facility (Note if alternate level of care is possible and which level required – i.e. Skilled Nursing)
- h. Discharge to Home:
 - a. Total Wheelchair Van/Bus Patients
 - b. Total for Standard Ground Transport

Disaster Struck Facility will identify the pick-up points for the different levels of care being evacuated (i.e. – Red, Yellow, Green, Behavioral and Discharge).

Additionally, the financing of transportation for patients to the Patient Accepting Facility is the responsibility of the Disaster Struck Facility (NOTE: Insurance may be able to be billed for this transportation).

The point of entry to the Patient Accepting Facility is designated by the Patient Accepting Facility at the time of the incident.

4. Patient Care Responsibility: Once admitted, the patient is under the care of the Patient Accepting Facility's admitting physician until discharged, transferred, or reassigned. The Disaster Struck Facility is responsible for transferring of extraordinary drugs or other special patient needs (e.g. equipment, blood products) along with the patient if requested and if possible. At the end of the disaster, patients may be returned and must be accepted at the Disaster Struck Facility. The following conditions immediately eliminate the potential for a transfer:
 - a. The patient is discharged to home or alternate level of care (rehabilitation hospital, skilled nursing facility, assisted living facility)
 - b. The patient/family/responsible party refuses transfer
 - c. The attending physician deems the patient unstable for transport.
5. Physician Services: The Patient Accepting Facility designates an admitting physician for each patient. If requested, the Patient Accepting Facility provides temporary courtesy privileges to the patient's original attending physician.
6. Notification: The Disaster Struck Facility is responsible for notifying both the patient's family or responsible party and the patient's attending or personal physician of the situation. The Patient Accepting Facility may assist in notifying the patient's family and personal physician.

- a. If the resources of the Disaster Struck Facility are overwhelmed, the utilization of a centralized Regional Call Center to receive the Patient Evacuation Tracking Form information (either by fax, in paper copy, e-mail, courier or through an database data portal entered by the receiving hospital) and proactively provide status information to families or responsible party and the patient's attending or personal physician. This Regional Call Center phone number is broadcast via Television, Radio, hospital operators and recorded messages in order to direct all phone traffic to the appropriate location (see Regional Call Center plan in the ESF 8 Plan.)

Categorization of Patients for Evacuation: Charge Nurse Criteria

- a. Patients requiring Critical Care Transportation (RN-staffed or Advanced-trained Paramedic)**
- IVs with medications running that exceed paramedic capabilities
 - IV pump(s) operating (can be provided by the transport crew)
 - Need any medications administered via Physician orders by any means in any dosage prescribed
 - Cardiac monitoring/pacing (can be provided by the transport crew – external pacing only is crew provided) / intra-aortic counterpulsation device / LVAD
 - Ventilator dependent (vent can be provided by the transport crew)
 - Pediatric patients requiring ECMO
 - Neurosurgical ventricular drains
 - Invasive hemodynamic monitoring which cannot be temporarily or permanently discontinued (i.e. intra-arterial catheter if noninvasive blood pressure have not been reliable for patient, they are hemodynamically unstable, and they have a continuing chance of survival)
- b. Patients requiring ALS transport (Paramedic)**
- IVs with medication running that are within paramedic protocols (varies by county)
 - IV pump(s) operating
 - Need limited medications administered via Physician orders by limited means in limited dosage prescribed
 - Cardiac monitoring/pacing (can be provided by the transport crew – external pacing only is crew provided)
 - Ventilator dependent with own or facility ventilator
 - Prone or supine on stretcher required
- c. Patients requiring BLS transport (EMT)**
- Oxygen therapy via nasal cannula or mask (can be provided by the transport crew)
 - Basic maintenance IVF including TPN (total parenteral nutrition)
 - IVs with clear fluids (no medications)
 - Visual monitoring / Vitals (BP/P/Resp)
 - Prone or supine on stretcher required or unable to sustain
 - If Behavioral Health, provide information regarding danger to self or others
- d. Patients requiring Chair Car/Wheelchair Accessible Bus (No medical training)**
- No medical care or monitoring needed, unless the patient has their own trained caregiver in attendance capable of rendering the care
 - Not prone or supine, no stretcher needed
 - No oxygen needed, unless patient has own prescribed portable oxygen unit that can be safely secured enroute.

NOTE: Some wheelchair van companies provide a standard wheelchair, if needed, for the duration of the trip. Buses do not provide wheelchairs. Some electric wheelchairs cannot be secured in wheelchair vans due to size or design. These are NOT to be transported with the patient.

- e. Patients requiring normal means of transport (any vehicle - No medical training)**
- No medical care or monitoring needed, unless the patient has their own trained caregiver in attendance capable of rendering the care
 - No oxygen needed, unless patient has own prescribed portable oxygen unit that can be safely secured enroute.
 - Not prone, supine, or in need of a wheelchair (can ambulate well enough to climb bus steps)

NOTE: A person with a folding wheelchair, who can ambulate enough to get in and out of a car, could go by car if there was room to bring/pack the wheelchair.

- f. Patients requiring bariatric ambulance or transport (>400lbs)**

SECTION 5: PLAN ACTIVATION & COMMUNICATIONS

For quick checklist, see Section 1, Algorithms

Notifications and Continuous Communications

Disaster Struck Facility:

At start of a disaster, the Disaster Struck Facility immediately notifies appropriate first responder agencies via 911 (i.e. Fire, Police, EMS) or non-emergency number based on the initial severity of the incident.

- Activate appropriate internal notifications for your staff and leadership and activate your Hospital Command Center based on your facility Emergency Operations Plan or Emergency Management Plan. **The internal facility Command Center must be active in order to request resources and support from this Mutual Aid Plan (MAP.)*
- Disaster Struck Facility assesses whether evacuation is necessary or whether they can continue to provide patient care and remain open with additional staff, supplies or equipment. **Evacuation is to be avoided at all costs provided patient and staff safety is not significantly compromised.**

1) If a facility requires Supplies, Equipment, Staffing or other Resources (avoid evacuation at all costs) to remain operational:

- Communicate with the **Public Health Duty Officer** who will in turn activate the **Health & Medical Area Command** (HM Area Command)
 - HM Area Command will:
 - Verify the local or city Emergency Manager is aware of the incident
 - Notify the Washington State DoH (if necessary)
 - Request a State Mission number through the City of Seattle or County Office of Emergency Management
 - Verify WATrac is operating appropriately to communicate with hospitals and other critical partners.
- Establish a Liaison Officer internally to communicate with the HM Area Command
- Review sending a liaison to the local EOC to assist with non-medical resource coordination.

NOTE: If regional resources are not available or are unable to handle the situation due to infrastructure damage, communicate directly with the State EOC and Member Hospitals and other Subscribing Organizations (which includes regional suppliers, etc.).

2) If Evacuating:

- Communicate with Hospital Control to prepare them for patient evacuation
- Ensure communication with private ambulance or transportation companies that you have contracts with.
- **Hospital Control** will be notifying the **Public Health Duty Officer** who will in turn activate the **Health & Medical Area Command (HM Area Command)**
 - HM Area Command will:
 - Verify the local or city Emergency Manager is aware of the incident
 - Notify the Washington State DoH for the evacuating hospital(s)
 - Request a State Mission number through the City of Seattle or County Office of Emergency Management
 - Verify WATrac is operating appropriately to communicate with hospitals and other critical partners.
- Establish an internal Liaison Officer to communicate with the HM Area Command
- Review sending a liaison to the local EOC to assist with non-medical resource coordination.

NOTE: If regional resources are not available or unable to handle the situation due to infrastructure damage, communicate directly with the State EOC and potential Patient Accepting Facilities.

3) In the event that the region is being overwhelmed in Phase I – III patient evacuation, the following communications take place:

- **Health & Medical Area Command (HM Area Command):**
 - In coordination with the King County ECC and/or Seattle EOC requests additional state resources from Washington State Department of Health and the State EOC to secure additional state resources.
 - Advises the State EOC if the Emergency Management Assistance Compact (EMAC) should be activated between states based on the scope of the incident.
 - Initiates the activation protocol for appropriate Federal Agencies (i.e. NDMS) requesting they provide resource coordination support for a large scale regional evacuation. Final decisions about if the request is accepted comes from the Washington State Emergency Management Division.
 - Via **Hospital Control**, continues to coordinate patient movement until outside area First Responder Agencies assume command.
- Disaster Struck Facilities should continue to follow their facility's internal Emergency Management / Emergency Operations Plan.

A representative of the Disaster Struck Facility goes (if applicable), as directed, to the On-Scene Incident Command Structure or the designated local Emergency Operations Center (EOC) to support resource coordination and communications.

This enhances communications between the Disaster Struck Facility Command Center, the local/regional First Responder Agencies and other healthcare facilities.

All Member Hospitals, during an after an event resulting in the evacuation of patients, must monitor satellite phones, 800MHz, and WATrac 24/7 for the duration of the event.

Communication Protocols specifically related to patient movement:

Single Facility Evacuation

- The Disaster Struck Facility (via Liaison Officer) communicates with Hospital Control regarding patient types and numbers being sent (see Patient Placement – Section IV)
- Hospital Control communicates with the Public Health Duty Officer as well as the Patient Accepting Facility to inform them of expected patient volume to prepare for and type of patients.

Multiple Facility Evacuation

- The Disaster Struck Facilities communicate with Hospital Control initially and overall coordination of activities taking place through HM Area Command
- A representative of the Disaster Struck Facility provides the appropriate information on the patient volume (see Patient Placement – Section IV)
 - HM Area Command consolidates data on the patient volume, type and transportation requirements and, through Hospital Control, prioritizes timing for patient movement and patient placement locations (see Patient Placement – Section IV - for Phase I – VI activities.)

Communication between Disaster Struck Facility and Patient Accepting Facilities

- Initial contact with Patient Accepting Facilities should be through the main Emergency Department phone number (or as designated through the attached Region 6 Hospital Communications List for facility-specific Communication Information)
- Request to speak with the Administrator-on-Call (AOC)
- Once the Patient Accepting Facility's Command Center is fully established, request to speak with the Liaison Officer
- After initial facility contacts, communications should be through each facility's Liaison Officer.

Modes of Communications: (see *Region 6 Hospital Emergency Response Plan* for additional details)

EMERGENCY PHONE NUMBERS FOR PLAN ACTIVATION AND STATE RESOURCES

For Any Potentially Life Threatening Emergency, Contact 9-1-1

Main Office/Region	Primary Phone	Alternate Phone
Hospital Control – Harborview (Primary)	206-744-4074	744-4025 (Charge Nurse)
Hospital Control – Overlake (Back-up)	425-462-5100	
Public Health Duty Officer	206-296-4606 (activation mode for Health & Medical Area Command)	
Washington State Emergency Management Division (EMD) and Emergency Operations Center (EOC)	1-800-562-6108 or 253-512-7000 for 24/7 emergency phone numbers	800-854-5406 or 253-912-4900 for State EOC, if active
Washington State Department of Health	800-525-0127 or 360-971-0601 (24/7 DoH Duty Officer)	
Western Washington Medical Services Communications Team (A.R.E.S. Medical Services Teams)	Text or Numeric Page: 2065590374@page.metrocall.com or 206-559-0374 (USA Mobility)	

REGION 6 HOSPITAL COMMUNICATION LIST

Hospital	Main Phone	Emergency Department	Disaster Command Center	Alternate Command Center	Failsafe Phone #	Key After Hours Contact	Satellite Phones	HAM	Cell Phone for Key Personnel	HEAR/Tone			Email Addresses for Key Disaster Contact (provide 3)		
Auburn Regional	253-833-7711	253-333-2561	253-939-5367			253-833-7711	254-387-3991			1 406222	107.2	1B			
Children's	987-2000	206-987-8899	987-2000 x2780			206-987-1412 (pgr), 206-987-2000	254-387-3710			1 407222	94.8	ZA			
Enumclaw	360-825-2505	360-802-3208	360-802-4017			360-825-2505, 360-802-3938(pgr)	254-387-5548			1 406522	146.2	4B			
Evergreen	425-899-2100	425-899-1711	425-899-4111			425-899-2100 and ask to page house supervisor	254-387-5363			1 442022	118.8	2B			
Fairfax	425-821-2000	N/A													
GH - Central	326-3000	206-326-3223	326-3627-4495			425-883-5496, 206-583-1607(pgr)	254-387-5361			1 407722	127.3	3A			
Harborview	744-3000	206-744-3074	744-4444			744-4025 Charge Nurse (request page)	877-851-9423			1 407822	103.5	1A			
Highline	244-9970	206-431-5316	431-5316			206-244-9970, 206-469-3711(pgr)	254-387-7862			1 407022	82.5	YZ			
Kindred	364-2050	N/A	361-7434			975-0107	254-387-3708			NO HEAR					
NAVOS (formely West Seattle Psych)	206-933-7299	N/A	(206) 935-2341			206-933-7299	254-387-8994			NO HEAR					
Northwest	368-1700	368-1765	368-1700			Nursing Supervisor 206-368-1296, 206-917-3030(pgr)	254-387-3707			1 408422	141.3	4A			
Overlake	425-688-5000	425-688-5200	425-922-1843			425-688-5000, 206-973-5878 (pgr)	877-273-9219			1 406422	91.5	ZZ			
Regional Hospital	206-248-4604	N/A	Charge Nurse			Charge Nurse	254-387-3712			NO HEAR					
Snoqualmie Valley Hospital	425-831-2300	425-831-2323	425-831-2300			Nursing Supervisor, 425-831-2323; 509-859-3629	254-387-5551			1 407522	186.2	7Z			
St. Francis	253-838-9700	253-952-7971	253-944-7960			House Supervisor, 253-944-7963, 253-687-1827(pgr), SJMC Command Center 253-426-6201	254-387-4314			NO HEAR					
Swedish - Ballard	782-2700	206-781-6341	206-781-6106			206-782-2700, 206-405-6028(Pgr)	254-387-4312			1 406922	85.4	YA			
Swedish - First Hill	386-6000	206-386-2573	206-215-2154			206-386-6000, 206-405-8292(pgr)	254-387-3709			1 409422	167.9	6Z			
Swedish - Cherry Hill	320-2000	206-320-2111	206-320-4043			206-320-2000, 206-995-5539(pgr)	254-387-5889			1 408522	88.5	7B			
Swedish - Issaquah	425-394-0600	425-394-0610	425-394-0610			425-394-0610									
UWMC	598-3300	206-598-4000	206-598-6703, 206-598-6704, 206-598-2611			206-598-6190 (Adminstrator on-call), 206-598-1538(STAT nurse pgr), 206-598-9539 (STAT nurse mobile), 206-598-6604 (direct line to IC)	254-387-5547			1 409622	97.4	ZB			
Valley Medical	425-228-3450	206-575-2574	425-228-3440 x 2277			Nursing Supervisor, 425-228-3440 x 4498	254-387-5887			1 406822	100	1Z			
Veterans Seattle	762-1010	206-764-2600	206.764.2299 main 206.764.2040 alt			206-764-2810, 206-699-2178(pgr)	888-254-1570			1 409822	71.9	YA			
Virginia Mason	624-1144	206-583-6450	206-341-0000			206-223-6600, Announce Emer Code Yellow/EOC direct	254-387-4311			1 409922	186.2	7Z			

ZONE 1, 3, 5 AND KC OEM AND HEALTH & MEDICAL EMERGENCY CONTACTS

CITY OF AUBURN			UPDATED 9/17/08					
PLANNING CONTACT INFORMATION	NAME	OFFICE	CELL	PAGER	FAX	E-MAIL	NEXTEL DC#	NEXTEL PIN#
PRIMARY	Jim Kelly	253-931-3001	253-261-7559			jkelly@auburnwa.gov	112*1060*28	40148172
SECONDARY	Bob Karnofski	253-804-3115	253-261-7462			bkarnofski@auburnwa.gov	112*1060*25	4001F003
TERTIARY	Sarah Miller	253-876-1909	253-261-2481		253-939-7769	skmiller@auburnwa.gov	112*1060*138	40160414
EMERGENCY OPERATIONS		253-288-3170			253-931-3055			
ValleyComm/ 24-7		253-931-3080						
800 MHz PRIMARY TALKGROUP = KC EM Z3					VHF/HAM: 147.240+PL 123			
800 MHz SCANLIST:	KCEOC COM	KCEOC OPS						
CITY OF BELLEVUE								
PLANNING CONTACT INFORMATION	NAME	OFFICE	CELL	PAGER	FAX	E-MAIL	NEXTEL DC#	NEXTEL PIN#
PRIMARY	Diane Carlson	425-452-4225	206-915-8341			dcarlson@bellevuewa.gov		
SECONDARY	Brad Miyake	425-452-4895	206-465-4970			bmiyake@bellevuewa.gov		
TERTIARY	Kim Becklund	425-452-4491	206-938-3487			kbecklund@bellevuewa.gov		
ECC/EOC / 24-7		425-452-6813 (1st)	425-452-4400 (2nd)					
800 MHz PRIMARY TALKGROUP =					VHF/HAM:			
800 MHz SCANLIST:	KCEOC COM	KCEOC OPS						
CITY OF BURIEN								
PLANNING CONTACT INFORMATION	NAME	OFFICE	CELL	PAGER	FAX	E-MAIL	NEXTEL DC#	NEXTEL PIN#
PRIMARY	Mike Martin	206-248-5503	206-391-0178		206-248-5539	mikem@burien.wa.gov	112*660*1110	
SECONDARY	Mike Marrs	206-242-2040 x101	206-391-1654	206-955-3811	206-433-6042	mmarrs@burienfire.org	112*660*1059	
TERTIARY	Doug Luedeman	206-242-2040 x102	206-391-1655	206-977-4497	206-433-6042	dloedeman@burienfire.org	112*660*1060	
ECC/EOC		206-296-3333						
ValleyComm /24-7		253-372-1490						
800 MHz PRIMARY TALKGROUP =					VHF/HAM:			
800 MHz SCANLIST:	KCEOC COM	KCEOC OPS	KCEM Z3					

ZONE 1, 3, 5 AND KC OEM AND HEALTH & MEDICAL EMERGENCY CONTACTS (Cont.)

As of:
9/11/08

CITY OF ENUMCLAW								
PLANNING CONTACT INFORMATION	NAME	OFFICE	CELL	PAGER	FAX	E-MAIL	NEXTEL DC#	NEXTEL PIN#
PRIMARY	Joseph Kolisch	360-825-5544	253-266-1049		360-825-9442	efd@ci.enumclaw.wa.us		
SECONDARY	Bing Basim	360-825-5544	253-709-0193					
TERTIARY	Keith Lambertus	360-825-5544	253-709-7452					
ECC/EOC		360-825-5544 (M-F, 0700-1600)		360-825-3505 (M-F, 1600-0700 & wknds)				
800 MHz PRIMARY TALKGROUP =					VHF/HAM: NONE			
800 MHz SCANLIST:	KCEOC COM	KCEOC OPS	KCEM Z3					
CITY OF FEDERAL WAY								
PLANNING CONTACT INFORMATION	NAME	OFFICE	CELL	PAGER	FAX	E-MAIL	NEXTEL DC#	NEXTEL PIN#
PRIMARY	Cary Roe	253-835-2701	253-261-3548		253-835-2079	cary.roe@cityoffederalway.com	112*24527*98	
SECONDARY	Ray Gross	253-835-2712	253-261-5802		253-835-2079	everett.gross@cityoffederalway.com	112*24527*173	
TERTIARY								
ECC/EOC		253-835-7074						
ValleyComm / 24-7		253-852-2121						
800 MHz PRIMARY TALKGROUP =					VHF/HAM: 147.040 + PL Tone 103.5			
800 MHz SCANLIST:	KCEOC COM	KCEOC OPS	KCEM Z3					
CITY OF ISSAQUAH								
PLANNING CONTACT INFORMATION	NAME	OFFICE	CELL	PAGER	FAX	E-MAIL	NEXTEL DC#	NEXTEL PIN#
PRIMARY	Bret Heath	425-837-3475	206-605-6714	206-996-0986		breth@ci.issaquah.wa.us		
SECONDARY	Steve Campbell	425-837-3464	425-985-7338			steveca@ci.issaquah.wa.us		
TERTIARY	Joe Meneghini	425-837-3020	425-864-3022			joem@ci.issaquah.wa.us		
ECC/EOC		425-837-3180						
Police Dispatch / 24-7		425-837-3200						
800 MHz PRIMARY TALKGROUP =					VHF/HAM:			
800 MHz SCANLIST:	KCEOC COM	KCEOC OPS						

ZONE 1, 3, 5 AND KC OEM AND HEALTH & MEDICAL EMERGENCY CONTACTS (Cont.)

As of:
9/11/08

CITY OF KIRKLAND								
PLANNING CONTACT INFORMATION	NAME	OFFICE	CELL	PAGER	FAX	E-MAIL	NEXTEL DC#	NEXTEL PIN#
PRIMARY	Helen Arens-Byington	425-587-3603	425-306-2493	206-998-8031		hahrens-byington@ci.kirkland.wa.us		
SECONDARY	Stephanie Day	425-587-3630	206-450-5969			sdlay@ci.kirkland.wa.us		
TERTIARY	Jeff Blake	425-587-3601	206-948-6948			jblake@ci.kirkland.wa.us		
ECC/EOC		425-587-3750						
24/7		425-587-3400						
800 MHz PRIMARY TALKGROUP =					VHF/HAM:			
800 MHz SCANLIST:	KCEOC COM	KCEOC OPS						
CITY OF REDMOND								
PLANNING CONTACT INFORMATION	NAME	OFFICE	CELL	PAGER	FAX	E-MAIL	NEXTEL DC#	NEXTEL PIN#
PRIMARY	Robert Schneider	425-556-2130	424-444-2094	425-444-2094		rschneider@redmond.gov		
SECONDARY	Tom Osborn	425-556-2276	425-444-9375			tosborn@redmond.gov		
TERTIARY	Phil Grieb	425-556-2225	425-289-9965			pgrieb@redmond.gov		
ECC/EOC		425-556-2511	425-444-2094		425-556-7250			
800 MHz PRIMARY TALKGROUP =					VHF/HAM:			
800 MHz SCANLIST:	KCEOC COM	KCEOC OPS						
CITY OF RENTON								
PLANNING CONTACT INFORMATION	NAME	OFFICE	CELL	PAGER	FAX	E-MAIL	NEXTEL DC#	NEXTEL PIN#
PRIMARY	Deborah Needham	425-430-7027	206-714-2594	206-534-5300	425-430-7044	dneedham@ci.renton.wa.us	112*62924*3	
SECONDARY	Dave Pargas	425-430-7023	206-713-7860	206-534-5022	425-430-7044	dpargas@ci.renton.wa.us		
TERTIARY	Dave Daniels	425-430-7051	425-691-7811	206-534-5192	425-430-7508	ddaniels@ci.renton.wa.us		
TERTIARY	Chuck Duffy	425-430-7531	206-930-4880	206-534-5077		cduffy@ci.renton.wa.us		
ALT- COMM.	Battalion 11	425 430-7150	206-799-1400	Valley Comm				
ECC/EOC		425-430-7111	Sat.254.241.6263	Sat:877.494.4222	425-430-7085	ecc@ci.renton.wa.us		
ALT-ECC COOR.	Lt. Karl Rufener	425 430-7170	253 797-1511	206 534-5078	425 430-7175	krufener@ci.renton.wa.us		
800 MHz PRIMARY TALKGROUP = Renton RFD Admin					VHF/HAM: 145.460 and 145.650			
800 MHz SCANLIST:	KCEOC COM	KCEOC OPS	KCEM Z3		Portable sat Phone 254.387.5448			

ZONE 1, 3, 5 AND KC OEM AND HEALTH & MEDICAL EMERGENCY CONTACTS (Cont.)

As of:
9/11/08

CITY OF SEATTLE								
PLANNING CONTACT INFORMATION	NAME	OFFICE	CELL	PAGER	FAX	E-MAIL	NEXTEL DC#	NEXTEL PIN#
PRIMARY	Barb Graff	206-684-0437	206-786-4332	206-540-1565 or barb.graff@my2way.com	206-684-5998	barb.graff@seattle.gov		
SECONDARY	Diane Newman	206-233-5075	206-423-2497	206-997-0059 or diane.newman@my2way.com	206-684-5998	diane.newman@seattle.gov		
TERTIARY								
ECC/EOC - 105 5th Avenue South; Seattle 98104		206-233-5076 (public #)				Seattle-eoc@seattle.gov		
Staff Duty Officer / 24-7		206-233-5147 (non-public #)						
					VHF/HAM: 146.96 MHz (PSRG Repeater tone 103.5)			
800 MHz SCANLIST:	OPS COM 1,2,3 KCOEMCOM KCEM Z5, Z1, Z3							
CITY OF SNOQUALMIE								
PLANNING CONTACT INFORMATION	NAME	OFFICE	CELL	PAGER	FAX	E-MAIL	NEXTEL DC#	NEXTEL PIN#
PRIMARY	Bob Rowe	425-888-1551				firechief@ci.snoqualmie.wa.us		
SECONDARY	Jim Schaffer	425-888-2332				jschaffer@ci.snoqualmie.wa.us		
TERTIARY								
ECC/EOC / 24-7		425-888-5911			425-888-5913	EOC@ci.snoqualmie.wa.us		
800 MHz PRIMARY TALKGROUP =					VHF/HAM:			
800 MHz SCANLIST:	KCEOC COM	KCEOC OPS						

ZONE 1, 3, 5 AND KC OEM AND HEALTH & MEDICAL EMERGENCY CONTACTS (Cont.)

As of:
9/11/08

KING COUNTY EM								
PLANNING CONTACT INFORMATION	NAME	OFFICE	CELL	PAGER	FAX	E-MAIL	NEXTEL DC#	NEXTEL PIN#
PRIMARY	Robin Friedman					Robin.Friedman@kingcounty.gov		
SECONDARY	Jeff Bowers	206-205-4060	425-680-9011		206-205-4056	Jeff.Bowers@kingcounty.gov		
TERTIARY								
Duty Officer		206-296-3830	206-296-3830	206-969-0022				
KC ECC		206-296-3830			206-296-3838	ecc.kc@kingcounty.gov		
3511 NE 2nd St.								
800 MHz PRIMARY TALKGROUP = KC EOC COMMON					VHF: Primary Secondary			
800 MHz SCANLIST:	KC EOC OPS	KC EMZ3						
HEALTH & MEDICAL AREA COMMAND								
PLANNING CONTACT INFORMATION	NAME	OFFICE	CELL	PAGER	FAX	E-MAIL	NEXTEL DC#	NEXTEL PIN#
PRIMARY	Michael Loehr	206-263-8687	206-423-0944			michael.loehr@kingcounty.gov		
SECONDARY	Cynthia Dold	206-263-8715	206-423-6027			cynthia.dold@kingcounty.gov		
TERTIARY	Bryan Heartsfield	206-263-8716	206-255-8170			bryan.heartsfield@kingcounty.gov		
EOC / Public Health Duty Officer / 24-7		206-296-4606						
800 MHz PRIMARY TALKGROUP = DPH Common					VHF/HAM: 147.08			
800 MHz SCANLIST:	Hosp Common	KCEOC Com	DPHops1	DPHops2	DPHops3			

SECTION 6: TRANSPORTATION OF PATIENTS

This is **coordinated through** town/city of disaster origin/Emergency Medical Services (EMS) – Medical Transportation Officer. The ideal plan is to transport the “sickest” patient to the nearest hospital available that could handle their acuity (based on the Hospital Patient Capacity Chart and Hospital Control information), while taking those who could handle the ride better to a more remote hospital. It is recognized that vehicle availability, specialized patient needs, bed and staff availability will dictate this. The Disaster Struck Facility Liaison Officer works with EMS. See facility estimated travel time charts (to be completed).

Once the Disaster Struck Facility’s Liaison Officer and EMS along with Hospital Control establish communications, the following occurs.

Transportation of Patients: The Disaster Struck Facility’s Transportation Officer is responsible for coordination with the local EMS Medical Transportation Officer. Hospital Control informs the individual healthcare facilities of the expected patient volume and that their minimum agreed upon patient count is being transported from the Disaster Struck Facility. The Healthcare facility’s Transportation Officer in consultation with Operations Section Chief and Planning Section Chief must assemble the following information (see Page 4.8 for the Charge Nurse criteria for Categorization of Patients for transport):

- a. Patient Pick-up Point
- b. Total requiring Critical Care Transport (i.e. Ventilator, NICU)
- c. Total requiring Isolation for Infectious Disease
- d. Total requiring bariatric transport (Non-ambulatory and >400lbs.)
- e. Total requiring ALS Transport
- f. Total requiring BLS Transport
- g. Total Wheelchair Van/Bus Patients - Transfer to another healthcare facility (Note if alternate level of care is possible and which level required – i.e. Skilled Nursing)
- h. Total for Standard Ground Transport – Transfer to another healthcare facility (Note if alternate level of care is possible and which level required – i.e. Skilled Nursing)
- i. Discharge to Home:
 - c. Total Wheelchair Van/Bus Patients
 - d. Total for Standard Ground Transport

The point of entry for patient drop-off is designated by the Patient Accepting Facility. Once admitted, that patient is under the care of the Patient Accepting Facility’s admitting physician until discharged, transferred, or reassigned. The Disaster Struck Facility is responsible for transferring (of) extraordinary drugs or other special patient needs (i.e. equipment, blood products) along with the patient, if possible.

Tracking and Transfer Forms: Refers to Section 7 of this plan for the appropriate forms. If the facility, due to the emergent nature of the event, has no ability to use the plan’s tracking forms and/or transport med records, the standard MCI management system by EMS is relied on until the Patient Evacuation Tracking Form was recovered and available for use. At minimum, the *Patient, Medical Record & Equipment Tracking Sheet* MUST be utilized.

Special Transportation Concerns (insufficient information at this time without hospital surge capacity capabilities):

In addition to the special patient population and acuity concerns due to the evacuation of larger facilities with large Intensive Care Units, such as Harborview, there are several other facilities that pose unique challenges to a single facility or regional evacuation:

- NAVOS (formerly West Seattle Psych), Fairfax, Children's, Harborview and Northwest: Buses along with a potential police presence (depending on voluntary or involuntary) are required to manage an evacuation from these facilities. Additionally, evacuation from these facilities may require the movement of Adult and Pediatric patients in involuntary lockdown to be taken outside of King County to Pierce County with Western State Hospital being the largest receiving institution and additional peds support from Mary Bridge Seattle Children's (MOUs will be established to support activation of this plan.)
- Seattle Children's : Due to the pediatric and neonate population, this creates a stress on patient care that King County may not be able to accommodate and evacuation outside of the region may be automatic for a percentage of the population. Additionally, transport challenges hinder the rapid movement of the NICU population.
- Harborview: Outside of the fact that Harborview is the only Level 1 Trauma Center in the state, there are a few groupings of patient population that would be exceptionally difficult to manage in the King County. Some areas of note:
 - Burn Patients – If burn patients were unable to leave the region due to the disaster or acuity, clinical burn teams from Harborview should move to other healthcare facilities to manage the care of these patients. It would enhance the overall process if the patient could be clustered in larger groups to minimize the impact on the staff and patient care. Additionally, teams from other states may be requested to provide short term support due to the potential for dispersing patients over a broad geographic area.
 - Adult ICU – The sheer volume and level of acuity will overwhelm regional capacity. Again, team and equipment deployment from Harborview will assist in short term management of the evacuation.
- Kindred Hospital and Regional Hospital: Due to the sheer magnitude of ventilator dependent patients and the long-term acute needs, these patients may force the activation of adjacent regions to support patient placement needs.
- Evergreen, UW and Swedish: ICU and NICU combined cause a regional ripple effect and could force out of region movement or staffing/equipment from these institutions to support surge capacity in other healthcare institutions.
- Transplant Patients: Due to unique patient needs, there may only be a set number and type of facilities in the state that could handle these patients. It is anticipated that members of the transplant team are traveling with the patients as necessary.

In addition to the patient transfer, special transportation may be needed for **transportation of equipment and staff** (See Section 8 of the Plan.)

NOTES:

1. Patient pickup points should be part of each facility's internal plan.
2. Advise EMS of any vehicles your hospital may have or private contracts for other transportation vehicles to help move patients, staff and equipment. A Staging Officer (from EMS, Fire, or other agency) provides support for the staging of these vehicles upon their arrival.
3. For planning movement of patients, support EMS and Hospital Control by preparing batches of patients (5-15) to support the EMS Strike Teams which are comprised of 5 ambulances and a focus on batch movement of patients.

Prioritization of Risk: When multiple healthcare institutions are overwhelmed, the Health & Medical Area Command (HM Area Command) works with the Seattle EOC and King County ECC to prioritize non-medical resources that are allocated to each Member hospital. Member hospitals need to internally prioritize risk to ensure the proper information is being provided to the HM Area Command.

Information included on WATrac, for planning purposes, provides EMS and Public Health Seattle & King County with additional planning information for the facility-specific acuity levels and special care requirements. Each Member hospital is providing the total number of patients that could be inpatients at the hospital at full occupancy and the special categories of the patients (see Section 4 – Patient Placement.) This dictates for EMS and other Member Hospitals the impact that each facility has on the patient bed capacity of King County.

Member Hospitals Internal Patient Prioritization: For internal full building evacuation plans, Member Hospitals should review how many patients can be moved per hour down the stairs in the event the elevators are non-operational. This assists EMS in knowing the patient volume they need to move over periods of time. Estimates should also be taken for standard patient movement using elevators and stairs for evacuation purposes.

- NOTE: This is a recommended approach and not mandated by the MOU.

Traffic Control: The Department of Transportation, State Patrol and the local police departments for the areas impacted are responsible for traffic control.

Other Forms of Transportation to supplement and expand upon EMS capabilities:

- AirLift Northwest and other helicopter transport firms: The primary utilization is for higher acuity patients, but the needs and prioritization of patient movement ultimately rests with the HM Area Command.
- Private/Public Wheelchair Accessible Buses and Wheelchair Cars/Vans: Move moderate to low acuity patients to other healthcare facilities, alternate care facilities or medical shelters.
- Private/Public Non-wheelchair Accessible Buses: Move ambulatory patients with minimal needs for care (including the outpatient population who have no ability to return to their homes) to other healthcare facilities, alternate care facilities, medical shelters or Red Cross shelters.
- NDMS/FEMA Transportation: This may include ambulance contracts, air transport or other means of patient movement and will only be activated upon a Federal Disaster Declaration.

- Air Evacuation Patient Tracking Section: Madigan Army Medical Center resources with the following capabilities (*NOTE: The military will determine the resources that will be provided and this only provides samples capabilities*):
 - C-9A/C Nightingale: 40 litter patients or four litters and 40 ambulatory patients or other combinations
 - C-17 Globemaster III: 48 litter patients and 54 ambulatory patients and attendants
 - C-141B Starlifter: 103 litters and 14 ambulatory patients and attendants
- Long Term Care Facilities: Many have vehicles that could help transfer patients, supplies or equipment from the Disaster Struck Facility to the Patient Accepting Facility.

The coordination of non-medical transportation should be a collaborative effort between the Member Hospital, the local EOCs, King County ECC and with support from the HM Area Command.

SEE ATTACHMENT C FOR LISTINGS OF HOSPITAL TRANSPORTATION VEHICLES AND MUTUAL AID PLAN MEMORANDUMS OF UNDERSTANDING WITH OTHER TRANSPORTATION FIRMS.

SECTION 7:

MEDICAL RECORDS & MEDICATIONS (going with patient)

PATIENT IDENTIFICATION AND TRACKING

MEDICAL RECORDS:

As patients leave the Disaster Struck Facility, the following items must accompany them:

- The *Patient Evacuation Tracking Form*, containing pertinent medical information for a quick review of the patient. This should be pinned to the patients' clothing (on their back or other area where this cannot come free)
 - **Review internally if there are better ways to attach this to the patient (i.e. clear lanyards around patients neck)**
- Patient Medical Record/Chart including the Medication Administration Record (MAR.)
 - All records are returned to the original facility (noting plan exceptions in the MOU).
 - Slow Evacuation – attempt to ensure the following information accompanies the patient from key areas of the chart (plus other facility specific information):
 - Face Sheet
 - All dictations
 - Labs for last 48 hours
 - Last EKG
 - Medication Sheets / MAR
 - H&P and consultation notes & all operative and procedure notes / Physician Orders
 - Emergency Department notes when applicable
 - Progress Notes
 - Radiology Reports (radiology studies on CD, if possible)
 - Problem History – family/social
 - Insurance Information (name / policy #)
 - Fast Evacuation – Take the entire chart if able or attempt to get all of the above with a minimum of the Face Sheet, MAR and Physician Orders
- *Patient / Medical Record & Equipment Tracking Sheet* (may follow a group of patients.)

NOTE 1: As nurses and physicians from the Disaster Struck Facility go to various Patient Accepting Facilities to resume care of their patients, it is recommended they bring the charts, if not already done, and controlled substances (if requested by the Patient Accepting Facility) needed to care for these patients.

NOTE 2: There are two options with regards to the charts for patients. When the Patient Record/Chart arrives with the patient, a review is conducted of the records along with an assessment of the patient and the facility begins documents in the following manner:

- **RECOMMENDED APPROACH:** Start a new chart for each newly accepted patient, clearly noting the time in the existing chart to delineate where the documentation ended.
 - If using the existing chart due to immediate need to care for the patient, clearly delineate when and where the Patient Accepting Facility began documenting in the chart.*

** The Patient Accepting Facility begins a new chart for the patient as soon as possible.*

NOTE 3: Many facilities are moving towards or have achieved electronic medical records. If electronic medical records are currently in place, it is critical that a strong effort be made to provide a clear and concise Patient Evacuation Tracking Form in the event that access to the computers are limited. Focus issues for consideration are:

- Can the electronic medical record be accessed from an off-site location and be printed out from that location? If yes, the facility's internal full building evacuation plan should address the steps necessary to secure access. Usually, this is accessed via a physician portal or other IT means with the Disaster Struck Facility granting access to the receiving facility.
- Is there independent emergency generator back-up to run the server(s), computer(s) and printer(s) that provide the facility the ability to print out the records?
- Can batch printing be completed by the facility either at one central location or to the floor in the event the floor does not have printing capability at the time or the floor is overwhelmed with the patient care needs to secure enough time to print out each record?

MEDICATIONS:

When sending patient-specific medications, package them along with their other personal affects, label with their name and Medical Administrative Number before sending with the patients (as they are transferred.)

Necessary **medications** are sent with the evacuated patient, if possible.

1. It is the discretion of the Patient Accepting Facilities to continue to use these meds or order their own. It is recommended that medications be placed in water resistant, tamper evident containers/bags.
2. Patients arriving with Physician Orders (MAR should accompany the patient) are filled by the Patient Accepting Facility, if necessary, until a physician with privileges at the Patient Accepting Facility is present and can write a new order.

If a **controlled substance** must go with the patient and the Patient Accepting Facility has limited pharmaceutical resources due to the disaster (controlled substances must be either locked or directly monitored during transport):

1. (Phase I evacuation): A licensed HCP may go with the patient and be responsible for the controlled substance.

OR

2. (Phase II - IV evacuation) The Patient Accepting Facility requests emergency support from pharmaceutical suppliers within the region and their regional or national supply chain. If unable to secure the medications from suppliers, the Patient Accepting Facility requests any state caches available for emergency distribution.

OR

3. (Phase II & III evacuation) A licensed HCP may bring the medications to the Patient Accepting Facility during or immediately post disaster. If large volumes of medications are necessary, the Disaster Struck Facility may provide larger quantity shipment to the Patient Accepting Facility.
 - a. If civil unrest is taking place or there is potential, consideration should be given for a security or law enforcement personnel presence for transfer of controlled substances

In any situation where the controlled substances are transferred from one healthcare facility to another, there should be clear and concise documentation of the transfer by a licensed nurse or a pharmacist. A DEA Form 222 should be used where applicable and the *Controlled Substance Transfer Form* should be utilized to support this process of transferring medications from facility to facility within King County. The process includes the following:

- form completed by licensed health care practitioner (this verifies a count done by sending and receiving facilities)
- name of patient, if applicable (*unless a facility to facility transfer*)
- name of medication, strength, amount (solid dose units)
- amount administered during transport
- medication received at new location, accounted for and documented

- place the transfer medication form and the prescription medications into a tamper-evident (preferably water resistant) container/bag
- If an EMT from a transport vehicle is involved in security of controlled substances: A nurse from the sending facility and an EMT from the transport vehicle must count the controlled substance and sign-off in duplicate. A copy of this sign-off sheet must accompany the EMT. When arriving at the Patient Accepting Facility the EMT and a nurse from the Patient Accepting Facility must confirm the count and again sign off. This sheet then becomes part of the patient's chart.

Experimental Medications (to be reviewed by the State Board of Pharmacy): Investigational New Drugs (IND) and Research Protocol/Experimental Medications will receive a waiver from the Institutional Review Board to allow an experimental protocol to continue therapy to protect the life of a patient at risk and protect their welfare. Competent staff must be present to administer and assess the patient for effects and side effects.

NOTES:

1. Only unopened vials or solid-dose medications can be transferred. Partially used vials of controlled substances are not to be transferred.
2. The evacuation process already includes the MAR and transferal of the patient record/chart, thus completing the second phase of required documentation. If the patient is returned to the Disaster Struck Facility following the event, this information should be returned with the patient.

PATIENT IDENTIFICATION AND TRACKING (see the next page)

All patients must have wrist bands (or some other form of identification). It is recommended that the following information should be contained on the wrist band:

- Name
- DoB (or MR# if necessary)
- Code status (if a hospital currently has this on the wrist band or if it is in the current facility protocol to put a colored code status wrist band, then please use this)

Patient Accepting Facilities **continue tracking** of incoming patients and the location of their original charts. They keep the Disaster Struck Facility advised by contacting them to confirm the patients' arrival.

TRACKING SHEETS

- A. The following form (*Patient/Medical Record & Equipment Tracking Sheet*) is intended to track patients, their medical records and equipment as the patients leave the Disaster Struck Facility. A facility may deem to replace this with an internal form that enables appropriate tracking, but similar fields should be used to capture aggregate patient data for anticipated transportation locations.

A sheet should be filled out for each facility that is receiving one or more of your patients. If a number of patients are all being sent to the same facility, these patients can all be listed on one Tracking Sheet. Additionally, if multiple patients are being discharged, several sheets could be used for “discharge to home” and note the vehicle they left in if possible to minimize the risk to the Member Hospital. The top sheet/copy of the tracking sheet is kept by the Disaster Struck Facility as a record of where the patients have been sent.

It is important that the Patient Accepting Facilities continue this tracking process. As evacuated patients arrive at the Patient Accepting Facility, the facility should make enough copies of this tracking sheet so that one copy can be placed with each patient’s chart. This information should remain with the patient and their medical records. The Patient Accepting Facility should confirm the arrival of the patients with the Disaster Struck Facility or, if unable to communicate with the Disaster Struck Facility, the Regional Call Center (if active) should be communicated with. If the Regional Call Center is not active, communication should take place with the HM Area Command.

When a new medical record number is assigned (due to a new patient medical record/chart being started) to the patient, this should be noted on the Tracking Sheet.

- Patient Accepting Facility should “flag” these charts either physically or electronically to aid in tracking/documenting patients cared for during an evacuation.

The chart must be “safely kept” for return to the Disaster Struck Facility at the appropriate time.

- B. The *Patient Evacuation Tracking Form* supplies critical information on the patient to enable care to start for the evacuated patient until the “chart” can be reviewed. It should be pinned to the patients’ clothing, on their back or other location where it cannot be lost. These forms should also be used on a day to day basis for the transfer of patients between healthcare facilities. Copies of this form are:
- Copy 4: Retained by the Disaster Struck Facility
 - Copy 3: Retained by the Alternate Care Facility (if activated)
 - Copy 2: Retained by the Patient Accepting Facility
 - Copy 1: Sent back to the Disaster Struck Facility, Regional Call Center or HM Area Command
- C. The *Controlled Substance Transfer Form* must be completed by a licensed HCP and be utilized for larger volume movement of pharmaceuticals – facility to facility.

Patient Transported From: _____
 Date: _____
 Patient Transported To: _____

Print Name of Person From Sending Facility Filling Out Form / Phone #: _____

* Each Receiving Facility will need it's own Tracking Sheet (use sheets for DISCHARGED TO HOME as well)

PATIENT / MEDICAL RECORD & EQUIPMENT TRACKING SHEET

Patient MR #	Date of Birth	Patient Name	Sex	Time & Date left unit	Time Arrived Holding / Time Left Building	Name, Vehicle # & Type of Transport	Original Chart Sent w/ Patient (Y) (N)	Meds & MAR Sent w/ Patient (Y) (N)	Equipment Sent	Family Notified: Name, Date & Time, Phone Number w/ Area Code		PMD Notified Name, Phone Number, Date & Time		Time Arrived - Alternate Care Facility/ Time Left	Time/ Date Arrived at Patient Accepting Facility
										Y	N	Y	N		
					A									A	
					L									L	
					A									A	
					L									L	
					A									A	
					L									L	
					A									A	
					L									L	
					A									A	
					L									L	
					A									A	
					L									L	
					A									A	
					L									L	

DISASTER STRUCK FACILITIES KEEP TOP SHEET (COPY).
PATIENT ACCEPTING FACILITIES MUST ALSO TRACK PATIENT, CHARTS & EQUIPMENT.
HAVE YOU ADVISED FACILITY THAT YOU HAVE RECEIVED PATIENT? YES _____ NO _____
Print Name of Person at Receiving Facility & Phone #: _____

Copy 1 – Disaster Struck Facility
 Copy 2 – Transporter
 Copy 3 – Patient Accepting Facility

PATIENT EVACUATION TRACKING FORM – ACUTE CARE

--

(Ascending Patient Tracking #)

**Place PATIENT Sticker Here
(on all 4 copies)**

Place FACILITY Sticker Here (on all 4 copies) or write in:
Facility Name / Phone # / Fax #
 _____ / _____ / _____

SENDING FACILITY - *Attach Face Sheet, if possible

PATIENT INFORMATION Completed prior to patient movement from the Unit (or Holding Area) -

Patient Name:	DOB: / /	Sex: M F	Weight:
Attending Physician:	MR #:	Room / Bed # :	
Family Member Notification: Y N	Interpreter: Y N	Language: _____	
Family Contact/Time/Phone #:			
Significant Dx/Major Problems:			Isolation Type: _____

Allergies:

RECOMMENDED TRANSPORT – Activity / Level of Assist:

Ambulance (Critical Care)
 Ambulance (ALS)
 Ambulance (BLS)
 Wheelchair Car/Bus
 Non-Medical

Patient ID Band or Nametag Confirmed?
 Yes
 No
 N/A

Time:	HR	BP:	RR:	O ₂ Sat:	Temp:	Pain:
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Code Status: Full Code / No Code:
 DNR
 DNI
Advance Directives: Is the Documentation Present? Y N

Safety: Fall risk? Y N
 Aspiration Precautions? Y N
 Seizure Precautions? Y N

IV Therapy / Tubes / Drains:

Resp: O₂ Therapy: _____ Suction – freq, type of secretions: _____
 Chest tubes: _____

GI: Diet: _____ Feeding precautions: _____
 Tube feeding – type, rate, acceptable residual: _____ Fdg Tube cm @ nares: _____

GU: Foley: _____

Skin / Wound Care / Incisions:

Transfers – how much assistance required? Devices?

Mental Status:
 Mentation: _____ Pupils: _____
 GCS:
 Eye opening: _____ Best Verbal: _____ Best Motor: _____ Precautions: _____

Behavior Concerns: None
 Wanders
 Danger to Self
 Danger to Others

Restraints: Type _____ How Long _____

Patient Belongings: (eg. glasses, hearing aid, etc.)

Additional Notes:

ESSENTIAL MEDICATIONS

See Attached MAR
 If no attached MAR include: Medication, Dose, Route and LAST DOSAGE

Diabetic: Y N	Last Insulin:	Last Meal:
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This Portion of Form Completed by (Printed Name / Signature):

PATIENT EVACUATION TRACKING FORM – ACUTE CARE

(Ascending Patient Tracking #)

HOLDING AREA - To be completed upon arrival and departure from

Patient Name: _____

Holding Area Location: _____ Time Arrived at Holding Area: _____ Received by (Name): _____

Time Departed Holding: _____ Destination Facility: _____ Vehicle ID (Name, Unit, etc.): _____

Patient ID Band or Nametag Confirmed? Yes No N/A

Accompanied by (facility staff person name/family member name): _____

Physician Notification: Y N **Physician Name/Time/Phone #:** _____

Time:	HR	BP:	RR:	O₂ Sat:	Temp:	Pain:
--------------	-----------	------------	------------	---------------------------	--------------	--------------

Neuro:	Mentation:	Pupils:
---------------	------------	---------

GCS:	Eye opening:	Best Verbal:	Best Motor:	Precautions:
-------------	--------------	--------------	-------------	--------------

Mental Status: Alert Lethargic Oriented Mildly Confused Severely Confused

Diabetic: Y N **Last Insulin:** _____ **Last Meal:** _____

Accompanying Equipment: (e.g. vent, bed, etc.) _____

Items Sent With Patient: Medical Record (Chart, MAR, etc.) Patient Belongings Medications

Additional Notes:

This Portion of Form Completed by (Printed Name / Signature): _____

ALTERNATE CARE FACILITY (ACF) – To be completed at time of arrival

Time / Date Arrived: _____ Facility Name: _____ Initial Care Location: _____

Time Departed ACF: _____ Destination Facility: _____ Vehicle ID (Name, Unit, etc.): _____

Patient ID Band or Nametag Confirmed? Yes No N/A

Accompanied by (facility staff person name/family member name): _____

Time:	HR	BP:	RR:	O₂ Sat:	Temp:	Pain:
--------------	-----------	------------	------------	---------------------------	--------------	--------------

Neuro:	Mentation:	Pupils:
---------------	------------	---------

GCS:	Eye opening:	Best Verbal:	Best Motor:	Precautions:
-------------	--------------	--------------	-------------	--------------

Mental Status: Alert Lethargic Oriented Mildly Confused Severely Confused

Additional Notes:

This Portion of Form Completed by (Printed Name / Signature / Phone #): _____

RECEIVING FACILITY - To be completed at time of arrival (N/A for Patients being Discharged)

Time / Date Arrived: _____ Facility Name: _____ Initial Care Location: _____

(Reception Area, ICU, etc.)

Patient ID Band or Nametag Confirmed?

Yes No N/A

Confirmed Receipt of Patient?

To Sending Facility OR To Regional Call Center

This Portion of Form Completed by (Printed Name / Signature / Phone #): _____

Copy 1 – 1) Return to Sending Facility / 2) If active, Regional Call Center / 3) Health & Medical Area Command (if other areas are not operational)

Copy 2 – To be retained by Receiving Facility
Copy 3 – To be retained by ACF / Stop-Over Site
Copy 4 – To be retained by Sending Facility

COPY 1

PATIENT EVACUATION TRACKING FORM – ICU / CRITICAL CARE

(Ascending Patient Tracking #)

**Place PATIENT Sticker Here
(on all 4 copies)**

Place FACILITY Sticker Here (on all 4 copies) or write in:
Facility Name / Phone # / Fax #
 _____ / _____ / _____

SENDING FACILITY - *Attach Face Sheet, if possible

PATIENT INFORMATION Completed prior to patient movement from the Unit (or Holding Area) -

Patient Name: _____ **DOB:** ____ / ____ / ____ **Sex:** M F **Weight:** _____
Attending Physician: _____ **MR #:** _____ **Room / Bed # :** _____
Family Member Notification: Y N **Interpreter:** Y N **Language:** _____
Family Contact/Time/Phone #: _____
Significant Dx/Major Problems: _____ **Isolation Type:** _____

Allergies: _____

RECOMMENDED TRANSPORT – Activity / Level of Assist: _____
 Ambulance (Critical Care) Ambulance (ALS) Ambulance (BLS) Wheelchair Car/Bus Non-Medical

Patient ID Band or Nametag Confirmed? Yes No N/A

Time: _____ **HR** _____ **BP:** _____ **RR:** _____ **O₂ Sat:** _____ **Temp:** _____ **Pain:** _____

Code Status: Full Code / No Code: DNR DNI **Advance Directives:** Is the Documentation Present? Y N

Cardiovascular: Cardiac Rhythm: _____
Medication Drips: Type / rate / site: _____ Type / rate / site: _____
 Type / rate / site: _____ Type / rate / site: _____
 Precautions / Considerations (e.g. Meds that cannot be discontinued)
 Other Invasive Lines / Tubes / Drains

Respiratory: Ventilator Settings - O₂: _____ Rate: _____ PEEP: _____ Volume: _____ ETT@teeth: _____
 O₂: Mask / Cannula – Flow: _____ Aspiration Precautions / Swallowing Eval
 Suction: frequency, type of secretions Chest Tube / level of sx

Neuro: Mentation: _____ Pupils: _____

GCS: Eye opening: _____ Best Verbal: _____ Best Motor: _____ Precautions: _____

Restraint: Type: _____ How Long? _____

GI / GU: _____

Diet: _____ **Tube feeding:** type / rate / acceptable residual: _____

Skin / Wound Care / Incisions: _____

Additional Notes (including pertinent labs, etc.):

ESSENTIAL MEDICATIONS

See Attached MAR **Include medication, schedule, and LAST DOSE GIVEN!**

Diabetic: Y N Last Insulin: _____ Last Meal: _____ Other: _____

This Portion of Form Completed by (Printed Name / Signature):

SECTION 8: STAFF, PHARMACEUTICAL, SUPPLIES & EQUIPMENT (In Need Of and Transportation of)

To enable a Patient Accepting Facilities to care for patients, extra **staff, pharmaceuticals, supplies and equipment** may be necessary.

Staff, pharmaceuticals, supplies and equipment may be needed by:

- a Disaster Struck Facility that is not evacuating but is overtaxed by the disaster and in need of emergency support
- a Patient Accepting Facility that needs additional resources
- an Alternate Care Facility to which a Disaster Struck Facility has evacuated.

A Patient Accepting Facility should be cautious about requesting staff, pharmaceuticals, supplies and equipment from a Disaster Struck Facility. While it is their responsibility to provide these resources and it is the intent of the Disaster Struck Facility to attempt to move staff to the Patient Accepting Facility to support their own patient population, the severity of their situation may prohibit this from taking place in the early phases of a disaster.

- It is important for hospitals to provide realistic orders to suppliers. In certain disasters, hospitals order a complete duplicate of their previous order and there are many supplies or pharmaceuticals that they do not need at that time. The ripple effect is that a vendor may fill an order for a hospital when another medical institution had greater needs at that time but they were unable to fill additional regional orders due to the overwhelming requests. Working together is a key to success and integration through Health & Medical Area Command will assist with the prioritization of resources as well.

Hospital Actions: In Phase I and Phase II of an evacuation, the Patient Accepting Facility opens existing staffed beds or areas. However, in Phase III (if necessary), overflow areas are utilized and staff, supplies and equipment to care for patients are necessary to support patient care. Providing staff, pharmaceuticals, supplies and equipment is the responsibility of the Disaster Struck Facility, if possible. It is assumed that Patient Accepting Facilities and other non-affected facilities help as necessary through staff call-back lists, lending of supplies and working together to ensure vendors are informed of the situation to provided support to the Patient Accepting Facilities. In Phase V, the evacuated hospitals are providing resources to the Alternate Care Facilities if these facilities are forced into activation.

WATrac (formerly KCHHealthTrac): It is the intent for the hospitals to utilize WATrac for an up-to-date listing/inventory of available staff, supplies and equipment to support other King County hospitals. It is the responsibility of the hospitals to update their inventory listings based on request or on an as needed basis and print a hard copy of information on an annual basis to ensure that the paper copy of information from WATrac is available in the event of a systems failure during a disaster.

NOTES:

1. When requesting staff, pharmaceuticals, supplies or equipment, it is recommended that you fax your written request to the Lender. This can be used at police road blocks as these resources are being sent to your hospital. Appropriate communication with the Local Emergency Operations Center (EOC) or Health & Medical Area Command should be completed to ensure they can inform the appropriate authorities of the resource/assets that should be allowed to access the hospital (*NOTE: Access may still be denied by authorities.*)
2. All medical needs should be coordinated through the Health & Medical Area Command (HM Area Command) and all non-medical needs should be coordinated through the Local Emergency Operations Center (EOC) or King County ECC.
3. It is in the best interests of the Disaster Struck Facility to have a representative in the Local EOC for coordination purposes.

Special Transportation and Supply Considerations for Vendors and

Town/City/County/State Agencies: There are three primary concerns in dealing with disaster transportation of supplies to Member Hospitals:

1. Elevated requests that overwhelm the inventory of the suppliers
2. Inability to communicate with the Member Hospital and distribution of pharmaceuticals, supplies or equipment without verification of the safe accessibility to the Member Hospital
3. Limited access to the Member Hospital due to the scope of the disaster.

Vendor Transportation Prioritization: In most situations, the vendor is able to meet the requests of the Member Hospitals and distribute supplies to their site (Elevated Requests – Minimal Impact.) When the requests are Elevated and the impact is High, the HM Area Command is the conduit for the vendor to support prioritization for pharmaceuticals, supplies and equipment. This by no means takes the control away from the Member Hospital, this approach helps to ensure that the Member Hospital is internally prioritizing their needs and working with the HM Area Command, with the exception being when the facility is faced with immediate threat to life and this is automatically escalated to the highest level of priority for the HM Area Command.

While Traffic Control is handled by the Department of Transportation, State Patrol and the local police departments for the areas impacted, appropriate coordination with Emergency Management within the appropriate EOC is of the utmost importance during a disaster that impacts the transportation capacity of the region.

The vendors and Town or City EOC and King County ECC must coordinate in order to ensure safe access to the Member Hospitals and coordinate with HM Area Command to verify if the risk to enter an area is too great based on where the facility is prioritized at that time.

Consolidated Distribution Point: It is recommended that Emergency Management from King County provide the vendors several points of distribution for Member Hospital pharmaceuticals, supplies and equipment. The locations should be determined based on the Seattle Fault Scenarios and be preplanned with resources necessary from the vendor to distribute the product. This is outlined on an area chart with locations under review (*Supply/ Pharmaceutical Staging Locations – See Page 8.9.*)

STAFF ASSISTANCE

1. Communication of request: The request for staff help initially can be made verbally. The request, however, must be followed up with written documentation. This should ideally occur prior to the arrival of personnel at the recipient facility.

It is recommended that hospitals prepare to create and deploy integrated clinical and non-clinical teams or specialty teams. These would either be on-call staff responding to the hospital for deployment or on-duty teams where staff call-backs are initiated and once the responding staff arrives, the hospital is able to deploy the on-duty teams. Requesting hospitals should be specific with the resources they request to properly utilize responding staff.

- Examples of teams include:
 - Cardiac Surgical Team (9 personnel):
 - 2 Surgeons
 - 2 Scrub Technicians/Nurses
 - 1 Circulating Nurse
 - 1 Perfusionist
 - 1 Anesthesiologist
 - 2 OR Aides/Support Staff/Turnover Techs
 - Ancillary and Support Services Team (depending on requested support):
 - 2 Environmental Services Staff
 - 2 Facilities/Maintenance Staff (depending on expertise requested)
 - 1-2 Security Staff
 - 1 Clinical Engineer or Biomedical Technician
 - 1 Pharmacists
 - 1 Laboratory Technician
 - 1 Radiologist
 - 1 Radiology Technician

Staff should not be requested from a facility in an active disaster. If the Lenders staff is at your facility when their facility goes into disaster activation, they must be allowed to return at once, if requested.

2. Documentation/Credentials: The arriving personnel are required to present their facility identification badge at the Borrowers facility upon arrival. The Borrower is responsible for the following:
 - a. Meeting the arriving personnel from a Lender facility
 - b. Confirming the personnel's ID badge with the list of personnel provided by the Lender facility
 - c. Providing additional identification, such as "visiting personnel" badge, per facility policy, to the arriving personnel.

The Borrower accepts the professional credentialing determination of the Lender facility but only for those services for which the personnel are credentialed for and have privileges to provide at the Lender facility and only if those privileges do not contradict with privileges provided for similar positions in the Borrower hospital.

3. Supervision: The Borrower's senior administrator or designee (Medical Care Branch Director, Casualty Care Unit Leader, Labor Pool & Credentialing Unit Leader) identifies where and to whom the donated personnel are to report, and professional staff of the Borrower's facility who supervise them.
4. Demobilization Procedures: The Borrower provides and coordinates any necessary demobilization procedures and post-event stress debriefing. The Borrower is responsible for providing the personnel transportation necessary for their return to the Lender facility and all documentation of hours worked while on-site.

DISASTER CREDENTIALING AND PRIVILEGING

As a facility evacuates, it is likely that clinicians from one facility will be working at different hospitals, throughout the duration of the disaster, as they help to care for their patients at the Patient Accepting Facilities.

This situation may also occur if physicians, nurses and other care providers from around the community and surrounding communities volunteer their time during a disaster.

Each member hospital should have an internal procedure for credentialing of emergency providers/volunteers and granting of temporary privileges in a disaster. These internal procedures should follow the base requirements from The Joint Commission. In order to activate these internal procedures, the facility's Emergency Operations Plan has been activated the facility (Incident Commander / Administrator-on-call, in consultation with Medical Director or designee) determines that it is unable to handle the immediate patient needs with their existing staff.

PHARMACEUTICALS, SUPPLIES & EQUIPMENT

I. SUPPLIES AND EQUIPMENT

1. Communication of request: The request for supplies and equipment from a vendor or for the transfer of supplies or equipment from another member facility initially can be made verbally. The request, however, must be followed up with written documentation. This should ideally occur prior to the receipt of any material resources at the Borrower's facility. The Borrower identifies to the vendor or Lender the following:
 - a. The quantity and exact type of requested items
 - b. Time estimate of when supplies/equipment is needed on-site
 - c. Time period for which the supplies/equipment are needed
 - d. Location to which the supplies/equipment should be delivered

The vendor or Lender identify how long it will take them to fulfill the request. Since response time is a central component during a disaster response, decision and implementation should occur quickly.

2. Documentation: The Borrower honors the vendor or Lender facility's standard order requisition form as documentation of the request and receipt of the materials. The Borrower's designee confirms the receipt of the material resources. The documentation details the following:
 - a. The items involved
 - b. The condition of the equipment prior to the loan (if applicable)
 - c. The responsible parties for the borrowed material.

The Vendor or Lender is responsible for tracking the borrowed inventory through their standard requisition forms. Upon the return of the equipment, the original invoice is co-signed by the senior administrator or designee of the Borrower, recording the condition of the borrowed equipment.

3. Transporting of supplies or equipment: The Borrower is responsible for coordinating the transportation of materials both to and from the Vendor or Lender through their local EOC, King County ECC or the Health and Medical Area Command (HM Area Command) if unable to receive support from the other groups. This coordination may involve government and/or private organizations and the vendor or Lender may also offer transport. The Borrower must return and pay the transportation fees for returning or replacing all borrowed materials.

4. Safety (equipment): The Lender is responsible to verify the operational status and preventative maintenance for all equipment being transported to the Borrower. All reporting requirements, policies, procedures and documentation following receipt of the equipment (i.e. Safe Medical Devices Act) is the responsibility of the Borrower.
5. Supervision: The Borrower is responsible to ensure appropriate staff competency for use and maintenance of all borrowed supplies and equipment.
6. Demobilization procedures: The Borrower is responsible for the rehabilitation and prompt return of the borrowed equipment to the vendor or Lender. To facilitate this, all facility equipment should be properly marked with identification.

II. PHARMACEUTICALS

Pharmaceuticals: Pharmaceuticals follow the same process as supplies and equipment with the exceptions seen in **Section 7**.

- For a Disaster Struck Facility that is not evacuating but is overtaxed by the disaster and in need of emergency support (the HM Area Command assists with this coordination):
 - The Disaster Struck Facility requests emergency support from pharmaceutical suppliers within the region and their regional or national supply chain
 - If response is inadequate to meet the facilities needs, the Disaster Struck Facility requests emergency support from other area pharmacies
 - If response is inadequate to meet the facilities needs, the Disaster Struck Facility requests emergency support from any state pharmaceutical caches through the State EOC
 - If response is inadequate to meet the facilities needs, the Disaster Struck Facility requests emergency support from other area hospitals. Depending on the severity of the incident, police and security measures should be taken into account to safeguard medications.
- For a Patient Accepting Facility that is in need of emergency support:
 - The Patient Accepting Facility requests emergency support from pharmaceutical suppliers within the region and their regional or national supply chain
 - If response is inadequate to meet the facilities needs, the Patient Accepting Facility requests emergency support from other area pharmacies
 - If response is inadequate to meet the facilities needs, the Patient Accepting Facility requests emergency support from any state pharmaceutical caches through the State EOC

- If response is inadequate to meet the facilities needs, the Patient Accepting Facility requests emergency support from other area hospitals. Depending on the severity of the incident, police and security measures should be taken into account to safeguard medications.
 - Note that it is expected patient medications will arrive with the evacuated patient and this is primarily referencing controlled substances.

**Supply / Pharmaceutical Staging Locations (BEING REVIEWED BY KC OEM,
Washington National Guard, City/Town OEM and selected facilities)**

Group 1: UW

Seattle Children's
University of Washington Medical Center

Group 2: UW with Backup as Ballard High School

Kindred Hospital Seattle
Northwest Hospital
Swedish - Ballard

Group 3: Seattle U

Group Health Cooperative - Central Campus
Harborview Medical Center (HC)
Swedish - Cherry Hill
Swedish - First Hill
Veterans Administration Hospital
Virginia Mason Medical Center

Group 4: Seattle Joint Training Facility

Highline Medical Center
Navos (formerly West Seattle Psychiatric)
Regional Hospital for Respiratory & Complex Care
St. Francis Hospital

Group 5: TBD

Auburn Regional Medical Center
Valley Medical Center

**Group 6: Bellevue Fire Training Facility or Costco or City Church -
Redmond**

Evergreen Healthcare
Fairfax Hospital
Overlake Hospital Medical Center (alternate HC)
Snoqualmie Valley Hospital
*Swedish - Issaquah

**Undefined Group – Determined that standard supply channels will support
the hospital**

Enumclaw Community Hospital

HC = Hospital Control (a back-up to Overlake is strongly recommended)

* = Emergency Department Capabilities – no patient beds

** = Can accept a Chinook helicopter landing (CH-47 or comparable)

ATTACHMENT A: PLAN MEMBERS

Auburn

Auburn Regional Medical Center

Burien

Highline Medical Center

Bellevue

Overlake Hospital Medical Center (alternate HC)

Enumclaw

Enumclaw Community Hospital

Federal Way

St. Francis Hospital

Issaquah

*Swedish - Issaquah

Kirkland

Evergreen Healthcare

Fairfax Hospital

Renton

Valley Medical Center

Seattle

Seattle Children's

Group Health Cooperative - Central Campus

Harborview Medical Center (HC)

Kindred Hospital Seattle

Northwest Hospital

Regional Hospital for Respiratory & Complex Care

Swedish - Ballard

Swedish - Cherry Hill

Swedish - First Hill

University of Washington Medical Center

Veterans Administration Hospital

Virginia Mason Medical Center

Navos (formerly West Seattle Psych)

Snoqualmie

Snoqualmie Valley Hospital

HC = Hospital Control (a back-up to Overlake is strongly recommended)

* = Emergency Department Capabilities – no patient beds

ATTACHMENT B: VENDOR MEMORANDUM OF UNDERSTANDING

Your organization provides needed items to member healthcare facilities located in King County and who are also members of the Regional Disaster Plan.

The intent of this agreement is for your organization to agree to deliver your products or services to disaster struck health care facilities, when requested, when these health care facilities are unable to obtain the needed products and their vendors have been overwhelmed by the disaster.

You also agree to deliver to any King County member facility who calls for your help, regardless of existing contracts. The requesting facility(ies) will initially provide a verbal order for services and then fax (if possible) their request to you. This written request can be used at police roadblocks to help justify your need to reach the disaster struck facility(ies). Payment is made by the requesting facility(ies). This payment commitment is confirmed when each member hospital signs onto the Regional Medical Evacuation and Patient Tracking Mutual Aid Plan (MAP).

By the hospitals signing onto this MAP, they have agreed to specific terms and methods of working with vendors that are utilized to either provide supplies, equipment or other resources and assets to assist the hospital to remain within their structure OR provide supplies, equipment or other resources and assets to support a hospital that has just received patients from an evacuating member hospital or outside healthcare facility.

It is important that the Vendor Company maintain an updated 24/7 contact number within the Regional Disaster Plan.

Name of Vendor Company [PRINT]: _____

Name of Person Representing this Vendor: [PRINT]: _____

Signature: _____

24/7 Contact Name and Phone Number [PRINT]:

*NOTE: Potential signatories include: EMS, Fire Service, Public Health Seattle & King County, Pharmaceutical Suppliers, Medical/Surgical Suppliers, etc.

**ATTACHMENT B:
HOSPITAL MEMORANDUM OF UNDERSTANDING
(OUTSIDE OF KING COUNTY)**

Your organization provides the ability for a King County hospital to safety evacuate special care populations (i.e. Patients from an Involuntary Psychiatric Locked Unit; Transplant Patients, Long Term Acute Care Ventilator Patients, NICU, etc.) out of the region in a disaster.

The intent of this agreement is for your organization to agree to accept these patients from the Disaster Struck health care facilities as requested when the hospitals within King County are unable to provide appropriate levels of care for these patients.

You agree to the language and content of this Mutual Aid Plan (MAP) and its terms to support the transfer/evacuation of these patients to your hospital.

It is important that you maintain an updated 24/7 contact number within this MAP.

Name of Hospital [PRINT]: _____

Name of Person Representing this Hospital: [PRINT]: _____

Signature: _____

24/7 Contact Name and Phone Number [PRINT]:

**ATTACHMENT C:
 FACILITY NAME
 HOSPITAL TRANSPORTATION VEHICLES
 FOR TRANSPORTATION OF PATIENTS**

TYPE OF VEHICLE	CAPACITY (i.e. – Wheelchair Lift with 2 spaces)

FOR TRANSPORTATION OF SUPPLIES AND EQUIPMENT

TYPE OF VEHICLE	TRANSPORTATION CAPABILITY

TRANSPORTATION COMPANIES (MOUs with the plan or Member Hospitals)

FOR TRANSPORTATION OF PATIENTS

COMPANY NAME	MOU WITH (Note Member Hospital Name or MAP)	TYPE AND NUMBER OF VEHICLES/TRANSPORTS	PATIENT CAPACITY

TRANSPORTATION COMPANIES

FOR TRANSPORTATION OF SUPPLIES/EQUIPMENT

COMPANY NAME	MOU WITH (Note Member Hospital Name or MAP)	TYPE & NUMBER OF VEHICLES/TRANSPORTS	CAPACITY

King County Hospitals Peak Staffed Bed Capacity May 2008

Hospital	Total Peak Staffed Beds	Burn	Burn ICU	Inpatient Dialysis Beds	Adult ICU
Auburn	149	0	0	12	39 (10-15 ICU plus 24 PCU)
Children's	250	0	0	36 (26 ICU/5MedSurg)	0
Enumclaw	25	0	0	0	2
Evergreen	260	0	0	10	20
Fairfax	95	0	0	0	0
GHC-Central	47	0	0	0	0
Harborview	413	24	18	0	83
Highline	100	0	0	58 (throughout med/surg/tele/ICU)	11
Kindred	NOT COMPLETE				
NAVOS	68	0	0	0	0
Northwest	148	0	0	2	10
Overlake	337	0	0	20	32
Regional	35	0	0	0	35
Snoqualmie	14	0	0	0	0
St. Francis	110	0	0	0	10
Swedish - FH	413	0	0	0	40
Swedish - Ballard (additional 29 addiction recovery beds)	38	0	0	0	0
Swedish - CH	171	0	0	0	27
UWMC	365	0	0	95 (50 non-ICU, 45 ICU)	50
VA - Seattle	201	0	0	13	36
Valley	215	0	0	15	16
Virginia Mason	268	0	0	4 Licensed	32
Totals	3722	24	18	265	443

King County Hospitals Peak Staffed Bed Capacity May 2008

Hospital	NICU	PICU	Labor, Delivery & Post Partum	Adult Med/Surg	Telemonitored Adult Med/Surg
Auburn	0	0	40 <i>(15 Labor & Delivery 25 Post-Partum)</i>	50	0
Children's	19	26	0	0	0
Enumclaw	0	0	4	19	14
Evergreen	23	0	49	146	0
Fairfax	0	0	0	0	0
GHC-Central	0	0	24	0	0
Harborview	0	6	0	221	27
Highline	0	0	14	60	0
Kindred	NOT COMPLETE				
NAVOS	0	0	0	0	0
Northwest	0	0	10	65	10
Overlake	4	0	55	213	103
Regional	0	0	0	0	0
Snoqualmie	0	0	0	14	5
St. Francis	0	0	33	57	57
Swedish - FH	<i>61 (30 NICU + 31 Intermediate ICU)</i>	6	84	222	26
Swedish - Ballard	0	0	8	30	5
Swedish - CH	0	0	0	135	50
UWMC	32	0	41	228	46
VA - Seattle	0	0	0	92	22
Valley	15	0	36	160	30
Virginia Mason	0	0	0	231	47
Totals	154	38	398	2002	442

King County Hospitals Peak Staffed Bed Capacity May 2008

Hospital	Peds Med/Surg	Telemonitored Peds Med/Surg	Psychiatric – Adult Locked (Involuntary)	Psychiatric – Adult Locked (Voluntary)
Auburn	0	0	0	25
Children's	185	43	0	0
Enumclaw	0	0	0	0
Evergreen	12	12	2	0
Fairfax	0	0	25	24
GHC-Central	0	0	0	0
Harborview	Also Burn beds. Are flexible.	0	14	47
Highline	0	0	0	0
Kindred	NOT COMPLETE			
NAVOS	0	0	68	0
Northwest	0	N/A	27	27
Overlake	0	0	0	14
Regional	0	0	0	0
Snoqualmie	0	0	0	0
St. Francis	0	0	0	10
Swedish - FH	29	29	0	0
Swedish - Ballard	0	0	0	0
Swedish - CH	0	0	0	10
UWMC	0	0	0	14
VA - Seattle	0	0		23
Valley	34	0	0	0
Virginia Mason	0	0	0	0
Totals		84	136	194

King County Hospitals Peak Staffed Bed Capacity May 2008

Hospital	Psychiatric – Peds Locked (Involuntary)	Psychiatric – Peds Locked (Voluntary)	# of Bariatric Patients based on Equipment	Estimate of # of patients >400 #'s in a week
Auburn	0	0	2	6
Children's	<i>20 (Either voluntary or involuntary)</i>		<i>12 (440 lbs Max for lifts)</i>	<1
Enumclaw	0	0	1	<1
Evergreen	0	0	5	1
Fairfax	16	30	0	0
GHC-Central	0	0	0	0
Harborview	0	0	12	5
Highline	0	0	6	2
Kindred	NOT COMPLETE			
NAVOS	0	0	0	0
Northwest	0	0	5	5
Overlake	0	0	2	1
Regional	0	0	4	10
Snoqualmie	0	0	0	<1
St. Francis	0	0	4	2
Swedish - FH	0	0	100	40
Swedish - Ballard	0	0	20	2
Swedish - CH	0	0	20	5
UWMC	0	0	all beds	6
VA - Seattle	0	0	<i>0 (rent equipment as needed)</i>	Flexible
Valley	0	0	14	5
Virginia Mason	0	0	1	1
Totals	36	30	208	79

King County Hospitals Peak Staffed Bed Capacity May 2008

Hospital	Holding area for outpatients or discharged w/o transportation	Capacity of holding area
Auburn	Y	30
Children's	N	n/a
Enumclaw	N	n/a
Evergreen	Y	25
Fairfax	N	n/a
GHC-Central	N	n/a
Harborview	Y	50
Highline	N	n/a
Kindred	NOT COMPLETE	
NAVOS	Y	4
Northwest	N	n/a
Overlake	Y	20
Regional	N	n/a
Snoqualmie	Y	30
St. Francis	4	20
Swedish - FH	Y	100
Swedish - Ballard	Y	50
Swedish - CH	Y	100
UWMC	Y	26 rooms
VA - Seattle	N	n/a
Valley	Y	60
Virginia Mason	Y	100
Totals		

King County Hospitals - Phase I: Opening Staffed Beds in 2-4 Hours (Range)

Hospital	Total Peak Staffed Beds	Burn	Burn ICU	Inpatient Dialysis Beds	Adult ICU
Auburn					
Children's					
Enumclaw					
Evergreen					
Fairfax					
GHC-Central					
Harborview					
Highline					
Kindred					
NAVOS					
Northwest					
Overlake					
Regional					
Snoqualmie					
St. Francis					
Swedish - FH					
Swedish - Ballard (additional 29 addiction recovery beds)					
Swedish - CH					
UWMC					
VA - Seattle					
Valley					
Virginia Mason					
Totals					

King County Hospitals - Phase I: Opening Staffed Beds in 2-4 Hours (Range)

Hospital	NICU	PICU	Labor, Delivery & Post Partum	Adult Med/Surg	Telemonitored Adult Med/Surg
Auburn					
Children's					
Enumclaw					
Evergreen					
Fairfax					
GHC-Central					
Harborview					
Highline					
Kindred					
NAVOS					
Northwest					
Overlake					
Regional					
Snoqualmie					
St. Francis					
Swedish - FH					
Swedish - Ballard					
Swedish - CH					
UWMC					
VA - Seattle					
Valley					
Virginia Mason					
Totals					

King County Hospitals - Phase I: Opening Staffed Beds in 2-4 Hours (Range)

Hospital	Peds Med/Surg	Telemonitored Peds Med/Surg	Psychiatric – Adult Locked (Involuntary)	Psychiatric – Adult Locked (Voluntary)
Auburn				
Children's				
Enumclaw				
Evergreen				
Fairfax				
GHC-Central				
Harborview				
Highline				
Kindred				
NAVOS				
Northwest				
Overlake				
Regional				
Snoqualmie				
St. Francis				
Swedish - FH				
Swedish - Ballard				
Swedish - CH				
UWMC				
VA - Seattle				
Valley				
Virginia Mason				
Totals				

King County Hospitals - Phase I: Opening Staffed Beds in 2-4 Hours (Range)

Hospital	Psychiatric – Peds Locked (Involuntary)	Psychiatric – Peds Locked (Voluntary)	# of Bariatric Patients accepted based on Equipment	
Auburn				
Children's				
Enumclaw				
Evergreen				
Fairfax				
GHC-Central				
Harborview				
Highline				
Kindred				
NAVOS				
Northwest				
Overlake				
Regional				
Snoqualmie				
St. Francis				
Swedish - FH				
Swedish - Ballard				
Swedish - CH				
UWMC				
VA - Seattle				
Valley				
Virginia Mason				
Totals				

King County Hospitals - Phase II: Opening Staffed Beds in 12-24 Hours (Range)

Hospital	Total Peak Staffed Beds	Burn	Burn ICU	Inpatient Dialysis Beds	Adult ICU
Auburn					
Children's					
Enumclaw					
Evergreen					
Fairfax					
GHC-Central					
Harborview					
Highline					
Kindred					
NAVOS					
Northwest					
Overlake					
Regional					
Snoqualmie					
St. Francis					
Swedish - FH					
Swedish - Ballard (additional 29 addiction recovery beds)					
Swedish - CH					
UWMC					
VA - Seattle					
Valley					
Virginia Mason					
Totals					

King County Hospitals - Phase II: Opening Staffed Beds in 12-24 Hours (Range)

Hospital	NICU	PICU	Labor, Delivery & Post Partum	Adult Med/Surg	Telemonitored Adult Med/Surg
Auburn					
Children's					
Enumclaw					
Evergreen					
Fairfax					
GHC-Central					
Harborview					
Highline					
Kindred					
NAVOS					
Northwest					
Overlake					
Regional					
Snoqualmie					
St. Francis					
Swedish - FH					
Swedish - Ballard					
Swedish - CH					
UWMC					
VA - Seattle					
Valley					
Virginia Mason					
Totals					

King County Hospitals - Phase II: Opening Staffed Beds in 12-24 Hours (Range)

Hospital	Peds Med/Surg	Telemonitored Peds Med/Surg	Psychiatric – Adult Locked (Involuntary)	Psychiatric – Adult Locked (Voluntary)
Auburn				
Children's				
Enumclaw				
Evergreen				
Fairfax				
GHC-Central				
Harborview				
Highline				
Kindred				
NAVOS				
Northwest				
Overlake				
Regional				
Snoqualmie				
St. Francis				
Swedish - FH				
Swedish - Ballard				
Swedish - CH				
UWMC				
VA - Seattle				
Valley				
Virginia Mason				
Totals				

King County Hospitals - Phase II: Opening Staffed Beds in 12-24 Hours (Range)

Hospital	Psychiatric – Peds Locked (Involuntary)	Psychiatric – Peds Locked (Voluntary)	# of Bariatric Patients accepted based on Equipment	
Auburn				
Children's				
Enumclaw				
Evergreen				
Fairfax				
GHC-Central				
Harborview				
Highline				
Kindred				
NAVOS				
Northwest				
Overlake				
Regional				
Snoqualmie				
St. Francis				
Swedish - FH				
Swedish - Ballard				
Swedish - CH				
UWMC				
VA - Seattle				
Valley				
Virginia Mason				
Totals				

King County Hospitals - Phase III: Open Area Surge in 12-24 Hours (Range)

Hospital	Total Peak Staffed Beds	Burn	Burn ICU	Inpatient Dialysis Beds	Adult ICU
Auburn					
Children's					
Enumclaw					
Evergreen					
Fairfax					
GHC-Central					
Harborview					
Highline					
Kindred					
NAVOS					
Northwest					
Overlake					
Regional					
Snoqualmie					
St. Francis					
Swedish - FH					
Swedish - Ballard (additional 29 addiction recovery beds)					
Swedish - CH					
UWMC					
VA - Seattle					
Valley					
Virginia Mason					
Totals					

King County Hospitals - Phase III: Open Area Surge in 12-24 Hours (Range)

Hospital	NICU	PICU	Labor, Delivery & Post Partum	Adult Med/Surg	Telemonitored Adult Med/Surg
Auburn					
Children's					
Enumclaw					
Evergreen					
Fairfax					
GHC-Central					
Harborview					
Highline					
Kindred					
NAVOS					
Northwest					
Overlake					
Regional					
Snoqualmie					
St. Francis					
Swedish - FH					
Swedish - Ballard					
Swedish - CH					
UWMC					
VA - Seattle					
Valley					
Virginia Mason					
Totals					

King County Hospitals - Phase III: Open Area Surge in 12-24 Hours (Range)

Hospital	Peds Med/Surg	Telemonitored Peds Med/Surg	Psychiatric – Adult Locked (Involuntary)	Psychiatric – Adult Locked (Voluntary)
Auburn				
Children's				
Enumclaw				
Evergreen				
Fairfax				
GHC-Central				
Harborview				
Highline				
Kindred				
NAVOS				
Northwest				
Overlake				
Regional				
Snoqualmie				
St. Francis				
Swedish - FH				
Swedish - Ballard				
Swedish - CH				
UWMC				
VA - Seattle				
Valley				
Virginia Mason				
Totals				

King County Hospitals - Phase III: Open Area Surge in 12-24 Hours (Range)

Hospital	Psychiatric – Peds Locked (Involuntary)	Psychiatric – Peds Locked (Voluntary)	# of Bariatric Patients accepted based on Equipment	
Auburn				
Children's				
Enumclaw				
Evergreen				
Fairfax				
GHC-Central				
Harborview				
Highline				
Kindred				
NAVOS				
Northwest				
Overlake				
Regional				
Snoqualmie				
St. Francis				
Swedish - FH				
Swedish - Ballard				
Swedish - CH				
UWMC				
VA - Seattle				
Valley				
Virginia Mason				
Totals				

**ATTACHMENT D:
Plan Taskforce and Special Experts Participant List**

Organization	Name	Title
Amerisource Bergen	Chuck Nelson	
Amerisource Bergen	Cory Kirkpatrick	
AMR	Bob Berschauer	
AMR	Brett Butte	
AMR	Greg Sim	
Auburn Regional Med Ctr	Dale Guffey	Chief Financial Officer
Auburn Regional Med Ctr	Denis Uhler	
Auburn Regional Med Ctr	Matt Counas	
Cardinal Health	Jefferson Wall	Kent – Med/surg Fife
Children's Hospital	Jeff Lim	Director, Safety Programs
Children's Hospital	Jeff Sconyers	VP & Chief Consultant
City of Seattle	Grant Tietje	Emergency Manager
DHHS Regional X ASPR	Dave Kerschner	Regional Emergency Coordinator
DOH	Jennifer Foster	State Emergency Response Coordinator
DOH	Tim Fuller	Pharmacist
DOH/SNS	Dave Owens	Strategic National Stockpile Coordinator
Evergreen Healthcare	Barb Jensen	Nursing Administration Mgr-Nursing Resources
Evergreen Healthcare	Kathy Gilles	Evergreen Corporate Compliance Officer
Evergreen Healthcare	Sheila Green-Shook	Director, Health Information Management
Group Health	Walter Sidles	Manager Pharmacy Materials
Harborview	Anne Newcombe	Clinical Nurse Mgr/Emer Dept.
Harborview	Lewis Rubinson, MD	Sr Medical Advisor for Healthcare Preparedness & Response
King County ECC	Shad Burcham	Emergency Manager
King County Healthcare Coalition	Allison Schletzbaum	Regional Medical Resource Center Manager
King County Healthcare Coalition	Danica Mann	Training & Exercise Coordinator
McKesson	Dave Yocom	
Medic 1	Jim Fogarty	Chief/KCM1
Metro	Mike DeCapua	Homeland Security Project Manager
MHZ Consulting services	Marina Zuetell	
Northwest Hospital	Gayle Ward	VP Nursing
NW Hospital	Kay Andersen	
NW Hospital	Michael Cernuska	Respiratory Therapist
NW Hospital	Peter Rigby	Director of Therapy Services/Safety Officer
Overlake Medical Center	Dianna Reely	Vice President of Quality and Patient Experience
Overlake Medical Center	Luis Gonzales	Security
Overlake Medical Center	Shirley Merkle	ED Director
Overlake Medical Center	Steve Marshall, MD	Medical Director
PHSKC	Bryan Heartsfield	Medical Response Manager
PHSKC	Cynthia Dold	Healthcare Coalition Manager
PHSKC	Kathryn Koelemay, MD	Medical Epidemiologist
PHSKC	Michael Loehr	Preparedness Manager
PHSKC	Michelle McDaniel	Behavioral Health Manager
PHSKC	Onora Lien	Special Projects Manager
PHSKC	Alvin Lee	ACF Consultant
Prosecuting Attorney's Office	Amy Eiden	Deputy Prosecuting Attorney
Russell Phillips & Associates	Scott Aronson	Principal

Seattle Fire	Craig Warren	Lieutenant- Ladder Co. #9
Shoreline Fire	Don Warner	Fire Chiefs Representative
St Francis	David Butcherite	Controller
St Francis	Eileen Newton	Regional Disaster Coordinator
Swedish	Marianne Klaas	Director Accreditation & Safety
Swedish	Suzanne Scroggins	Director, Net Revenue and Contracting
TriMed Ambulance	Dave Nelson	
US Army	Angel Ortiz-Nieves	
US Army	Col Carl Rebstock	
UW	Andy Stergachis, PhD, R.Ph	Professor of Epidemiology
UW Medical Center	Beth Wickwire	Materials Manager
UW Medical Center	Leeann Dawson	Controller
UW Medical Center	Leslie Bahr	
UW Medical Center	Tamlyn Thomas	UWMC Emergency Management Coordinator
Valley Medical Center	Cathy McAbee	
Valley Medical Center	Paul Hayes	
Virginia Mason Med Ctr	Fred Savaglio	Director of Facilities
Washington Poison Center	Joe Copley	Puget Sound Call Center Coordination Project
West Seattle Psych	Elizabeth Ward	Chief Inpatient Services
WSDOT	John Himmel	Emergency and Security Operations Manager
WSDOT	Leslie Forbis	HOV Operations Engineer - NW Region