

State of Wisconsin Hospital Bioterrorism Preparedness Plan

(Version 2.3)

Section One: Purpose and Objectives

In recognition of the fact that, for a variety of reasons, the occurrence of a biological, chemical, radiological or natural disaster can easily overwhelm or damage the capability of local healthcare resources to meet community needs, this State of Wisconsin Hospital Bioterrorism Preparedness Plan (hereinafter, "PLAN"), a mutual aid plan, is developed.

The purpose of this PLAN is to establish the necessary structure and process to enable the participating institutions to meet community, county and regional needs in a collaborative and organized manner. This PLAN will integrate with county and state emergency operational plans, public health, hospital, other local plans and border state plans, as appropriate.

This PLAN provides the necessary structure to allow all participant institutions in the state to call upon each other's resources in the event of a disaster situation. It describes the process for activating the PLAN, operational parameters during the event between participant institutions and field operations, termination of the event, recovery and the process for evaluating performance under the PLAN

An emergency is defined as a natural or manmade event that suddenly disrupts the environment of care; disrupts care and treatment; or changes or increases demands for the organization's resources (JCAHO).

In addition, this PLAN is meant to address response to bioterrorism, other infectious disease outbreaks and other public health threats and emergencies (BOIDDOOPHTE) that may involve large numbers of patients.

Further, the PLAN establishes the following:

1. a disaster response system that enables the participant institutions to meet community healthcare needs in an event, in which the individual institution's capacity is exceeded.
2. a disaster response system for the participant institutions that is consistent with and integrates with the community disaster response plans developed by civil authorities with an emphasis on integrating pre-hospital, hospital and home care.
3. a disaster response system to evacuate partially or fully any participant institution, should it be necessary as a result of either an internal or external disaster, affecting a participant institution

4. pre-hospital communication, resource mobilization and transportation to the appropriate hospital(s) and/or off-site treatment facilities.

Section Two: Membership

- A. Primary and Affiliate members of the Regional Hospital Bioterrorism Preparedness Planning Team are found in Part C, Resource Listing. .
- B. The members of the Team are composed of all organizations, which are necessary to respond to a disaster, which exceeds any individual institution's capacity. Membership will involve hospitals, local health departments, Emergency Management offices, Emergency Medical Services (EMS), physician offices and other organizations (participant institutions).
 1. Participant institutions have the right to choose which Team they consider as their "primary" Team.
 2. Participant institutions have the right to choose which Team they consider as their "affiliate" Team.
 3. Participant institutions have the right to choose as their "primary" or "affiliate" Team a Team located in a border state.
 4. Participant institutions choosing a "primary" Team in a border state must have an "affiliate" Team in a Wisconsin region.

Section Three: Scope of Plan

- A. This PLAN is used to coordinate regional resources to respond to a BOIDDOOPHTE event. A disaster for this PLAN is an event, which overwhelms the resources (physical plant and staff) of a participant institution(s) and requires mutual aid with other participant institutions and/or community, regional, state or national resources. The disaster may be defined in terms of varying levels of severity. For example:
 1. Level 1 – the participant institution(s) in the affected community can care for all the patients
 2. Level 2 – the participant institution(s) in the affected community require the resources of other participant institutions and off-site treatment facilities in the region.
 3. Level 3 – the participant institution(s) in the community require the support of other participant institutions and off-site treatment facilities in one or more neighboring regions or those of a neighboring state.

4. Level 4 – the event is national in scope in that a Level 3 disaster exists in 2 or more states.
- B. There are likely to be two types of disasters depending upon the agents used.
1. “Lights and Sirens” Incident - The first type of disaster develops rapidly and produce a large number of casualties in a very short period of time.
 2. Biological Incident - The second type of disaster develops gradually over time and produces a large number of casualties over a sustained period of time. The use of biological agents or the outbreaks of infectious diseases may cause this type of disaster.
- C. In implementing this PLAN, the participant institutions agree to comply with applicable Federal and state laws such as COBRA, EMTALA, HIPAA , unless otherwise suspended per statute.

Section Four: Notification of an Event

- A. “Lights and Sirens” Incident

In the event of such a disaster, notification of the hospital(s) and other participant institutions will come from credible sources such as the Incident Commander, EMS, fire, Public Health, 911, law enforcement, participant institutions and state or regional agencies, depending on the scope of the disaster. It is possible that patients may arrive at the hospital, seeking treatment, prior to any notification.

1. Level I: The hospital(s) will be notified by the responding EMS service, 911 or the Incident Commander. No further notification is necessary unless the disaster expands to Level 2 or higher.
2. Level 2, 3 or 4: The hospital(s) and other participant institutions are notified by the responding EMS service, 911 or the Incident Commander that the incident is likely to exceed local capabilities. The hospital(s) are to activate their internal and regional disaster plans. The Incident Commander is to instruct the 911 Center to notify City/County Emergency Management of the disaster and the need to activate the City/County Emergency Operations Center (EOC). County Emergency Management will notify State Emergency Management of the disaster.
3. Internal Hospital Damage: Hospital(s), suffering internal damage, will notify the 911 Center that it is unable to accept patients. This information is to be communicated to the City/County EOC as soon as possible.

B. Biological Incident

In a biological disaster, where the precipitating event is unknown until the appearance of syndromes or disease cases, the local health department(s) along with the hospital(s) and clinics will monitor the situation.

1. Health care facilities that identify any of the CDC Category A, B, C diseases, which may indicate use of a biological agent, or outbreaks of other infectious diseases are to notify the local health department immediately according to the protocols outlined in Section Twenty-One – Surveillance.
2. The local health department in collaboration with the State Division of Public Health will confirm their findings in collaboration with the hospital(s) and clinics.
3. If the situation involves a CDC Category A, B, C disease or an outbreak of infectious disease, the state and local health departments will communicate that information to all health care facilities.
4. The state and local health departments will consult with state and City/County Emergency Management on the need to activate the state and City/County EOCs.
5. After deciding to activate State and City/County EOCs, State and City/County response agencies and hospitals will be notified.
6. The State EOC will inform the FEMA Region V Emergency Operations Center (ROC) of events, taking place in Wisconsin.

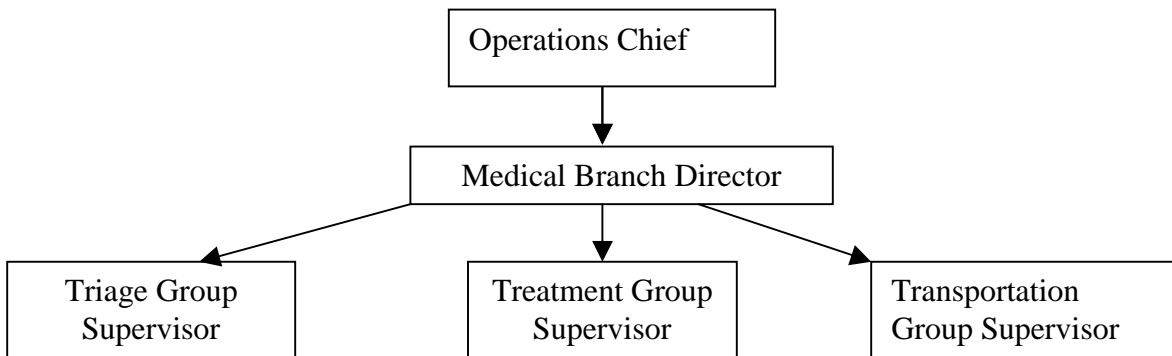
Section Five: Plan Activation

- A. Upon notification of a disaster, which will involve hospitals, the hospital(s) and other participant institutions in the affected community will activate their internal and regional disaster plans. This includes sending a representative(s) to the City/County Emergency Operations Center (EOC) to participate in coordinating the health and medical aspects of the response.

If the City/County EOC has not yet been activated, the hospital that is nearest to the incident will be designated as the "Base Hospital" until the City/County EOC is activated. The "Base Hospital" is responsible for notifying other participant hospitals that the PLAN has been activated and their assistance is required. The "Base Hospital" is responsible for communications with other participant hospitals as outlined in Sections 5 and 6 below until the City/County EOC is activated.

- B. The EOC in the affected county will notify the County Emergency Management Directors in the other cities/counties in the Region of the disaster and the need for them to activate their Emergency Operations Centers. As the other cities/counties in the Region activate their EOCs, they will notify the hospitals in the city/county of the disaster and the need for them to activate their disaster plans.
- C. All participant hospitals in the Region upon receipt of notification to activate their plan will be responsible for:
 - 1. implementing their disaster plan as needed
 - 2. ensuring that a hospital representative is sent to the City/County EOC
 - 3. notifying the City/County EOC with an estimate of the number of patients they are able to receive and actions they are taking.
- D. Each City/County EOC in the Region will pass on information of their hospital(s)' capability to receive patients to the EOC of the affected city/county.

Section Six: Field Medical Command



- A. The Incident Commander will manage the disaster scene. The Medical Branch Director in the Operations Section will be in charge of patient care activities. Depending on the size of the incident and available personnel, the Medical Branch Director may further delegate and assign duties to the Triage Group Supervisor, the Treatment Group Supervisor and the Transportation Group Supervisor.
 - 1. The Triage Group Supervisor is responsible for initiating the Triage Sector, which will sort and categorize all patients.
 - 2. The Treatment Group Supervisor is responsible for initiating the Treatment Sector, which will provide on-scene treatment of patients.

3. The Transportation Group Supervisor is responsible for ensuring that all patients are transported to the appropriate facility. In the early stages of the disaster, the Transportation Group Supervisor will coordinate with the 911 Center and the hospital(s) in the affected city/county to ensure that patients are transported to the appropriate hospital.
- B. After the EOC in the affected city/county is activated, the hospital EOC representatives will coordinate with the Transportation Group Supervisor at the scene and with the hospital EOC representative in the City/County EOCs of the other cities/counties in the region to transport patients to the appropriate facility.
 - C. The hospital EOC representatives and the EMS EOC representatives in the affected City/County EOC will coordinate their activities for the transport of patients to other hospitals in the region.
 - D. The Transportation Group Supervisor shall relay basic information such as the number of victims by treatment priority category, an estimated time of arrival (ETA) and the transporting ambulance identification (service/unit number). The receiving hospital or the EOC may advise the Transportation Group Supervisor Commander to divert patients to other participant institutions.
 1. In order to facilitate better care for the victims, each EMS unit, transporting victims to a participant hospital will communicate directly (by radio or cell phone) and provide any additional patient information available and confirm ETA to the receiving hospital.
 2. Under this PLAN, each participant hospital shall have available (see Part C, Resource Listing a listing of alternate communications systems, including, but not limited to:
 - a. EMS radio frequencies,
 - b. Emergency Room telephone number(s),
 - c. Disaster Control telephone number(s) and/or Incident Command Center
 - d. Cellular or power failure telephone numbers for the above locations.
 - e. Preferred method to contact the hospital Incident Commander (pager, phone, switchboard, etc.)
 - f. Such listing for each hospital shall be attached to this PLAN in Part C, "Resource Listing", and provided to all participant institutions.

Section Seven: Patient Field Triage

- A. The Medical Branch Director is responsible for all aspects of field triage and treatment up to the point of receipt of these patients at a participant hospital.
- B. As a result of the field triage process, each patient is classified into one of four treatment priority categories that serve as the basis for subsequent actions. These categories are:
1. Category I: Immediate Care Red
 2. Category II: Delayed Care Yellow
 3. Category III: Minor Injury Green
 4. Category 0: Expired Black
- C. Initial patient distribution from the site of the event is the responsibility of the Medical Branch Director, based upon estimated capacity information received from the participant hospitals. The appropriate distribution of patients is based on patient need and facility capacity.
- D. Each victim routed to a participant hospital for treatment through the EMS system will be tagged with a disaster tag (as described in B above), which contains the following mandatory information:
1. Date and Time
 2. Field Tag Identification Number
 3. Treatment Priority Category
- E. In addition, each victim, routed to a participant hospital for treatment through the EMS system, will be tagged with a disaster tag, which contains the following information, if time permits:
1. Physical Assessment (Pictograph of injuries and vital signs information)
 2. IV/IM Information and Time (if appropriate)
 3. Patient Identification Information (names and address, if available)
 4. Treatment Notes
- F. Existing inter-facility transfer policies will be followed.

- G. Each participant hospital shall develop and maintain a method for recording and correlating the EMS Disaster Tag ID number with the patient number assigned to the victim on arrival at the hospital (e.g., account number or other similar number). This may be accomplished by whatever means each hospital determines is the most appropriate and feasible (e.g., log sheets, computer records, etc.)

Section Eight: Hospital Receiving, Triage And Treatment

- A. These functions will be managed in accordance with the individual participant hospital's disaster plan and its transfer policies.
- B. In the event that a participant hospital needs to transport a patient, whether one already received as the result of the accident or an existing patient in order to accommodate victims of the incident, it is the responsibility of that hospital to arrange such transportation.

The transportation of such patients should be coordinated through the EOC, if activated, in concert with the hospital EOC representative . Such requests should not be considered a part of the EMS incident and are not the responsibility of the Medical Commander.

Section Nine: Pre-Hospital Incident Termination

- A. Upon completion of field triage, treatment and transportation activities at the site, the Medical Commander will notify the EOC that the incident is terminated pre-hospital.
- B. The EOC will notify all participant hospitals, activated under this PLAN that the incident is terminated pre-hospital.
- C. Each participant hospital will notify any associated support providers (Immediate Care Services, etc.), which it activated under this PLAN, that the pre-hospital phase is terminated at the site of the event.

Section Ten: Post Incident Evaluation

- A. As per established protocols, the Emergency Management Directors for the affected cities/counties, involved in the incident, will organize a meeting for the purpose of conducting an overall After Action Report of the incident.
- B. In addition, the Chairs of the Regional Teams for the affected regions, involved in the incident, will organize a meeting for the purpose of conducting an overall evaluation of the incident under the PLAN.

Such a meeting and evaluation should be conducted in a timely manner (2 – 3 weeks) so that maximum benefit is derived and information is not lost due to the passage of time. For purposes of this PLAN, such evaluation session should identify

1. The course of events at the participant institutions and any associated support providers it activated,
2. Problems encountered during the incident related to this PLAN,
3. (Within one or two weeks), the strengths/weaknesses of the PLAN or opportunities for improvement identified as a result of the incident, and
4. Any other information, which may be useful.
5. These evaluations should be posted on the Wisconsin Health Alert Network.

Section Eleven: Plan Approval

- A. This PLAN shall be routinely reviewed and modified, minimally every two years. A State Plan Review Committee shall be established to accept recommendations for PLAN improvement.
- B. This PLAN is subject to modification or improvement as an outcome of the evaluation process under Section Eleven above at any time, or if deemed appropriate, such modification or improvement may be deferred to the next annual review process.
- C. Copies of this modified or improved PLAN will be distributed to all participant institutions.

Part B: Operational Components

Section Twelve: Increasing Inpatient Bed Capacity

A. Increasing Inpatient Bed Capacity: Once the hospital determines that an incident is of such a nature as to activate the plan to increase inpatient bed capacity, the following protocols will be implemented in either a mass casualty or a biological incident and may be applicable for other internal or external disaster situations when evacuation or receiving an influx of patients may be required.

1. **Early Discharge:** There is a method in place to contact all attending physicians to alert them to activate the plan to increase inpatient bed capacity. Physicians caring for inpatients and outpatients will assess all patients for possible discharge. The physician will determine the need for home health care, follow-up appointments or other ongoing care needs for discharged patients.
2. **Transfer Outside the Hospital:** The hospital's emergency plan provides for the transfer of patients to other hospitals and nursing homes.
 - a. **Interfacility Transfer:** The physician will evaluate patients, where require transfer to another facility to determine the appropriate mode of transportation, necessity for medical personnel to accompany the patient during transfer and other transfer arrangements per established patient transfer policies.
 - b. **Pertinent records and personal belongings** will be transferred with the patient. Notification to other units or facilities will be made in keeping with patient transfer policies.
3. **Transfer Within the Hospital:** Patients may be transferred to other patient care units to maximize inpatient bed capacity or to free negative pressure beds. Physicians will evaluate these patients and arrange for transfer as needed.
4. **Cancellation of Surgery:** Inpatient and outpatient surgical cases in progress are to be completed. Cases, which have not been started, are to be evaluated for urgency and delayed if possible.
5. **Admission Control:** A mechanism is to exist to prioritize admissions. All attending physicians are to be notified of the need to cancel or divert elective admissions, admitting only those with immediate medical necessity.
6. **Alternate Emergency Department (ED):** According to established diversion plans, Emergency Departments may divert patients to other area hospitals, urgent care clinics, or primary care clinics.

7. Alternate ICU: Hospitals will have mutual aid agreements with other healthcare agencies for transfer of critical patients to appropriate intensive care units for purposes of accommodating increased numbers or types of patients.
8. Isolation Bed Availability: The need for isolation rooms is to be assessed and their use prioritized. If isolation rooms are not available, plans to prevent the spread of infection are to be considered according to the protocols as outlined in Section Thirteen: Isolation.
9. Conversion of Rooms: Private rooms are to be considered for conversion into semi-private rooms.
10. Opening of Closed Areas: Patient Care areas that have been closed are to be considered for their potential to serve as patient care areas.
11. On-Site Capacity: Other areas of the hospital such as meeting rooms, waiting areas, etc. are to be evaluated for their potential to serve as patient care areas.

B. Determining and Communicating Patient Census, Capacity: Hospitals are to designate an individual to complete the “Hospital Capacity and Patient Census Report” (See Appendix 8-A), indicating the number of occupied inpatient and outpatient beds on each nursing unit along with the number of available beds. This includes Emergency, Surgical Centers, Dialysis, etc. Attending physicians and nurses are to assign each occupant an acuity category. **These definitions for acuity levels are developed for the purpose of increasing bed capacity and may differ from other acuity categories used by hospitals.**

1. Red indicates inpatients, which require critical care resources (life-sustaining medication, mechanical ventilation, hemodynamic stabilization). These patients require continued hospitalization and advanced life support personnel for ambulance transfer. They will require placement in a critical care unit upon transfer.
2. Yellow indicates inpatients, which require continued hospitalization, but do not require critical care resources during transfer and may be placed on a general inpatient unit. They may require ambulance transfer or patient transport vehicles.
3. Green indicates inpatients, which are eligible for early discharge or may be cared for at home with home health care or in a nursing home setting. They may be transferred using private vehicles or patient transport vehicles.

C. Staff Augmentation: The administrator in coordination with nursing is to determine the adequacy of staffing for the incident. Hospitals are to initiate their staff call-in procedures to care for increased patients. When staffing is insufficient to meet the increased patient load despite attempts to call-in staff, the need for additional staff is

to be communicated to the local Emergency Operations Center. Additional staff or staff who have been vaccinated against certain agents may be required. Considerations are to be made for staff safety and the need for prophylaxis or any prevention/treatment measures as needed. The hospital emergency plan is to include a procedure for credentialing medical and nursing staff from other healthcare agencies during times of disaster.

Section Thirteen: Isolation

To be inserted into the PLAN on August 1, 2003

Section Fourteen: Special Needs Patients

To be inserted into the PLAN on September 26, 2003

Section Fifteen: Off-Site Facilities

To be inserted into the PLAN on August 29, 2003

Section Sixteen: Security

- A. The purpose of this section is to address hospital security issues unique to a bioterrorism event or a mass casualty incident involving large numbers of victims.
- B. The scope of this section addresses the security needs of both individual hospitals and the regional hospitals in their response to the incident.
- C. For a successful security response, there are three key planning elements:
 - 1. all hospitals have a written security response plan , based on a Hazards Vulnerability Analysis
 - 2. these plans are to be established using the incident command system
 - 3. all hospitals are to share and integrate their respective security plans into the regional or county security plans.
- D. A successful security response is to include both pre-incident planning and plan implementation elements.
 - 1. A Pre-Incident Planning Checklist is available to assess the scope of current security planning and provide guidelines for enhancements.
 - 2. The Security Response Plan is to include, but is not limited to:
 - a. Notification and calling-in security staff to respond and implement the security plan
 - b. Initiation of the hospital lockdown.
 - i. Manually or automatically close designated doors and entrances.
 - ii. Dispatch security staff to security checkpoints.
 - iii. Place door signage in accordance with the security plan.
 - c. Set up ingress and egress traffic paths inside the hospital and outside on hospital grounds. If streets outside of hospital grounds are to be barricaded, contact law enforcement or incident command.
- E. The protocol for the direction of patients, family, media and hospital response staff at the security check points are to be implemented.

Section Seventeen: Disposal of Waste

To be inserted into the PLAN on August 29, 2003

Section Eighteen: Interim Stockpile

To be inserted into the PLAN on August 1, 2003

Section Nineteen: Decontamination

To be inserted into the PLAN on a date to be determined

Section Twenty: Personal Protective Equipment

To be inserted into the PLAN on August 1, 2003

Section Twenty-One: Surveillance

To be inserted into the PLAN on August 29, 2003

Section Twenty-Two: Risk Communications

To be inserted into the PLAN on September 26, 2003

Section Twenty-Three: Responder Workforce

To be inserted into the PLAN on September 26, 2003

Section Twenty-Four: Training/Education

- A. The State of Wisconsin will provide on an annual basis the Core Curriculum for BOIDDOOPHTE. This Core Curriculum is developed based on recommendations from Public Health Consortia, Regional Hospital Bioterrorism Preparedness Teams, information provided by agencies such as CDC, HRSA, APIC and from the assessments distributed through the Health Professions and Education Coalition. The Core Curriculum will outline the
 - 1. the courses available
 - 2. core competencies
 - 3. methodologies to access the course
 - 4. proficiency testing
 - 5. reporting capabilities

- B. The State of Wisconsin will present its Core Curriculum at the beginning of the federal Fiscal Year, i.e. September.

- C. The Regional Hospital Bioterrorism Preparedness Steering Committees are to make recommendations on any aspects of Training/ Education to the Program Director. The Program Director shall make these recommendations to the CDC Focus Area G Training/Education Coordinators under whom all training and education for BOIDDOOPHTE is coordinated.

- D. The Regional Steering Committees may develop other courses as they determine necessary and which may not be able to be offered under the Core Curriculum. It is recommended, however, that all training/education be reviewed by the CDC Focus Area G Training/Education Coordinators so that
 - 1. all curriculum is standardized across the State of Wisconsin
 - 2. course offerings developed by the Regional Hospital Bioterrorism Preparedness Steering Committees be considered for adoption by the State as Core Curriculum

Part C: Resource Listing

Part D: Appendices

Part E: Section Checklists