



Medical surge is the ability to provide adequate medical evaluation and care during events that exceed the limits of the normal medical infrastructure of an affected community.¹⁹⁴ It encompasses the ability of the healthcare system to survive a hazard impact and maintain or rapidly recover operations that were compromised.¹⁹⁵

This capability consists of the ability to perform the following functions:

- Function 1:** Assess the nature and scope of the incident
- Function 2:** Support activation of medical surge
- Function 3:** Support jurisdictional medical surge operations
- Function 4:** Support demobilization of medical surge operations

Function 1: Assess the nature and scope of the incident

In conjunction with jurisdictional partners, coordinate with the jurisdiction's healthcare response through the collection and analysis of health data (e.g., from emergency medical services, fire service, law enforcement, public health, medical, public works, utilization of incident command system, mutual aid agreements, and activation of Emergency Management Assistance Compact agreements) to define the needs of the incident and the available healthcare staffing and resources.

Tasks

This function consists of the ability to perform the following task:

- Task 1:** At the time of an incident, participate in a unified incident management structure. *(For additional or supporting detail, see Capability 3: Emergency Operations Coordination)*
- Task 2:** At the time of an incident, complete a preliminary assessment of the incident and document initial resource needs and availability (e.g., personnel, facilities, logistics, and other healthcare resources). *(For additional or supporting detail, see Capability 3: Emergency Operations Coordination, Capability 7: Mass Care, Capability 9: Medical Materiel Management and Distribution, Capability 13: Public Health Surveillance and Epidemiological Investigation, and Capability 15: Volunteer Management)*
- Task 3:** At the time of an incident, provide health-related data to healthcare organizations or healthcare coalitions that will assist the healthcare organizations or healthcare coalitions in activating their pre-existing plans to maximize scarce resources and prepare for any necessary shifts into and out of conventional, contingency, and crisis standards of care.

Performance Measure(s)

At present there are no CDC-defined performance measures for this function.

Resource Elements

*Note: Jurisdictions must have or have access to the resource elements designated as **Priority**.*

PLANNING (P)

- P1: (Priority)** Written plans should include documentation of staff assigned and trained in advance to fill public health incident management roles as applicable to a given response. Health departments must be prepared to staff emergency operations centers at agency, local, and state levels as necessary.^{196,197,198} *(For additional or supporting detail, see Capability 3: Emergency Operations Coordination)*
- P2: (Priority)** Written plans should include documentation that all joint (e.g., healthcare organizations, public health, and emergency management) emergency incidents, exercises, and preplanned (i.e., recurring or special) events operate in accordance with Incident Command Structure organizational structures, doctrine, and procedures, as defined in the National Incident Management System.^{199,200} *(For additional or supporting detail, see Capability 3: Emergency Operations Coordination)*
- P3: (Priority)** Written plans should include process to ensure access into the jurisdiction's bed-tracking system to maintain visibility of bed availability across the jurisdiction.

Suggested resources

- Hospital Preparedness Program, Office of the Assistant Secretary of Preparedness and Response:

Function 1: Assess the nature and scope of the incident
Resource Elements (continued)

PLANNING (P)

- <http://www.phe.gov/preparedness/planning/hpp>
Hospital Preparedness Program Guidance FY10:
http://www.phe.gov/preparedness/planning/hpp/Documents/fy10_hpp_guidance.pdf

P4: (Priority) Written plans should include processes to engage in healthcare coalitions and understand the role that each coalition partner will play to obtain and provide situational awareness.^{201,202,203} Coalitions are not expected to replace or relieve healthcare systems of their institutional responsibilities during an emergency, or to subvert the authority and responsibility of the state or local jurisdiction. The purpose of jurisdictional healthcare coalitions is as follows:

- Integrate plan and activities of all participating healthcare systems into the jurisdictional response plan and the state response plan
- Increase medical response capabilities in the community, region and state
 - Prepare for the needs of at-risk individuals and the general population in their communities in the event of a public health emergency
 - Coordinate activities to minimize duplication of effort and ensure coordination among federal, state, local and tribal planning, preparedness, response, and de-escalation activities
 - Maintain continuity of operations in the community vertically with the local jurisdictional emergency management organizations
 - Unify the management capability of the healthcare system to a level that will be necessary if the normal day-to-day operations and standard operating procedures of the health system are overwhelmed, and disaster operations become necessary
 - Support sufficient jurisdiction-wide situational awareness to ensure that the maximum number of people requiring care receive safe and appropriate care, which may involve, but is not limited to, facilitating the triage and/or distribution of people requiring care to appropriate facilities throughout the jurisdiction and providing appropriate support to these facilities to support the provision of optimal and safe care to those individuals

Suggested resource

- Medical Surge Capacity and Capability: A Management System for Integrating Medical and Health Resources During Large-Scale Emergencies:
<http://www.phe.gov/preparedness/planning/mscc/handbook/pages/default.aspx>

P5: (Priority) Written plans should include processes (e.g., MOUs or other written agreements) to work in conjunction with emergency management, healthcare organizations, coalitions, and other partners to develop written strategies that clearly define the processes and indicators as to when the jurisdiction's healthcare organizations and health care coalitions transition into and out of conventional, contingency, and crisis standards of care.²⁰⁴ Jurisdiction should utilize the risk assessment to build jurisdiction-specific strategies and triggers.^{205,206} (For additional or supporting detail, see *Capability 1: Community Preparedness*)

Suggested resources

- Guidance for Establishing Crisis Standards of Care for Use in Disaster Situations: A Letter Report, Institute of Medicine, 2009. Examples of triggers for action identified (by the Institute of Medicine in 2009) include:
 - Critical infrastructure disruption
 - Disruption of facility or community infrastructure and function (e.g., utility or system failure in healthcare organization, more than one hospital affected in the region, and more than five hospitals affected or critical-access hospital affected in the state)
 - Failure of 'contingency' surge capacity (i.e., resource-sparing strategies overwhelmed)
 - Human resource/staffing availability
 - Emergency medical services call volume twice the usual amount
 - Emergency department wait time more than 12 hours
 - Staff illness rate more than 10%
 - Material resource availability
 - Less than 5% ventilators available in healthcare organization

Function 1: Assess the nature and scope of the incident
Resource Elements *(continued)*

PLANNING (P)

- Patient care space availability
- Overall hospital bed availability less than 5% available or no available beds or less than 12 beds in healthcare organization
- No intensive care unit bed availability in healthcare Organization
- Disaster declaration in more than one area hospital in the region or more than two major hospitals in the state
- Mass Medical Care with Scarce Resources: A Community Planning Guide <http://www.ahrq.gov/research/mce/>
- Abbreviated version, The Essentials <http://www.ahrq.gov/prep/mmcessentials/>

P6: Written plans should include documentation that public health has participated in/collaborated in the development of jurisdictional healthcare organizations emergency operations plans and standard operating procedures, incorporating National Incident Management System and National Response Framework components, principles, and policies in their planning, training, response, exercises, equipment, evaluation, and corrective actions.^{207,208,209}

Suggested resources

- Medical Surge Capacity and Capability: A Management System for Integrating Medical and Health Resources During Large-Scale Emergencies: <http://www.phe.gov/preparedness/planning/mscc/handbook/pages/default.aspx>
- Medical Surge Capacity and Capability: The Healthcare Coalition in Emergency Response and Recovery: <http://www.phe.gov/Preparedness/planning/mscc/healthcarecoalition/Pages/default.aspx>
- National Health Security Strategy: <http://www.phe.gov/Preparedness/planning/authority/nhss/strategy/Documents/nhss-final.pdf>
- Homeland Security Presidential Directive 5: http://www.dhs.gov/xabout/laws/gc_1214592333605.shtm
- Hospital Preparedness Exercise Pocket Guide: <http://www.ahrq.gov/prep/hospdpcktgd/hospdpcktgd.pdf>

P7: Written plans should include lists and points of contact for potential surge operation partners, including, but not limited to the following elements:

- Emergency medical services
- Fire service
- Law enforcement
- Healthcare organizations

P8: Written plans should include a process for ongoing communications and data sharing with 911 and emergency medical services. This may include requesting and utilizing National Emergency Medical Services Information System interoperable emergency medical services response data such as the following:

- Incident street address
- Complaint reported by dispatch
- Provider’s primary impression
- Mass casualty incident
- Destination/transferred to, name
- Type of destination
- Reason for choosing destination
- Hospital disposition

Suggested resources

- National Emergency Medical Services Information System Data Dictionary Version 3.0 (www.nemsis.org)
- Emergency Medical Services: www.ems.gov
- National 911 Program: www.911.gov

Function 1: Assess the nature and scope of the incident
Resource Elements *(continued)*

SKILLS AND TRAINING (S)	<p>S1: Public health personnel who may participate in medical surge operations should be aware of how to use local and state National Emergency Medical Services Information System and 911 data.</p> <p>S2: Public health staff who may participate in medical surge operations should be trained to use the jurisdictional bed-tracking system to obtain data for jurisdictional situational awareness activities.</p> <p>S3: Staff should understand the role of the public health department in incident management as described in the following resources:^{210,211}</p> <ul style="list-style-type: none"> – Emergency Support Function #8 – Public Health and Medical Services (IS-808) – Introduction to Incident Command System (IS-100.b) – Incident Command System for Single Resources and Initial Action Incidents (IS-200.b) – National Incident Management System, An Introduction (IS-700.a) – National Response Framework, An Introduction (IS-800.b)
EQUIPMENT AND TECHNOLOGY (E)	<p>E1: Have or have access to a computer with primary and back-up internet connection to access local and state National Emergency Medical Services Information System, 911 data, or access bed-tracking data. <i>(Does not apply to territories)</i></p> <p>E2: Have or have access to the jurisdictional bed-tracking system that complies with current Hospital Preparedness Program standards.</p> <p>E3: Bed-tracking data are to be reported in aggregate by the state, therefore the state must have a system that collects bed-tracking data from the participating healthcare systems, or states may use existing systems to automatically transfer required data to the HAVBED server using the HAVBED EDXL Communication Schema, found at https://havbed.hhs.gov/v2/</p> <p>Suggested resources</p> <ul style="list-style-type: none"> – Further information on the HAVBED system can be found at www.ahrq.gov/prep/havbed/ – HAVBED Communications Schema: https://havbed.hhs.gov/v2/

Function 2: Support activation of medical surge

Support healthcare coalitions and response partners in the expansion of the jurisdiction's healthcare system (includes additional staff, beds and equipment) to provide access to additional healthcare services (e.g., call centers, alternate care systems, emergency medical services, emergency department services, and inpatient services) in response to the incident.

Tasks

This function consists of the ability to perform the following tasks:

- Task 1:** If indicated, support the mobilization of incident-specific medical treatment personnel, public health personnel, and non-medical support personnel to increase capacity (e.g., healthcare organizations and alternate care facilities). *(For additional or supporting detail, see Capability 7: Mass Care and Capability 15: Volunteer Management)*
- Task 2:** During an incident, assist healthcare organizations and healthcare coalitions in the activation of alternate care facilities if requested.
- Task 3:** During an incident, assist in the expansion of the healthcare system (inclusive of healthcare coalitions), which includes hospitals and non-hospital entities (e.g., call centers, 911/emergency medical services, home health, ambulatory care providers, long-term care, and poison control centers).
- Task 4:** At the time of an incident, support situational awareness by utilizing the ongoing real-time exchange of information among response partners and coalitions (e.g., emergency medical services, fire, law enforcement, public health, and public works). *(For additional or supporting detail, see Capability 6: Information Sharing)*

Function 2: Support activation of medical surge

Tasks *(continued)*

Task 5: During an incident, provide information to educate the public, paying special attention to the needs of at-risk individuals (e.g., information is linguistically appropriate, culturally sensitive, and sensitive to varied literacy levels) regarding changes to the availability of healthcare services. *(For additional or supporting detail, see Capability 1: Community Preparedness, Capability 2: Community Recovery, and Capability 4: Emergency Public Information and Warning)*

Performance Measure(s)

At present there are no CDC-defined performance measures for this function.

Resource Elements

*Note: Jurisdictions must have or have access to the resource elements designated as **Priority**.*

PLANNING (P)

P1: (Priority) Written plans should include the following elements:

- Documentation of process or protocol for how the health agency will access volunteer resources through the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) and the Medical Reserve Corps program of credentialed personnel available for assistance during an incident.²¹²
- Documentation of processes for coordinating with health professional volunteer entities (e.g., MRC) and other personnel resources from various levels. (ESAR-VHP Compliance Requirements)^{213, 214}

(For additional or supporting detail, see Capability 15: Volunteer Management)

P2: (Priority) Written plans should include documentation of the process for how the public health agency will engage in healthcare coalitions and other response partners regarding the activation of alternate care systems.²¹⁵ Documentation should also include the following elements:

- Written list of healthcare organizations with alternate care system plans
- Written list of home health networks and types of resources available that are able to assist in incident response
- List of pre-identified site(s) that have undergone an initial assessment to determine their adequacy to serve as an alternate care facility

(For additional or supporting detail, see Capability 7: Mass Care)

Suggested resource

- Disaster Alternate Care Facility Selection Tool: <http://www.ahrq.gov/prep/acfselection/index.html>

P3: (Priority) Written plans should include processes and protocols to identify essential situational awareness information for federal, state, local, and non-governmental agencies; private sector agencies; and other Emergency Support Function # 8 partners. Jurisdictional processes to identify essential situational awareness requirements should consider the following elements:

- Identifying essential information
- Defining required information
- Establishing requirements
- Determining common operational picture elements
- Identifying data owners
- Validating data with stakeholders

(For additional or supporting detail, see Capability 6: Information Sharing)

P4: (Priority) Written plans should include documentation of participation from jurisdictional and regional pediatric providers and leaders from a variety of settings (e.g., maternal and child health programs, clinic-based, hospital-based, home healthcare, and rehabilitation) in jurisdictional response planning.^{216, 217, 218} Plans should include but are not limited to the following elements:

- Process to identify gaps in the provision of pediatric care
- Process to access pediatric providers or pediatric medical liaisons for consultation related to clinical care. In order to access the appropriate level of care or consultation, plans should include lists of healthcare organizations that can stabilize and/or manage pediatric traumatic and medical emergencies and that have written inter-facility transfer agreements that cover pediatric patients.

Function 2: Support activation of medical surge
Resource Elements *(continued)*

PLANNING (P)

Suggested resources

- Pediatric Hospital Surge Capacity in Public Health Emergencies: <http://www.ahrq.gov/prep/pedhospital/>
- Coordinating Pediatric Medical Care During an Influenza Pandemic: http://emergency.cdc.gov/healthcare/pdf/hospital_workbook.pdf
- Health Resources and Services Administration’s Emergency Medical Services for Children website: <http://bolivia.hrsa.gov/emsc/>

P5: Written plans should include process to connect healthcare organizations and providers with additional volunteers or other personnel (through ESAR-VHP, the Medical Reserve Corps, or the National Disaster Medical System) resources if necessary.²¹⁹ *(For additional or supporting detail, see Capability 15: Volunteer Management)*

P6: Written plans should include a process to support the integration of Medical Reserve Corps units with local, regional, and statewide infrastructure.^{220, 221} Considerations should include the following elements:

- Supporting Medical Reserve Corps personnel/coordinators for the primary purpose of integrating the Medical Reserve Corps structure with the state ESAR-VHP program
- Including Medical Reserve Corps volunteers in trainings that are integrated with that of other local, state, and regional assets, healthcare systems, or volunteers through the ESAR-VHP program and/or include Medical Reserve Corps volunteers in exercises that integrate the Medical Reserve Corps volunteers with other local, state, and regional assets such as healthcare system workers or volunteers that participate in the ESAR-VHP program

(For additional or supporting detail, see Capability 15: Volunteer Management)

P7: Written plans should include formal and informal partnerships with jurisdictional volunteer sources (may include memoranda of understanding, memoranda of agreement, or letters of agreement with partner agencies, if needed).^{222, 223} *(For additional or supporting detail, see Capability 15: Volunteer Management)*

P8: Written plans should include process to coordinate with the applicable U.S. Department of Health and Human Services Regional Emergency Coordinator to assess these sites and environmental suitability and pre-identify potential federal medical station sites.

Suggested resource

- Federal Medical Station Site Selection Criteria: <https://www.orau.gov/snsnet>

P9: Written plans should include process to coordinate with the applicable U.S. Department of Health and Human Services Regional Emergency Coordinator to address the need for wrap around services (e.g., biomedical waste and medical waste disposal) or provide information regarding accessing other services (e.g., food service and waste disposal) at potential federal medical stations.

P10: Written plans should include processes to disseminate volunteer resources to healthcare organizations and healthcare coalitions for the establishment of call centers to respond to call volumes. *(For additional or supporting detail, see Capability 15: Volunteer Management)*

Suggested resources

- Adapting Community Call Centers for Crisis Support: Adapt existing community call centers to allow callers to retrieve critical information during a hurricane: <http://www.ahrq.gov/prep/callcenters/>
- CDC, Coordinating Call Centers for Responding to Pandemic Influenza and Other Public Health Emergencies: A Workbook for State and Local Planners: http://www.airs.org/files/public/Disaster_CallCenterPandemicWorkbook.pdf

P11: Written plan should include a process to communicate medical surge information to the public.^{224,225} Plans should include a process for message clearance and approval.



CAPABILITY 10: Medical Surge

Function 2: Support activation of medical surge

Resource Elements *(continued)*

PLANNING (P)	<p>Plans should also take the following into consideration:</p> <ul style="list-style-type: none"> - Translation of materials/resources for populations with limited language proficiency - Development of materials/resources for population with low literacy - Development of materials/resources that are easy-to-read for population with impaired vision - Development of materials/resources for the hearing-impaired <p><i>(For additional or supporting detail, see Capability 4: Emergency Public Information and Warning)</i></p> <p>P12: Written plans should include a process for the local emergency medical services system to request additional resources (e.g., pediatric equipment and staffing) for the needs of pediatric cases as part of the jurisdictional Emergency Support Function #8 annex or other documentation. <i>(For additional or supporting detail, see Capability 15: Volunteer Management)</i></p>
SKILLS AND TRAINING (S)	<p>S1: Training for staff involved in personnel management</p> <p>Suggested resource</p> <ul style="list-style-type: none"> - Developing and Managing Volunteers (Federal Emergency Management Agency: IS-244): http://training.fema.gov/EMIWEB/is/is244.asp <p>S2: Competency identified in jurisdiction to recognize sick infants and children (either through telemedicine arrangements, neighboring partnerships, or other mechanism). Identify the appropriate personnel to complete training for pediatric care.</p> <p>Suggested resources</p> <ul style="list-style-type: none"> - American Heart Association, Pediatric Advanced Life Support—(comprehensive course): http://www.heart.org/HEARTORG/CPRAndECC/HealthcareTraining/Pediatrics/Pediatric-Advanced-Life-Support-PALS_UCM_303705_Article.jsp - American Heart Association, Pediatric Emergency Assessment, Recognition, and Stabilization (for those who do not routinely perform pediatric care): http://www.americanheart.org/presenter.jhtml?identifier=3052085 - National Association of Children’s Hospitals and Related Institutions: www.nachri.org - http://pediatrics.aappublications.org/cgi/content/abstract/peds.2009-1807v1
EQUIPMENT AND TECHNOLOGY (E)	<p>E1: Promote and assure that equipment, communication, and data interoperability are incorporated into the healthcare organizations’ acquisition programs. <i>(For additional or supporting detail, see Capability 6: Information Sharing)</i></p>

Function 3: Support jurisdictional medical surge operations

In conjunction with health care coalitions and response partners, coordinate healthcare resources in conjunction with response partners, including access to care and medical service, and the tracking of patients, medical staff, equipment and supplies (from intra or interstate and federal partners, if necessary) in quantities necessary to support medical response operations.

Function 3: Support jurisdictional medical surge operations

Tasks

This function consists of the ability to perform the following tasks:

- Task 1:** During an incident, coordinate and maintain communications throughout the incident per jurisdictional authority/ jurisdictional incident management structure with federal, state, local, and non-governmental agencies; private sector agencies; and other Emergency Support Function #8 partners to maintain situational awareness of the actions of all parties involved, determine needs, and maintain continuity of services during response operations. *(For additional or supporting detail, see Capability 3: Emergency Operations Coordination and Capability 6: Information Sharing)*
- Task 2:** During an incident, assess resource requirements during each operational period based on the evolving situation and coordinate with partners, including those able to provide mental/behavioral health services for the community, to obtain necessary resources (e.g., personnel, facilities, logistics, and other healthcare resources) to support the augmentation of services during surge operations. *(For additional or supporting detail, see Capability 9: Materiel Management and Distribution)*
- Task 3:** During an incident, coordinate with jurisdictional partners and healthcare coalitions to facilitate patient tracking during all phases of the incident. *(For additional or supporting detail, see Capability 6: Information Sharing)*

Performance Measure(s)

At present there are no CDC-defined performance measures for this function.

Resource Elements

*Note: Jurisdictions must have or have access to the resource elements designated as **Priority**.*

PLANNING (P)

- P1: (Priority)** Written plans should include processes and protocols to communicate situational awareness information to federal, state, local, and non-governmental agencies; private sector agencies; and other Emergency Support Function #8 partners at least weekly, but potentially more frequently (e.g., as often as once per operational period).^{226,227,228} *(For additional or supporting detail, see Capability 6: Information Sharing)*
- P2: (Priority)** Written plans should include documentation that public health participates in the development and execution of healthcare coalition plans to address the functional needs of at-risk individuals.^{229, 230, 231} Plans should include a written list of healthcare organizations and community providers that are able to address the functional needs for at-risk individuals and a process to communicate with healthcare organizations and community providers to maintain a current list of available services that support the functional needs of at-risk individuals. *(For additional or supporting detail, see Capability 1: Community Preparedness)*
- P3: (Priority)** Written plans should include processes to support or implement family reunification. Considerations should include the following elements:
- Capturing and transferring the following known identification information throughout the transport continuum:
 - Pickup location (e.g., cross streets, latitude & longitude, and/or facility/school)
 - Gender and name (if possible)
 - For nonverbal or critically ill children, collect descriptive identifying information about the physical characteristics or other identifiers of the child.
 - Keep the primary caregiver (e.g., parents, guardians, and foster parents) with the patient to the extent possible
- P4:** Written public health and healthcare coalition documentation should include processes to coordinate the inventory and requests for resources from jurisdictional, state, federal, and other Emergency Support Function #8 partners, based on the evolving situation. *(For additional or supporting detail, see Capability 9: Materiel Management and Capability 15: Volunteer Management)*
- P5:** Written plans should include protocols to participate in or coordinate with the jurisdiction's patient tracking system. *(For additional or supporting detail, see Capability 6: Information Sharing)*

Function 3: Support jurisdictional medical surge operations
Resource Elements *(continued)*

PLANNING (P)

P6: Written plans should include a process to coordinate their patient tracking efforts with local and state emergency medical services and 911 authorities. *(For additional or supporting detail, see Capability 6: Information Sharing)*

P7: Written plans should include process to establish a jurisdictional patient-tracking system in conjunction with state and local emergency management, emergency medical services, healthcare organizations, and other jurisdictional partners.

- Jurisdictional patient tracking system should be (1) closely coordinated with state government systems, (2) interoperable with relevant state and national patient-tracking systems, and (3) consistent with federal and state-approved privacy protection, regulations and standards for patient tracking systems.

(For additional or supporting detail, see Capability 6: Information Sharing)

EQUIPMENT AND TECHNOLOGY (E)

E1: Have or have access to electronic or other data storage systems that will be utilized to maintain situational awareness such as the Joint Patient Assessment and Tracking System. Electronic or other data storage systems must be consistent with national standards for communication. *(For additional or supporting detail, see Capability 6: Information Sharing)*

Suggested resource

- Recommendations for a National Mass Patient and Evacuee Movement, Regulating, and Tracking System: <http://www.ahrq.gov/prep/natlsystem/natlsys.pdf>

Function 4: Support demobilization of medical surge operations

In conjunction with other jurisdictional partners, return healthcare system to pre-incident operations by incrementally decreasing surge staffing, equipment needs, alternate care facilities, and other systems, and transition patients from acute care services into their pre-incident medical environment or other applicable medical setting.

Tasks

This function consists of the ability to perform the following tasks:

Task 1: During and after an incident, assist in the return movement of patients, to include the following:

- Assist or coordinate with medical facilities; emergency medical services; local, state, tribal, and federal health agencies; emergency management agencies; state hospital associations; social services; and participating non-governmental organizations to assure the return of patients to their pre-incident medical environment (e.g., prior medical care provider, skilled nursing facility, or place of residence) or other applicable medical setting.
- Facilitate the linkage of patients to healthcare services as requested.

Task 2: After an incident, coordinate with partners to demobilize all healthcare resources. *(For additional or supporting detail, see Capability 3: Emergency Operations Coordination, Capability 7: Mass Care, Capability 9: Medical Materiel Management, and Capability 15: Volunteer Management)*

Task 3: After an incident, coordinate with partners to demobilize alternate care facilities, resources obtained through mutual aid mechanisms, Emergency Management Assistance Compact, and/or federal assistance. *(For additional or supporting detail, see Capability 3: Emergency Operations, Capability 7: Mass Care, Capability 9: Medical Materiel Management, and Capability 15: Volunteer Management)*

Performance Measure(s)

At present there are no CDC-defined performance measures for this function.

Function 4: Support demobilization of medical surge operations
Resource Elements

Note: Jurisdictions must have or have access to the resource elements designated as **Priority**.

PLANNING (P)

- P1: (Priority)** Written plans should include a process for the jurisdiction to coordinate with state emergency medical services to demobilize transportation assets used in the incident.
- P2: (Priority)** Written plans should include a process to demobilize surge staff to include other state (e.g., MRC) and federal medical resources (e.g., NDMS). Process should include identification of triggers that would identify the need for demobilization. *(For additional or supporting detail, see Capability 15: Volunteer Management)*
- P3:** Written plans should include processes to assist the lead agency with the facilitation or coordination of medical transportation for patients requiring assistance.
- P4:** Written plans should include process to communicate with healthcare organizations and community providers to maintain a current list of healthcare services that are available to provide information to patients if requested.
- P5:** Written plans should include process to coordinate, if requested by healthcare organizations, case management or other support to assist the transition to pre-incident medical environment or other applicable medical setting.
- P6:** Written plan should include processes to communicate with U.S. Department of Health and Human Services Regional Health Administrators, Regional Emergency Managers, and Regional Emergency Coordinators to address the functional needs of patients.
- P7:** Written plans should include a process to coordinate with jurisdictional authorities and partner groups to support volunteer and other personnel post-deployment medical screening, stress, and well-being assessment and, when requested or indicated, referral to medical and mental/behavioral health services. *(For additional or supporting detail, see Capability 2: Community Recovery, Capability 14: Responder Safety and Health, and Capability 15: Volunteer Management)*
- P8:** Written plans should include a process for releasing volunteers and other personnel, to be used when the health department has the lead role in volunteer or other personnel coordination. Plans should include steps to achieve the following:
- Demobilize volunteers and other personnel in accordance with the incident action plan
 - Assure all assigned activities are completed, and/or replacement volunteers are informed of the activities' status
 - Determine whether additional assistance is needed from the volunteer or other personnel
 - Assure all equipment is returned by volunteer or other personnel
 - Confirm the volunteer and other personnel's follow-up contact information
- (For additional or supporting detail, see Capability 3: Emergency Operations Coordination and Capability 15: Volunteer Management)*
- P9:** Written plans should include a protocol for conducting exit screening during out-processing, to include collection of the following:
- Any injuries and illnesses acquired during the response
 - Mental/behavioral health needs due to participation in the response
 - When requested or indicated, referral of volunteer to medical and mental/behavioral health services.
- (For additional or supporting detail, see Capability 14: Responder Safety and Health and Capability 15: Volunteer Management)*