

## Annex E – RESOURCE MANAGEMENT

When the capabilities of the county public health agency are inadequate for it to continue to perform the activities needed to protect the health of the public, the agency may obtain personnel, equipment, supplies, and other types of resources from other jurisdictions through the use of a mutual aid agreement, such as a “28E” agreement.

Limited state government assistance, including consultation about technical topics, may be available to LPHA’s directly through IDPH. In many instances, however, the LPHA will need to work in cooperation with its local emergency management agency to:

- Access the resources of other Iowa jurisdictions through the state mutual aid compact process;
- Access municipal, county, and state government resources; and
- Access to federal resources, such as pharmaceuticals or smallpox vaccine through the Strategic National Stockpile, which are requested from the federal government through the state.

Note that before these three channels for obtaining assistance can be accessed, the county’s senior elected official(s) must formally declare a state of emergency.

**Important note: Under some circumstances, such when a county emergency management agency is not accessible, LPHAs may contact the IDPH Center for Acute Disease Epidemiology directly at its 24-hour number (800-362-2736) to request state and federal resources needed to respond to an emergency.**

The following are a few essential resource management activities:

*The logistics section records use of resources and equipment, the planning section documents personnel, and the finance section tracks expenses for both.*

Keeping track of where equipment and/or supplies are borrowed from or purchased; Logistics and Finance Sections.

Keeping track of personnel hours devoted to emergency-response-related activities (this includes volunteer hours); Planning and Finance Sections

Keeping track of the location of personnel, equipment, and supplies during all phases of the response; Logistics

Maintaining an accurate accounting of all emergency-response-related expenditures; Finance

Ensuring that borrowed resources are returned to the lender in good condition and that purchased resources are paid for in a timely manner. Finance, Logistics

Named for the chapter in state statute that establishes a standard mutual aid framework.

The twelve articles of the compact are listed in section 29C.22 of Iowa Code.

Refer to SNS toolkit provided to each county by IDPH for information about supplies available and how they are requested.

Rigorous performance of these activities throughout the response period will minimize problems with obtaining disaster-related financial reimbursement from the federal government (when available), and will also provide valuable data for future planning purposes.

A bio-emergency often will not be confined to a single jurisdiction, and may affect the entire state. Therefore, county public health agencies should not rely entirely on the possibility of obtaining additional resources from other jurisdictions or from state government. If practicable, each agency should maintain a stock of supplies sufficient to carry out essential functions under emergency conditions for three to five days, or

until such time as it is reasonable to expect replenishment of these supplies from normal channels, such as vendors. Supplies to consider stocking include, but are not limited to, those listed on the following page.

Attachment 1 – Emergency Supply Stockpile in storage at CHP

- Emergency medical kits
- Masks (n-95 for those fit tested; surgical)
- Waterless hand wash
- Band-aids
- 1 X 1 gauze pads
- Paper tape
- Dixie cups, alcohol
  - Disposable gloves (at least some should be non-latex)
  - Blood pressure cuff/stethoscope
  - Needles and syringes
  - A CPR mask
  - Sharps containers
  - Office supplies

## **ANNEX E: MASS CARE AND MASS CASUALTY**

### **PURPOSE**

The CHP Mass Patient Care and Mass Casualty annex serves to establish plans, procedures, and guidelines for providing assistance to the Sioux county Emergency Manager to serve the general welfare of individuals home bound or forced to evacuate their homes and support medical care and treatment response to those ill or injured as a result of a natural disaster, bio-event, chemical spill, explosion, or Bioterrorism.

### **MASS PATIENT CARE**

Mass Patient Care comprises of services to individuals confined or displaced from their homes during an extended or widespread emergency. Under the coordinated direction of Homeland Security, CHP will be one of many local agencies responsible for the provision of food, medical supplies, and other essential support for those individuals. CHP Homeland Security Annex G: mass care establishes plans, procedures, policies and guidelines for functional operation.

### **MASS CASUALTY**

Mass Casualty provides assurance that the maintenance of essential medical care and treatment for the ill and injured during, or as a result of, a natural disaster, bio-event, chemical spill, explosion, or Bioterrorism is not interrupted. CHP will provide necessary services under the direction of EMA Annex G: Health and Medical.

The four hospitals in Sioux County, functioning under their emergency response plans, will operate under the auspices of Sioux County EMA and serves as primary leaders in Mass Casualty incident situation. They will establish need for existing resources, isolation units, additional auxiliary hospital facilities, and financial resources.

### **MORTUARY SERVICES**

Primary responsibility for Mortuary Services is determined by each hospital. They will provide proper handling of victims remains to include identification, respectful care, family notification, disposition, and provide status reports to Sioux County EMA. If necessary, CHP will provide information and recommendations related to proper handling of victims and need for cremation if mortality is related to an infectious biological agent.

### **ROLES AND RESPNSBILITIES**

In the event of a natural disaster, chemical spill, or explosion, the Health Department will integrate into the Sioux County Mass Patient Care Annex and/or Mass Casualty Annex and serve as a primary resource if necessary. CHP Incident command will contract maintaining critical EOC support positions as needed. CHP will remain operational under Annex A: Direction and Control, provide public information as referenced in Annex B: Risk Communication, and provide disease surveillance and recommend isolation/quarantine measures, if necessary, described in Annex C: Epidemiology and Surveillance.

**SITUATION**

Bio-emergencies can be broadly categorized into two types: those that are contagious among humans and those that are not.

- A. BIO-EMERGENCIES INVOLVING NON-CONTAGIOUS AGENTS:** In some ways these are similar to typical rapid-onset disasters of a non-biological nature. Examples include bioterrorist attacks using the anthrax bacteria or widespread food-borne toxicities like botulism or salmonella poisoning emanating from a food processing plant. Individuals exposed in a non-contagious event will require medical triage and evaluation, although the propagation of the event will be limited because of the lack of person-to-person transmission. Chaos and misinformation will be significant and persistent problems.
- B. BIO-EMERGENCIES INVOLVING CONTAGIOUS AGENTS:** These could affect many geographic areas simultaneously. Examples include an influenza pandemic or a smallpox outbreak. Every community should develop some level of self-sufficiency in preparation for this type of emergency since resources from contiguous counties or state government may not be available.

If illness associated with a bio-emergency is especially severe, local health agencies could become overwhelmed very quickly with one or more of the following conditions:

- Shortfalls of ICU beds, ventilators, and other critical-care needs;
- Shortages of antibiotics and/or antiviral agents;
- Demand for ancillary or "non-traditional" treatment centers;
- High demand for mortuary/funeral services; and
- High demand for social and counseling services.

Moreover, unlike natural disasters, demands on health-care providers in each community will be prolonged as the illness spreads from susceptible person to susceptible person.

Unlike the typical disaster, essential public-sector response personnel (e.g., medical-care personnel, police, firefighters, ambulance drivers, and other first responders) may be even more likely than the general public to be affected by an outbreak involving a contagious disease because of their ongoing exposure to a large cross section of the population.

Because of the threat of exposure to influenza or other infectious diseases, the elderly and other high-risk and special-needs populations may be fearful of leaving their homes, or in some cases unable to do so, for the purpose of seeking proper medical attention for chronic medical conditions, and may require home visits for health care, when practicable.

The situation is further complicated when a bio-emergency is precipitated by a terrorist attack because, unless they have received special training, most health-care providers will not be familiar with the characteristics of the disease-causing agents that experts think are most likely to be used by a terrorist. See Attachment 7 to this annex for a list of biological terrorism agents and their characteristics.

In summary, high attack rates<sup>7</sup> associated with a bio-emergency, accompanied by a perception of personal danger among the public, will place overwhelming demands on the health-care system. Health-care providers, emergency response and public safety personnel, and public health professionals will be equally or more likely to become infected than the general public. Certain high-risk groups will be less likely to have access to information and services (e.g., people who are homeless, homebound, mentally disabled, or who do not speak English). Because the epidemic will be widespread, it is unlikely that resources could be diverted from other geographic areas. Every community will have to be prepared to be self-sufficient, while at the same time sharing available resources such as hospitals beds, mortuary services, etc.

**ACTIVITIES BY RESPONSE LEVEL**

*No Threat or Emergency (Threat condition green or blue: guarded or low)*

1. The following table can be used to obtain rough estimates of the effects of an influenza pandemic on our jurisdiction.

| <b>Percent of Population Affected by Next Pandemic (CDC Estimates)</b> | <b>No. Affected in Iowa (Pop. 2,936,7609)</b> | <b>No. Affected in Your Community (Pop. 31,589)</b> |
|--|---|---|
| Up to 37% of pop. will become ill with flu                             | 1,086,601                                     | 11,688  |
| Up to 17% of pop. will require out-patient visits                      | 499,249                                       | 5,370   |
| Up to 0.4% of pop. will require hospitalization                        | 11,747  | 126   |
| Up to 0.1% of pop. will die of flu-related causes                      | 2,937   | 32  |

2. For emergency planning purposes, assume that the morbidity and mortality resulting from a bioterrorist release of smallpox or pneumonic plague will be similar to or greater than those associated with a major influenza outbreak.
3. Assist community personnel with understanding the plan and their role in implementing it by providing training and organizing exercises.
4. Develop contingency plans to provide food, medical supplies, and other essential items for persons confined to their homes by choice or by direction from state or local health officials (i.e., via a temporary or court order to isolate or quarantine an individual or group). Enlist appropriate voluntary and/or civic organizations as needed to implement these plans.
5. Develop a list of essential community services (and corresponding personnel) whose absence would pose a serious threat to public safety or would significantly interfere with the ongoing response to the emergency.
6. Develop contingency plans for emergency backup of essential services and/or provision of replacement personnel. Replacement personnel could come from lists of retired government or private sector employees with relevant expertise. Note that critical personnel in the non-health sector should also be considered high-priority candidates for vaccination, pharmaceuticals or other forms of treatment/prophylaxis.

8 CDC's National Vaccine Program Office has developed an automated tool for performing this analysis, which can be accessed [www2.cdc.gov/od/fluid/default.htm](http://www2.cdc.gov/od/fluid/default.htm).

9 US Census 2002 Total State Population Estimate.

*Threat (threat condition yellow and orange: elevated or high)*

1. Meet with appropriate partners and stakeholders from health and relevant non-health sectors to review the major elements of their respective emergency response plans and operating procedures.

## 2. Modify plans and procedures as needed to account for significant changes to the universe of likely causes

and consequences of a bio-emergency. Ensure that those people and organizations whose roles are affected by these modifications fully understand the implications and, if necessary, receive supplemental training.

3. Implement contingency plans developed for the purpose of obtaining critical equipment (e.g., ventilators) and drugs (e.g., antibiotics for treatment of secondary pneumonia) when not available in sufficient quantities through normal channels.
4. Meet with appropriate partners and stakeholders and review major elements of this plan. Identify training needs at this time, as well as a plan to meet these needs.
5. Ensure that human resources and logistics are in place to provide medical care and to maintain essential community services. This may require activation of the local emergency operations center and additional training.
6. Coordinate activities with bordering jurisdictions, including those in neighboring states, if applicable.

### *Actual Bio-Emergency (threat condition red or severe)*

1. Fully activate all applicable components of this plan and the jurisdiction's multi-hazard emergency response plan (this includes activating the local emergency operations center).
2. Continue to coordinate activities with neighboring jurisdictions.
3. Interface with appropriate counterparts at the state level.

## **PLANNING TO MEET THE NEEDS OF PERSONS CONFINED TO THEIR HOMES**

During an extended or widespread emergency, persons may be confined to their homes by choice, out of fear of being exposed and becoming ill, or by direction from state or local health officials in order to reduce transmission in the community (i.e., via a temporary or court order to isolate or quarantine an individual or group).

The provision of food, medical supplies, and other essential support for persons confined to their homes will be the responsibility of local communities. Local communities are encouraged to make use of civic organizations and other volunteers to meet these needs. For instance, local agencies already engaged in providing services to the homebound (Meals-on-Wheels, etc.) may become the nucleus for voluntary efforts to provide services to people confined to their homes.

In addition, there will likely be situations in which those who care for children, the elderly, or others with special needs will become ill and unable to do their jobs.

Communities will need to have plans in place to identify these situations (e.g., hotlines and/or home visiting programs) and contingency plans for caring for these individuals. Possible resources to staff hotlines or home visiting programs include civic/volunteer organizations, local colleges, and senior citizens. Using these resources on a regular basis to staff flu clinics, health fairs, etc. will ensure a ready group of volunteers in a bio-emergency.

### **1. Medical Care for People Sick at Home**

Families will need information about how to take care of sick family members at home, and guidelines regarding when to seek professional medical care. This first-line triage will be essential to eliminating unnecessary calls and decreasing the burden on health-care providers, freeing them to care for the seriously ill.

ill. The information that families will need should be available through multiple sources, included local print, TV and radio media, web sites and hotlines.

### **Maintenance of Other Essential Community Services**

Personnel who provide essential community services, including public safety and emergency response, will be as likely to become ill during a bio-emergency as the general public. A process for replacing essential personnel during periods of high absenteeism due to illness needs to be in place and widely adopted to ensure continuation of essential community services during the pandemic.

Each local agency should develop (or review and update, if they already exist) lists of essential services and personnel. Contingency plans should be developed to provide backup for any personnel whose absence would pose a threat to public safety or would significantly interfere with the ongoing response to a bio-emergency. Back up personnel could be obtained through the reassignment of personnel from non-essential programs within the local agencies, retired personnel, and /or private-sector personnel with relevant expertise.