Michigan Medical Surge Support Plan

Annex #9 to the Emergency Operations Plan.

Michigan Department of Health and Human Services
Bureau of Emergency Preparedness, EMS and Systems of Care

MDHHS | Bureau of Emergency Preparedness, EMS and Systems of Care

Michigan Department of Health & Human Services

Contents

Purpose and Scope

The Michigan Medical Surge Plan is a functional annex to the Michigan Department of Health and Human Services (MDHHS) Emergency Operation Plan (EOP). The MDHHS Bureau of Emergency Preparedness, EMS and Systems of Care (BEPESoC) Hospital Preparedness Program (HPP) works collaboratively with the Administration for Strategic Preparedness and Response (ASPR) as well as the eight regional healthcare coalitions (HCC) to prepare for, mitigate and respond to medical surge across the state.

This document provides a proposal for preparedness and response guidance for a mass casualty incident that challenges the medical resources at the local, regional, and/or state level.

The purpose of the Medical Surge Plan is to outline Michigan's strategy to enhance medical surge capacity and capability during an incident. This plan seeks to:
- Provide information and guidance to effectively plan for, organize, and manage the response to a medical surge incident.
- Describe how local jurisdictions can request and receive assistance, offer and aid other organizations, and exchange information to maximize awareness during a medical surge incident.
- Maximize efficiency and effectiveness during a disaster or emergency.
- Provide a tiered framework, and the interface requirements for each tier to effectively operate under emergency conditions and facilitate receiving or sharing resources.
- Integrate with other sections of the MDHHS EOP.

Authorities

The legal authorities to protect the public during an emergency that impacts the public health are contained in two statutes, Michigan's Public Health Code, P.A. 368 of 1978 and Emergency Management Act, P.A. 390 of 1976. MDHHS is the lead state agency for Emergency Support Function (ESF) 8, Public Health and Medical Services, working with the HCCs and local health departments (LHD).

Assumptions

Hospital EOPs include provisions to identify staff, space and supplies to surge above 20% of the average daily census. However, the point at which a hospital can no longer handle a surge is decided at the hospital level. Additionally, as an incident worsens, resource imbalance increases, and the risk of morbidity and mortality to patients increases, response and assistance from agencies will be requested.
- A mass casualty incident will stress the entire medical system, including emergency responders such as EMS or medical specialties, which can disrupt the continuity of operations as well as continuum of care.
- Mass casualty, resulting in a medical surge, will produce individuals seeking healthcare services that may severely overwhelm local, regional and state resources.

- Healthcare coalitions operate regional medical coordination centers (MCC) to coordinate response to an incident that crosses jurisdictions and/or exceeds the capacity of local agencies to respond.
- A large-scale mass casualty or medical surge incident may require a sustained operational response.
- The peak time of demand for surge capacity will be within the first 24-48 hours.
- Each hospital, healthcare organization (HCO) and HCC are unique, with its own capabilities.
- Interstate and federal healthcare resources can be activated in conjunction with the State Emergency Operations Center (SEOC).
  - The Great Lakes Healthcare Partnership (GLHP) members have signed a Memorandum of Understanding (MOU) to share resources if needed.
- Efficient coordination of medical resources during a public health emergency requires the use of structured management systems.
  - Management and coordination of all medical resources including personnel, procedures, equipment, and communications will be managed through the Incident Command System (ICS).
  - The [Incident Command System (ICS)](#) is a standardized approach that guides the command, control, and coordination of emergency response, facilitating consistent communication and effective operations.
- Establishing alternate care sites (ACS) will challenge healthcare delivery including space, staffing and supplies.
- Regional MCCs have limited medical supply/equipment caches.
- State supplies are limited and will be prioritized based upon the greatest projected medical benefit.

Response Structure

Roles and Responsibilities

Healthcare Coalitions

Michigan's HCCs support HCOs to deliver a coordinated and effective response to an emergency that impacts medical or public health in Michigan.

- Coordination among local healthcare assets through their National Incident Management System (NIMS) compliant MCC.
- Serve as a central integration mechanism for information sharing.
- Manage coordination among healthcare assets.
- Coordination among local and regional HCOs and local emergency operations centers (EOC).
- Assist, through coalition-level workgroups, in rapidly developing clinical and facility best practices or formalized information sharing strategies.
- Provide situational awareness with the MDHHS CHECC.
- Coordinate information flow including data between local and state agencies.

Emergency Preparedness Regions and Local Health Department Districts

Michigan has 45 local health departments representing one city (Detroit), 30 counties and 14 multi-county districts.

Michigan has eight regional Health Care Coalitions/Emergency Preparedness Regions defined by geographical boundaries. These coalitions work with local partners within each region to prepare hospitals, emergency medical services and other health care organizations to prepare for, respond to and recover from incidents.

Local Health Department Districts
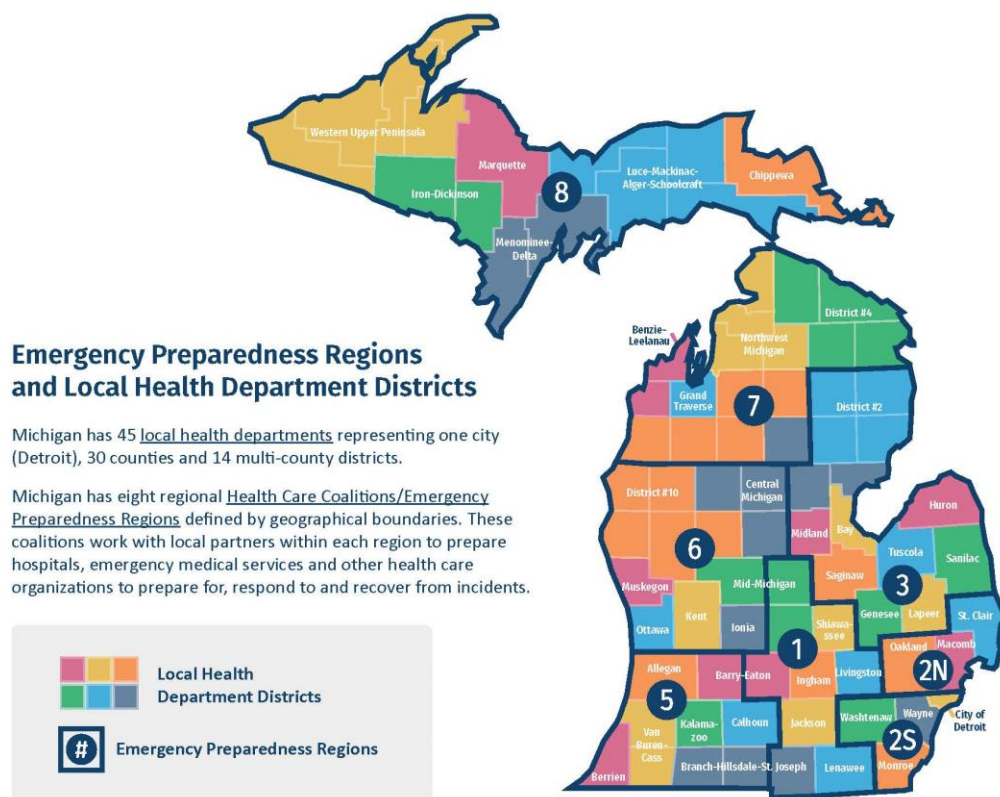
Emergency Preparedness Regions

Figure 1: Michigan's healthcare coalitions are regionally based to align with the Michigan State Police's (MSP) Emergency Management Regions. The map shows those regions along with the placement of Michigan's 45 local health departments.

Healthcare Facility

- Facilitate system decompression.
- Collect and share data using common language on a pre-determined schedule with regional partners through EMResource.
- Vet and credential staff.
- Use quantitative and qualitative data to help with decision making.
- Implement surge contingency plans including the use of backup units, addressing staffing shortages and strategies for conservation.

Local Health Department

- Provide situational awareness to impacted jurisdiction(s) Local Emergency Operations Center (LEOC).
- Provide situational awareness and facilitate information sharing amongst HCO partners.
- Maintain situational awareness with MDHHS and with the MDHHS Community Health Emergency Coordination Center (CHECC), when activated.
- Provide staff for ESF 6 (Mass Care, Emergency Assistance, Temporary Housing, and Human Services) and ESF 8 (Public Health and Medical Services) functions to the LEOC when requested and in accordance with local plans.
- Coordinate and/or provide risk communications to the media and the public.

Local and State Emergency Management

- Provide support for medical surge response activities.
- Assist in the coordination of information sharing for situational awareness.
- Assist in the coordinated efforts of intra- and inter-state mutual aid.
- Facilitate interaction and planning between affected jurisdictions.

Medical Control Authority

- Provide coordinated EMS transportation and care of patients during a medical surge incident, as per the *State Special Operations Mass Casualty Protocol*, as provided by MCL 333.20965 of Part 209 of PA 368 of 1978.

State Level Responsibilities

State level responsibilities are defined in the MDHHS EOP, the Michigan Emergency Management Plan (MEMP) and Public Act 368 of 1978, as amended, part 209. The role of state agencies may vary based upon the nature of the medical surge incident. Roles may include support for incidents managed at the jurisdictional level, coordinating multijurisdictional incident responses, and providing resources and support for the incident response.

The State Emergency Operations Center (SEOC) is activated when deemed appropriate.

- The Emergency Management and Homeland Security Division (EMHSD) within the MSP will support response activities and mobilize resources as required in

collaboration with MDHHS, HCCs, local public health, and local emergency management.

BEPESoC operates the CHECC, which is the central point for emergency coordination and guides actions between the MDHHS, healthcare, EMS, local public health, healthcare coalitions and the SEOC.

- The CHECC serves as the coordination center between LHD, Centers for disease Control and Prevention (CDC), ASPR and other state agencies on public health and healthcare related issues.
- Assist with the coordination of public health actions and recommendations.
- Request medical countermeasures when necessary.
- Coordinate risk communications with partners.
- Assist healthcare agencies and local public health partners in the detection, investigation, intervention and recovery of a medical surge.
- Vet and credential volunteers.
- Deploy mortuary services, when requested.

Figure 2 outlines examples of coordination and responsibilities with state agencies.

MDHHS Bureau of Laboratories	- Guidance to clinical laboratories. - Expedite specimen packing and transport.
MDHHS Division of EMS and Systems of Care (DESoC)	- Deployment of state EMS protocols. - Support MCA and local EMS agencies with patient transport and care.
MDHHS Division of Victim Services	- Psychological and financial support to victims after a criminally caused mass casualty incident or public health emergency.
MDHHS Health Services	- Outreach to community mental health providers. - Federal behavioral health grant applications. - Community assessments and subject matter expertise on trauma informed care.
MDHHS Vital Records	- Collect and maintain death records.
Licensing and Regulatory Affairs (LARA)	- Provide guidance and requirements for worker health and safety, waste management, sanitation practices and Personal Protective Equipment (PPE) standards.

Figure 2: Examples of State of Michigan divisions that often play a role in responses, coordinated through the Community Health Emergency Coordination Center (CHECC).

### *Federal Level Responsibilities*

The U.S. Department of Health and Human Services (DHHS) provides technical assistance for state and local public health, hospitals and impacted HCOs if a federal disaster is declared.

- The Federal Emergency Management Agency (FEMA) Region 5 ASPR Regional Emergency Coordinator is the liaison between MDHHS and FEMA.
- The FEMA Ambulance Agency Contract can be activated by FEMA if warranted and under a federal disaster declaration.

Response Communications

Communication is a key component in all emergency response efforts. Figure 3 delineates the communications pathway during an emergency response specific to medical management. The SEOC remains the lead agency for any state emergency response. All state agencies support the SEOC in varying degrees depending on the nature of the incident and according to the ESF as described in the MEMP. The MDHHS is the lead state agency for ESF 8 and all health and medical related incidents such as medical surge, mass prophylaxis, and other infectious diseases such as pandemic influenza.
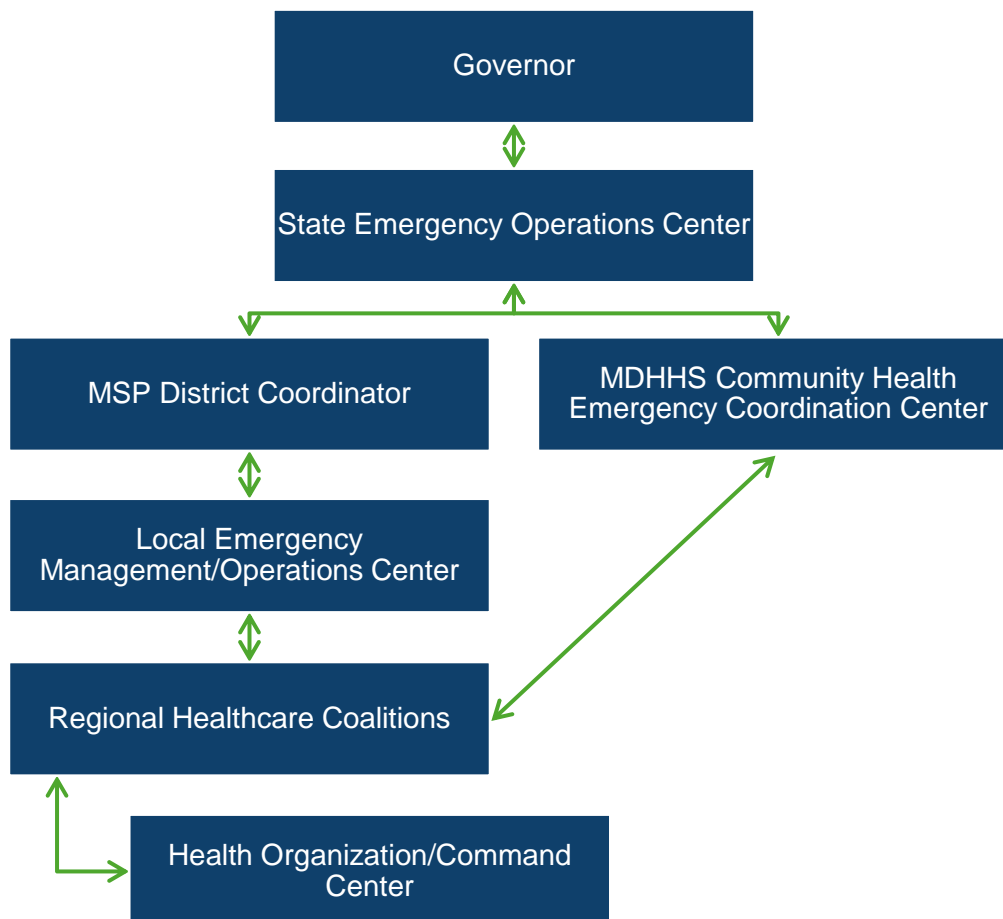
Figure 3: Medical Communications Pathways During Emergency Response.

Essential Elements of Information (EEI)

Essential Elements of Information (EEI) are critical information requirements regarding the incident that is occurring, the impact on the facility, and requested resources or

assistance. A general EEI form has been developed and included in Appendix A.
Specific types of incidents may require specific EEI forms.

Intra- and Inter-state Coordination and Collaboration

Intra-state

When local and regional resources have been exhausted, the HCC can request
resources through the CHECC for intra-state medical surge management resources.
These requests may utilize the Michigan Emergency Management Assistance Compact
(MEMAC).

Inter-state

When it is apparent that the effort required to effectively handle the medical surge
incident is beyond the capability of in-state resources, the Regional MCC will request
additional resources through the MDHHS CHECC to the SEOC, as established above in
the Response Communications section. The SEOC, in conjunction with the CHECC, will
make the request for inter-state medical surge management resources via the
Emergency Management Assistance Compact (EMAC), Northern Emergency
Management Assistance Compact (NEMAC) or National Disaster Medical System
(NDMS) using established processes through the SEOC.

Expanding incidents require expanded coordination with additional jurisdictions. Figure
4 outlines response tiers and the roles that align within each tier.

Tiered Framework

Tier 1: Federal support to state and locals is coordinated in partnership with the State Emergency Operations Center (SEOC).

Federal Response

Tier 2: Inter-state regional coordination/mutual support. The SEOC liaises with emergency operations in other impacted states.

State A **State B**

Tier 3: State response and coordination of intrastate jurisdictions. In Michigan, this is the SEOC.

State A

Tier 4: Jurisdiction incident management at the local emergency operations center (LEOC).

Jurisdiction 1 **Jurisdiction 2**

Tier 5: Healthcare coalition coordinates with healthcare organizations to mitigate impacts to the state's healthcare system.

Healthcare Organization A **Healthcare Organization B** **Healthcare Organization C** **Non Healthcare Organizations**

Tier 6: Healthcare asset management. Isolated response.

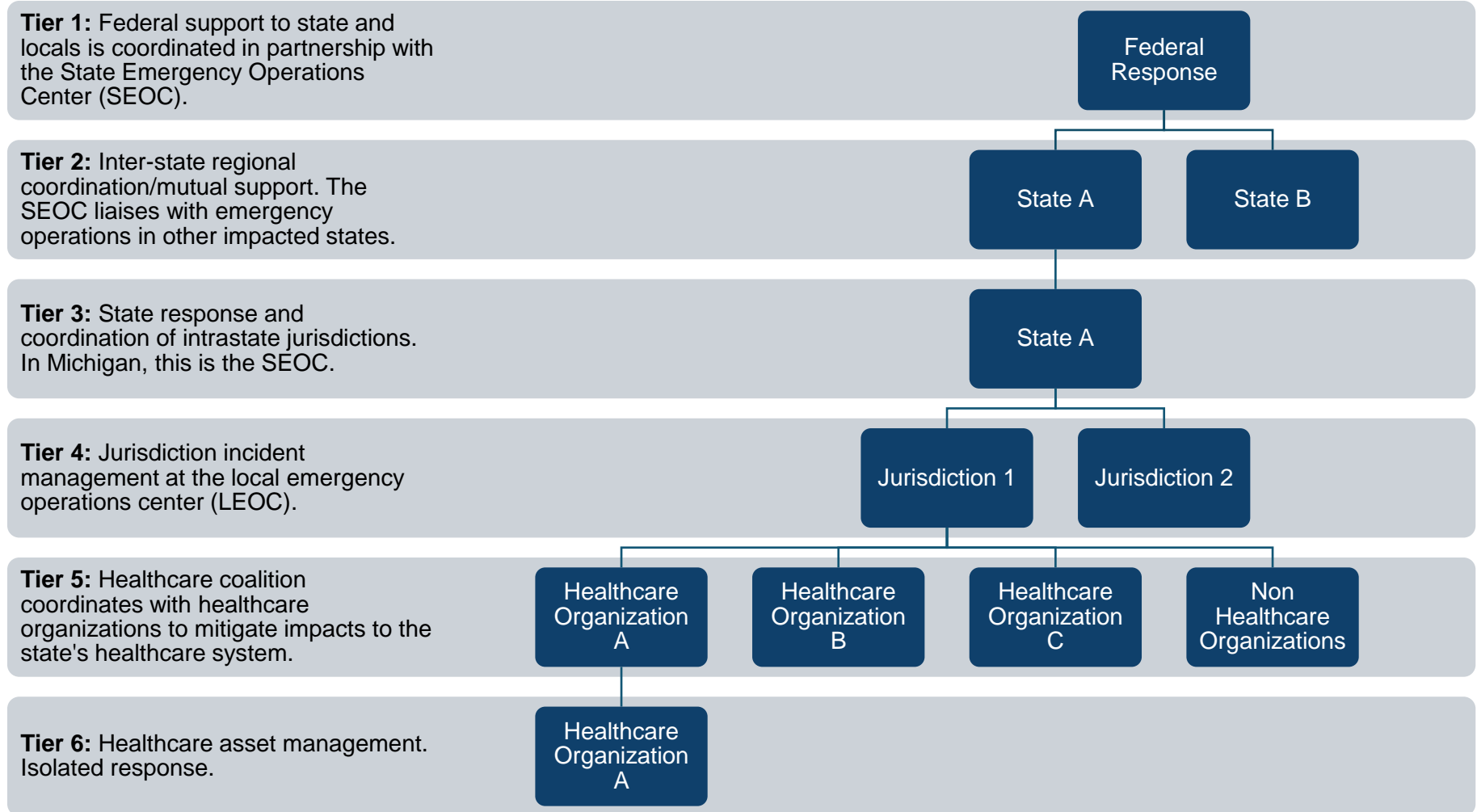**Healthcare Organization A**

Figure 4: Michigan's response structure is outlined through a tiered framework to support inter- and intra-state coordination.

Medical Ethics

During a public health emergency, decision-makers must carefully consider the development and implementation of practical, logistical, and scientific methods necessary for effective response and recovery. The [Michigan Guidelines for Implementation of Crisis Standards of Care and Ethical Allocation of Scarce Medical Resources and Services During Emergencies and Disasters](#) serve to inform local, state and federal governments; regional healthcare coalitions; relevant agencies and organizations; and other preparedness and response partners to plan for medical ethics considerations specific to a mass casualty incident within the state of Michigan.

Medical Surge Triggers

Foreseeing every disaster situation is unattainable. Using an all-hazards approach, along with regular hazard vulnerability assessments, will allow for planning, training and exercises that both consider likely scenarios, but is also adaptable and flexible enough to accommodate any hazard which results in a medical surge. The guidelines referenced above delineate examples of indicators and triggers for healthcare agencies, including long-term care facilities.

Additional guidance for indicators, triggers and tactics is published in the MDHHS [Crisis Standards of Care Indicators and Triggers](#).

For each of the critical system components (space, staff and supplies) needed to respond to a medical surge incident, there are three measurements that provide guidance to overall surge capacity at each of the tiered levels. An incident does not have to overwhelm assets in all the categories to have an impact on healthcare.
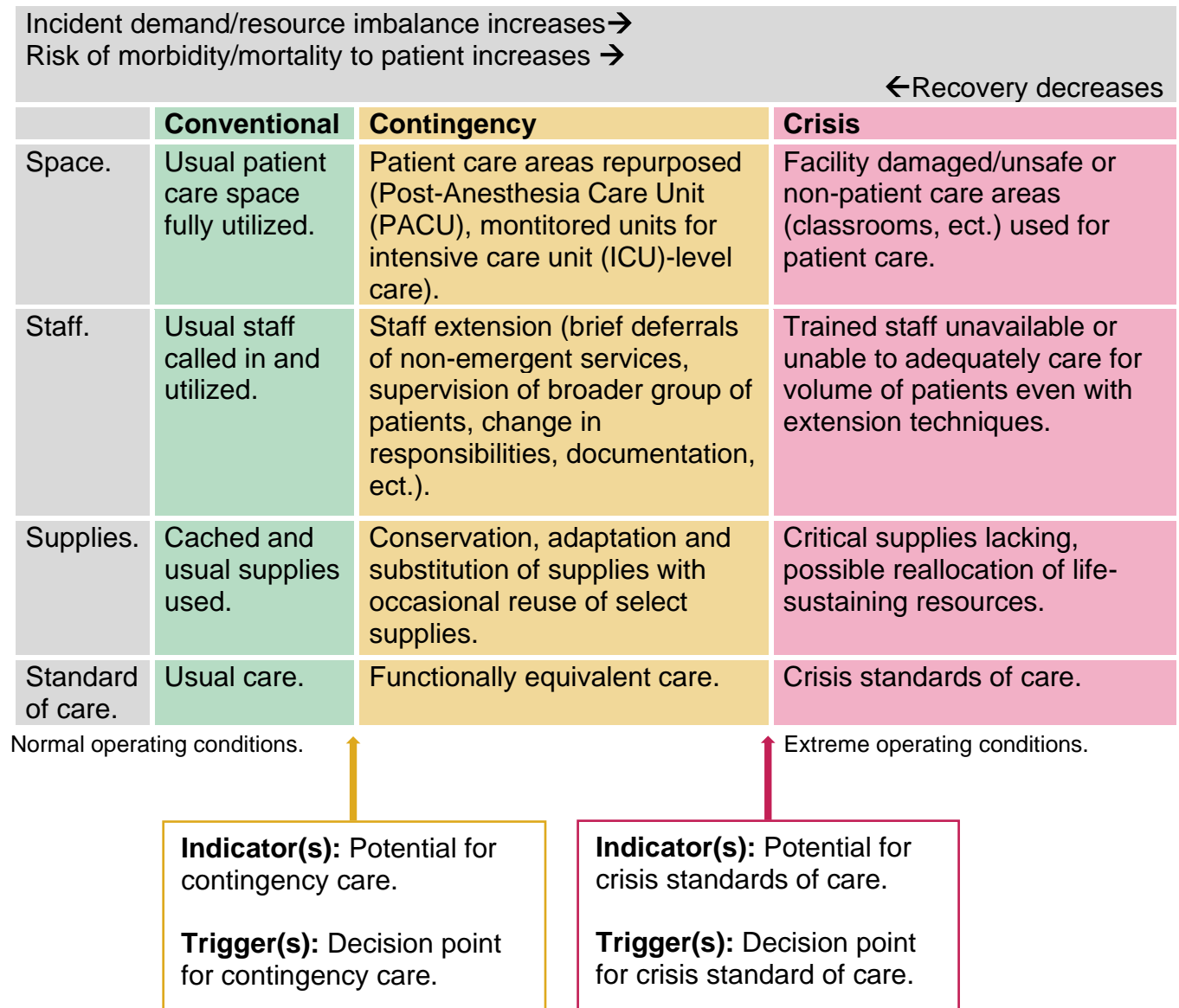
- **Conventional capacity** is the ability for hospitals to manage a surge, while operating daily practices with little or no impact on the patient or facility.
- **Contingency capacity** affects the ability for hospital daily practices to be consistent but has minimal impact on usual patient care. At this point, the demand has not yet overwhelmed available community resources. During this phase, HCOs need to begin planning for an internal surge of patients by determining bed availability or the potential use of a local or regional ACS.
- **Crisis capacity** is not consistent with daily practices, but the standard of care is coherent within the setting of an emergency. The best possible care is provided to patients under these circumstances.

As outlined in Figure 5, indicators and triggers guide transitions along the continuum of care from conventional to contingency to crisis and in the return to conventional. Taking specific steps can help emphasize the key sources of information that act as indicators, helping to determine whether the information confirms the decision to trigger specific tactics. Four steps form the basis of this approach:

- Identify key response strategies and actions necessary to respond to an incident.

- Identify and examine potential indicators that form the decision to initiate actions.
- Determine trigger points for taking these actions.
- Determine tactics that could be implemented at these trigger points.

Incident demand/resource imbalance increases→
Risk of morbidity/mortality to patient increases →

←Recovery decreases

	Conventional	Contingency	Crisis
Space.	Usual patient care space fully utilized.	Patient care areas repurposed (Post-Anesthesia Care Unit (PACU), montitored units for intensive care unit (ICU)-level care).	Facility damaged/unsafe or non-patient care areas (classrooms, ect.) used for patient care.
Staff.	Usual staff called in and utilized.	Staff extension (brief deferrals of non-emergent services, supervision of broader group of patients, change in responsibilities, documentation, ect.).	Trained staff unavailable or unable to adequately care for volume of patients even with extension techniques.
Supplies.	Cached and usual supplies used.	Conservation, adaptation and substitution of supplies with occasional reuse of select supplies.	Critical supplies lacking, possible reallocation of life-sustaining resources.
Standard of care.	Usual care.	Functionally equivalent care.	Crisis standards of care.

Normal operating conditions.　　　　　　　　　　　Extreme operating conditions.

Indicator(s): Potential for contingency care.

Trigger(s): Decision point for contingency care.

Indicator(s): Potential for crisis standards of care.

Trigger(s): Decision point for crisis standard of care.

Figure 5: Continuum of Incident Care.

Patient Tracking/Triage

One function of the MCC led by the HCCs may be to preserve load-balancing across healthcare facilities and systems so the highest possible level of care can be provided to all patients who need care before shifting hospitals toward crisis measures.

The MCC focuses on the delivery of healthcare services and operates as a component of the ESF 8 activities, bringing the medical aspect of ESF 8 into emergency operation centers (EOCs) to guide the appropriate movement of patients along the care continuum. Some states refer to this operation as the Medical Operations Coordination Cell. Objectives and priorities of the MCC:

- Objectives: To make decisions based on data and partner information to equalize patient load and provide appropriate care to the needs of the injured. MCC determinations support the movement of patients and resources from one facility to another, or re-direct referrals that normally go to a besieged facility or system to one having capacity.
- Priorities:
  - Collecting, analyzing and disseminating hospital-capacity information.
  - Establishing protocols, systems, indicators, and triggers.
  - Acting as a single point of contact (POC) and/or facilitate communications for referral requests and life-saving resources.

Triage Methodology
MDHHS recommends the use of Sort, Assess, Life Saving Interventions and Treatment and/or Transport (SALT) triage for mass casualty incidents. The [Centers for Disease Control and Prevention (CDC) developed guidelines based on the best existing science and consensus opinion](). SALT combines features from all prevailing triage systems to produce a distinct overarching guide for the unification of mass casualty triage. Michigan adopted the SALT triage method as the statewide mass casualty incident triage system.

Special Populations

Mass casualty incidents can happen in any community at any given time. As such, it is important to consider and plan for the access and functional needs of at-risk and vulnerable population(s). Planning for medical surge incidents should include, but not be limited to, children, pregnant women, older adults, people with disabilities, people with limited English proficiency, non-English speaking populations and transportation barriers.

The [emPOWER program]() provides federal data, mapping and other tools as well as training resources to help communities nationwide protect the health of at-risk Medicare beneficiaries. The [MDHHS EOP]() provides planning considerations for special populations. Hospitals should play a role in the community assessment of population needs, while LHDs should have a role in the social determinants of health.

Response Resources

Local Medical Surge Resources

Local health departments, healthcare coalitions, and local emergency management have resources that may be useful during a medical surge incident. Preparedness efforts should include activities to understand the resources available locally, regionally and statewide. Additionally, healthcare facilities should have in place mutual aid agreements, memoranda of understanding and contracts to support the needs of patients, staff, etc. during a medical surge. When preparing healthcare facilities to manage surge capacity, it is essential to have comprehensive planning resources. The AHRQ Surge Toolkit and Facility Checklist provides practical tools and templates for assessing surge needs, ensuring readiness, and enhancing facility response during medical emergencies.

The HCC maintains limited medical supplies and pharmaceuticals to be deployed when triggered at the contingency level. Hospitals may contact the regional MCC to determine the available resources within the region. This may include facilities, equipment/supplies, personnel, communications, etc. The regional MCC provides support and coordination for incident prioritization, critical resource allocation, communications systems integration and information coordination. Each regional MCC maintains regional operation guidelines for decision-making processes and trigger points to activate equipment/supply and pharmaceutical caches.

Incident Management Teams (IMT) are available at the local, state and federal level to support command and control of the incident. IMTs are requested through local emergency management or by the SEOC. IMTs may be requested as a whole unit or as individual subject matter experts to fulfill a role within ICS.

State Medical Surge Resources

The following platforms are supported by MDHHS and the HCCs and are accessible by HCOs throughout the state. The MDHHS will support the HCCs and HCOs in education, training opportunities and work to expand the use of platforms to coalition membership. Additional resources may be available. Conversations through the CHECC can facilitate resource identification.

Communication Platforms

The MDHHS continues to build upon established situational awareness and resource sharing system platforms. Systems used for information sharing include the Michigan Health Alert Network (MIHAN), EMResource, EMTrack, SharePoint Inventory Request and Tracking Module, and the Michigan Critical Incident Management System (MI CIMS). The utilization of the MIHAN and sustainment of bi-directional communication systems for emergencies and the impact of medical and public health is critical to partners. State of Michigan 800 MHz radios have been programmed for each HCC and are available in the CHECC, hospitals, LHDs, MCCs and EMS agencies and vehicles by Michigan Public Safety Communications System (MPSCS). Additionally, the Medical Communication (MEDCOM) Plan for Emergency Medical Services further delineates

emergency communications system requirements between hospital Emergency Departments and EMS vehicles.

MIHAN is a secure, web-based communication system. It serves to alert key public health, healthcare and public safety personnel of conditions that could adversely impact the health and safety of Michigan's citizens. It also provides situational awareness about important by non-emergency health-related information.

MI CIMS is used to capture incident response activities by local emergency management, state emergency management and state agency emergency coordination centers. It provides a platform for information sharing across disciplines and levels of government during response.

Telemedicine equipment is available and may be used to connect subject matter experts from designated Level I or Tertiary Centers with lower-level trauma centers and critical access hospitals that may be required to provide initial stabilization, treatment and holding of patients until able to transfer to a higher level of care.

Data Platforms

Bed Availability - EMResource

EMResource is an interoperable emergency communications solution that streamlines communications required to prepare for, respond to, and recover from individual and large-scale incidents across the hospital and emergency medical services spectrum. EMResource facilitates monitoring of healthcare assets, emergency department capacity, long-term care (i.e., skilled nursing facilities), and behavioral health, as well as National Disaster Medical System (NDMS) reporting. EMResource is an expandable platform that allows for development of additional boards for clinical and other information gathering (such as therapeutics, supplies, and morgue availability) as necessary.

EMResource tracks additional incident-specific resources, such as decontamination facilities, ventilators, and specialty services. It creates a common operating picture, as described by NIMS, and delivers the most comprehensive and flexible exchange of information between EMS providers, hospitals, healthcare entities, and EOCs.

All hospitals maintain the capability to enter their facility aggregate bed availability and diversion status into EMResource. Data helps identify healthcare system capacity and demand during a mass casualty incident or public health emergency, bed data categories for reporting include capacity or total and availability: Adult/Pediatric Intensive Care Unit (PICU), Medical-Surgical, Burn, and Negative Pressure Isolation. Other queries include operating rooms, Neonatal Intensive Care (NICU), Extracorporeal Oxygen Membrane (ECMO) and transfer capabilities for NICU and PICU patients.

Through EMResource, the Regional MCC may be able to help identify hospitals nearby that have patient beds available to help support the medical surge incident. Patients may be transferred outside of the system to receive care.

Patient Tracking - EMTrack

Patient tracking resources are provided by the MDHHS for HCOs and HCCs to assist with patient tracking during an incident at any and every point along the continuum of care.

EMTrack is a web-based, interoperable, HIPAA compliant emergency preparedness software system. It is primarily used by local hospitals and EMS providers to rapidly scan patients and patient information; usually on-scene, and can track patients through initial patient triage, hospital admission, treatment, transfer and discharge.

EMTrack notifies hospitals in advance of a patient's arrival. This allows hospitals to prepare for high-risk patients, thus saving time and lives. It can be used to notify the EOC about the number and acuity of patients on-scene, dispatch about the number of patients in need of transport and hospitals about patients dispatched to their facility.

Alternate Care Site Support

An ACS can be activated during significant incidents in which routine healthcare systems have exceeded capacity and there are no alternate brick and mortar healthcare facilities to meet demand. Components of an ACS may be activated, depending upon the incident. This activation is consistent with the local and state emergency operation centers. The following are ways in which an ACS may be activated:

- A local declaration from a local Emergency Operations Center (EOC). When this occurs, consultation with the CHECC for resource allocation is necessary.
- A state declaration from the State Emergency Operations Center (SEOC). The CHECC maintains the responsibility to communicate with senior MDHHS leadership and the SEOC.
- The State Chief Medical Executive, in conjunction with the MDHHS Director, may activate ACS outside of a local or state declaration.
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Refer to the Alternate Care Site Plan for full details. *Plans and appendices referenced in this document are for official use only and may be available on request on a need-to-know basis.*

Immediate Bed Availability

Michigan Immediate Bed Availability (IBA) guidelines provide a framework to open beds in a medical surge incident by using strategies such as rapid discharge of stable patients and transferring patients who are stable but cannot be discharged. This toolkit contains general conceptual information about the models related to IBA and associated recommended checklists and templates that may be used by hospitals to achieve the nationally recommended goal of opening 20% of the facility's staffed beds within four hours of incident notification to receive a surge of patients. It also provides information to assist with the development of documents and forms that can be adapted by each individual facility to aid in the process of rapid discharge.

Refer to the Immediate Bed Availability Plan for full details. *Plans and appendices referenced in this document are for official use only and may be available on request on a need-to-know basis.*

Medical and Non-Medical Countermeasures

MEDDRUN

MEDDRUN is a state resource cache, which contains pharmaceuticals, PPE and critical medical supplies for use in the event of a chemical or biological emergency. MEDDRUN is located at air and ground EMS agencies, strategically located throughout the state to arrive within one-hour of activation. MEDDRUN can be used to treat exposure to:

- Nerve agents.
- Organophosphate pesticides.
- Toxic industrial chemicals.
- Radiological dispersion devices.
- Biological incidents, such as anthrax.
- Plague.

CHEMPACK

CHEMPACK is a federal resource managed by the state. It can be used to treat nerve agents and organophosphate exposures during a large-scale incident. CHEMPACK caches contain antidotes and anticonvulsants and are located strategically in hospitals throughout the state. Envisioned as a comprehensive capability for the effective use of medical countermeasures in the event of an attack on civilians with nerve agents.

- [Michigan's MEDDRUN, CHEMPACK & SNS Programs](#) training module.
- To request MEDDRUN and/or CHEMPACK, contact the MEDDRUN/CHEMPACK Dispatch Center at 877-633-7786. A backup dispatch center is available at 616-391-5330.

Special Pathogens Response Network

[Michigan's Special Pathogens Response Network](#) (SPRN) was formed in 2014 to provide a structure for response to the threat posed by the West African Ebola outbreak. This network is designed to support the care of a patient with any special pathogen of high consequence to coordinate the care and transport of patients who have or are suspected of having a highly communicable infectious disease.

Strategic National Stockpile

When all treatment, mass prophylaxis medications and other countermeasure management materials at the local, regional and state level have been exhausted, or it is anticipated that available countermeasures will be exhausted, hospitals may [request assets from the Strategic National Stockpile (SNS),](#) facilitated by MDHHS.

Staffing Support

During a medical surge incident, hospital staff may be assigned within the hospital to perform duties outside of their normal jobs that they can safely perform. Less trained personnel may assume non-critical responsibilities, including deferring non-emergency services and providing supervision for a broader group of patients, etc. Hospital incident command centers will need to closely monitor staffing ratios. Memorandums of Understanding (MOUs) through pre-existing partnerships and the HCCs may be activated at this point to bring in system staff from partnering hospitals. This can be done through communication with the regional MCC, which has access to intra- and inter-regional personnel resources throughout the state. Hospitals must ensure that they have developed policies and procedures to receive and task external personnel in their EOPs. Considerations include credentialing, issuing appropriate identification, orientation, just-in-time training, assignment of mentors or supervisors, potential liability, workers' compensation, etc.

Other staffing resources to consider include existing staffing agency contracts, Michigan Volunteer Registry (MVR), Medical Reserve Corps (MRC), Emergency Care Task Force (ECTF) and ambulance strike teams.

MI-MORT

The Michigan Mortuary Response Team (MI-MORT) and the Disaster Portable Morgue Unit (DPMU) support the needs of a mass fatality incident that exceeds local resources. These MDHHS resources are available when requested by the medical examiner through a LEOC to the SEOC. The MI-MORT team is comprised of forensic professionals, funeral directors, search and recovery personnel and many volunteers willing to assist in a mass fatality situation. Depending on the magnitude of the incident, these resources can manage an incident exclusively on their own or provide a stopgap until additional inter-state or federal resources can be mobilized.

MI-TESA

The Michigan Transportable Emergency Surge Assistance (MI-TESA) Medical Unit is supported by the MDHHS BEPESoC. MI-TESA is a mobile field hospital that is stored and maintained by the Region 2 South HCC. The purpose of the MI-TESA Medical Unit is to expand surge capacity, re-establish emergency triage, and establish treatment in an area where the healthcare infrastructure has been disrupted. The unit may be deployed anywhere within the state through an established request and deployment process. It can be deployed to other states through EMAC.

Michigan Volunteer Registry

The Michigan Volunteer Registry (MVR) can query for volunteer individuals available to deploy to assist in providing care for patients during an incident. The MVR allows individuals to pre-register, undergo a background check, and have their medical credentials verified prior to deployment. MVR recruitment focuses on medical professionals such as nurses, physicians, dentists, paramedics, social workers, and medical examiners and support personnel such as electricians, security and administrative.

The MVR also coordinates volunteer components of responses with other state agencies such as the Michigan Community Service Commission.

Subject Matter Experts (SME)

The MDHHS can also provide access to subject matter experts to assist with patient care during a medical surge incident.

State Burn Coordinating Center

The State Burn Coordinating Center (SBCC) is part of the MDHHS Burn Mass Casualty Incident (BMCI) Surge Plan to expand the ability to provide burn care and to safeguard and prioritize the utilization of limited resources. The SBCC is located at Michigan Medicine in Ann Arbor, Michigan, and is an American College of Surgeons verified burn center. The SBCC provides 24/7 coverage statewide by a burn surgeon and burn disaster response support team.

The State of Michigan's Burn Mass Casualty Incident (BMCI) Surge Plan Version 25 and its accompanying Pediatric Annex Version 7 provide detailed guidance for managing a surge of burn patients during mass casualty incidents. These documents outline protocols for triage, treatment, transportation, and resource allocation, with specific considerations for pediatric burn victims.

Health Services

MDHHS Health Services brings together Medicaid, behavioral health, and aging programs to support vulnerable populations during emergencies. With help from the Office of Public Health Preparedness, partners can access resources for:

– Mental health crisis response
– Long-term care and aging services
– Home- and community-based supports
– Surge and emergency planning

Find tools, contacts, and more at: MDHHS Partner Resource Page.

Pediatrics

Pediatric SMEs can provide hospitals statewide with readily available just-in-time training, telehealth consultation options, and critical care pediatric expertise that augments pediatric resources and assists with coordinating care of children during surge incidents. For more information and resources to support pediatric surge preparedness on the Michigan Department of Health and Human Services Pediatric Readiness page.

State Ethics Advisory Committee

This committee provides ethical guidance during crisis standards of care, advising MDHHS and other state agencies on:
– Allocation of scarce medical supplies and life-sustaining resources
– Ethical principles: reallocate, reuse, adapt, substitute, then conserve

- Monitoring indicators and advising when to shift between contingency, crisis, or conventional standards of care

Requests for consultation are coordinated through the Community Health Emergency Coordination Center (CHECC), which works closely with MDHHS, regional Healthcare Coalitions, and the State Emergency Operations Center (SEOC).

To engage the committee, contact the CHECC Duty Officer at **checcdeptcoor@michigan.gov** or **517-335-8150**. Visit the [Michigan Crisis Standards of Care page for detailed information.](#)

Public and Private Partnerships

When the SEOC is activated, additional support for coordination of public and private sector partners is available. Facilities can work through local emergency management or the CHECC to seek public and private partner support through the SEOC.

Partner Organizations

- [Michigan Pharmacists Association](#).
- [Michigan Funeral Directors Association](#).
- [Michigan Association of Local Public Health](#).
- [Michigan Primary Care Association](#).
- [Michigan Centers for Rural Health](#).
- [Michigan Association of Ambulance Services](#).

The Great Lakes Healthcare Partnership (GLHP)

During an incident, the potential to impact multiple states and cross state boundaries is significant. Therefore, strong coordination and cooperation among jurisdictions is crucial. The Great Lakes Healthcare Partnership (GLHP) is a consortium of HPP leads located within FEMA Region V. Through the GLHP, MDHHS has established pre-existing relationships with the HPP programs in the FEMA Region V including:

- City of Chicago
- Illinois
- Indiana
- Michigan
- Minnesota
- Ohio
- Wisconsin

Plans have been developed among the GLHP to improve interstate healthcare system preparedness and response. These plans are not intended to replace mutual aid agreements at the local, state or federal level; rather, they are designed to provide immediate assistance during a significant incident when other resources are being activated through conventional channels such as EMAC. Planning has included:

- Communications and alerting.
- Burn surge.
- Pediatric medical surge.

- Special Pathogens Response Network (SPRN).

Federal Medical Surge Resources

Federal public health and medical assistance can include medical supplies, personnel, and technical support managed and deployed through the HHS. The National Response Framework (NRF) offers a comprehensive, all-hazards approach to incident response, outlining key principles, roles, and structures that guide a unified and coordinated effort across government levels and the private sector.

Strategic National Stockpile

Managed by ASPR, the SNS is a national repository of antibiotics, chemical antidotes, antitoxins, vaccines, antiviral drugs, and other life-saving emergency medical countermeasures (MCM). It is designed for rapid deployment and includes five types of assets:

- 12-Hour Push Pack (PPK): A ready-to-deploy package that can arrive anywhere in the United States or its territories within 12 hours of a federal decision. These packs contain a broad spectrum of medical supplies to address various public health threats.
- Managed Inventory: When the specific nature of a public health emergency is identified, the CDC may deploy Managed Inventory from designated facilities across the U.S. Managed Inventory can also resupply previously deployed 12-Hour Push Packages and is expected to arrive within 24 to 36 hours of deployment.
- Purchasing Capabilities, Medical Waste Management System, and Federal Medical Stations (FMS) are also part of the SNS to ensure flexible and responsive support.
- The SNS mission is to provide critical MCM to the site of a national emergency efficiently and effectively.

Federal Medical Station

A Federal Medical Station (FMS) is a deployable healthcare system that can provide large-scale primary healthcare services anywhere in the U.S. Staffed by approximately 100 personnel, each FMS is equipped to sustain 250 stable primary care-based patients for three days, with a supply of medical and pharmaceutical resources. An FMS is requested and validated through the CHECC and the SEOC, in coordination with federal partners.

Department of Military and Veterans Affairs

The Department of Military and Veterans Affairs (DMVA) may support medical surge response efforts by providing personnel, logistical assistance, and facilities that help expand healthcare system capacity. This may include aiding in the establishment of alternate care sites or temporary field hospitals to increase bed availability. While DMVA does not manage or distribute medical countermeasures directly, it may assist in the transportation or security of such materials in coordination with the State Emergency Operations Center (SEOC) and other lead agencies.

National Disaster Medical System (NDMS) Teams

Accessing NDMS Teams is accomplished through a coordinated request through the CHECC to the SEOC.

Disaster Medical Assistance Team

The Disaster Medical Assistance Team (DMAT) provides primary and acute care, triage of mass casualties, initial resuscitation and stabilization, advanced life support and preparation of sick or injured for evacuation. The basic deployment configuration of a DMAT consists of 35 people; it includes physicians, nurses, medical technicians, and ancillary support personnel. They can be mobile within six hours of notification and can arrive at a disaster site within 48 hours. They can sustain operations for 72 hours without external support.

Disaster Mortuary Operational Response Team

Disaster Mortuary Operations Response (DMORT) teams work under the guidance of local authorities by providing technical assistance and personnel to recover, identify, and process deceased victims. Teams are composed of funeral directors, medical examiners, coroners, pathologists, forensic anthropologists, medical records technicians and transcribers, fingerprint specialists, forensic odontologists, dental assistants, x-ray technicians, and other personnel.

National Veterinary Response Team

The National Veterinary Response Team (NVRT) aids in identifying the need for veterinary services following major disasters, emergencies, public health or other incidents requiring Federal support and in assessing the extent of disruption to animal and public health infrastructures.

National Medical Response Team (NMRT)

The National Medical Response Team (NMRT) provides medical care following nuclear, biological, and/or chemical incidents. This team can provide mass casualty decontamination, medical triage, primary and secondary medical care to stabilize victims for transportation to tertiary care facilities in a hazardous material environment. The basic deployment configuration of an NMRT consists of 50 personnel.

Federal Subject Matter Experts

ASPR TRACIE

The [Technical Resources, Assistance Center, and Information Exchange](#) (TRACIE) was created to meet the information and technical assistance needs of regional ASPR staff, healthcare coalitions, healthcare entities, healthcare providers, emergency managers, public health practitioners, and others working in disaster medicine, healthcare system preparedness, and public health emergency preparedness.

NACCHO

The [National Association of County and City Health Officials](#) provides a resource hub that includes information on public health by providing a source for tools, resources and information to help local health departments.

CSTE

The [Council of State and Territorial Epidemiologists](#) uses the power of epidemiology to improve the public's health.

References

Barbera, J.A., & Macintyre, A.G. (2007). *Medical Surge Capacity and Capability: A Management System for Integrating Medical and Health Resources During Large-Scale Emergencies* (2nd ed.). U.S. Department of Health and Human Services, Office of the Assistant Secretary for Preparedness and Response. Retrieved from https://aspr.hhs.gov/HealthCareReadiness/guidance/MSCC/Pages/default.aspx

Bureau of Emergency Preparedness, EMS and Systems of Care (BEPESoC) & Wayne State University. 2009. *Guidelines for Ethical Allocation of Scarce Medical Resources and Services During Public Health Emergencies in Michigan.*

Institute of Medicine (IOM). 2013. *Crisis Standards of Care: A Tool Kit for Indicators and triggers.* Washington DC: The National Academies Press.

Institute of Medicine (IOM). 2012. *Guidance for Establishing Crisis Standards of Care for Use in Disaster Situations: A Letter Report.* Washington DC: The National Academies Press. http://www.nap.edu/catalog/12749.html

Hick, J. L., Barbera, J. A., and. Kelen, G.D. 2009. Concepts in Disaster Medicine, Refining Surge Capacity: Conventional, Contingency and Crisis Capacity. Disaster Medicine and Public Health Preparedness. 3: 59-56.

Hick, J. L., et al. 2004. *Heath Care Facility and Community Strategies for Patient Care Surge Capacity. Annals of Emergency Medicine. 44: pg. 253-261.*

Michigan Department of State Police Emergency Management and Homeland Security Division. 2012. *Michigan Hazard Analysis.* https://www.michigan.gov/msp/-/media/Project/Websites/msp/EMHSD/Publications/2024-Michigan-Hazard-Analysis.pdf

Homeland Security. (2019). *National Response Framework.* https://www.fema.gov/emergency-managers/national-preparedness/frameworks/response. 4th Edition.

Appendix A – Essential Elements of Information

Essential Elements of Information (EEIs) contain situational awareness information that is critical to the initial response, ongoing response, and recovery operational periods for the HCCs. Specific elements stated here may not apply in every incident, may not be all-inclusive, and should be modified to obtain the appropriate information. EEIs should be added or deleted for each operational period depending on the specific circumstances and phase of response.

Examples of EEI data include:
- Facility operating status.
- Status of evacuations/shelter in place operations.
- Critical medical services (e.g., critical care, trauma).
- Critical services status (e.g., electric, water, sanitation, heating, ventilation, air conditioning).
- Critical healthcare delivery status (e.g., surge status, bed status, deaths, medical and pharmaceutical supply, and medical equipment).
- Staffing status.
- EMS status involving patient transport, tracking and availability.
- Electronic patient tracking.

Essential Elements of Information Template

INCIDENT NAME:
ORGANIZATION: _____ COMPLETED BY:
DATE/TIME: _____ CONTACT INFORMATION:

EEI # and STATUS	Specific Information Required	Task Description	Assigned To:
1 – INITIAL RESPONSE	Determine primary communication means		
2 – INITIAL RESPONSE	Evaluate healthcare staff and supplies		
3 – INITIAL RESPONSE	Determine health department status		
4 – INITIAL RESPONSE	Determine Emergency Management Status (Incident Command Structure)		
5 – INITIAL RESPONSE	Identify who needs to know		
6 – INITIAL RESPONSE	Identify resources to be deployed		
7 – INITIAL RESPONSE	Determine documentation systems/methods		
8 – INITIAL RESPONSE	Consider hospital decompression initiatives		
9 – ONGOING RESPONSE	Projections for healthcare staff and supplies		
10 – ONGOING RESPONSE	Forecast duration for incident		
11 – ONGOING RESPONSE	Update response partners		
12 – ONGOING RESPONSE	Status of critical infrastructure		
13 – RECOVERY	Prioritizing essential functions		
14 – RECOVERY	Identify support resource systems		
15 – RECOVERY	Identify documentation		
16 – RECOVERY	Address regulatory requirements for reimbursements		
17 – RECOVERY	Assess functional staff		

Appendix B—1135 Waiver

When a disaster or emergency is declared by the President under the Stafford Act or National Emergencies Act and the Health and Human Services (HHS) Secretary declares a public health emergency under Section 319 of the Public Health Service Act, the Secretary is authorized to take certain actions in addition to their regular authorities. For example, under section 1135 of the Social Security Act (SSA), they may temporarily waive or modify certain Medicare, Medicaid, and Children's Health Insurance Program (CHIP) requirements to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in SSA programs in the emergency area and time periods and that providers who provide such services in good faith can be reimbursed and exempted from sanctions (absent any determination of fraud or abuse).

Examples of these 1135 waivers or modifications include:
- Conditions of participation or other certification requirements.
- Program participation and similar requirements.
- Preapproval requirements.
- Requirements that physicians and other health care professionals be licensed in the State in which they are providing services, so long as they have equivalent licensing in another State.
    - This wavier is for purposes of Medicare, Medicaid, and CHIP reimbursement only – state law governs whether a non-Federal provider is authorized to provide services in the state without state licensure.
- Emergency Medical Treatment and Labor Act (EMTALA) sanctions for direction or relocation or of an individual to receive a medical screening examination in an alternative location pursuant to an appropriate state emergency preparedness plan (or in the case of a public health emergency involving pandemic infectious disease, a state pandemic preparedness plan) or transfer of an individual who has not been stabilized if the transfer is necessitated by the circumstances of the declared emergency.
    - A waiver of EMTALA requirements is effective only if actions under the waiver do not discriminate based on a patient's source of payment or ability to pay.
- Stark self-referral sanctions.
- Performance deadlines and timetables may be adjusted (but not waived).
- Limitations on payment for health care items and services furnished to Medicare Advantage enrollees by non-network providers.

The waivers under section 1135 of the SSA typically end no later than the termination of the emergency period, or 60 days from the date the waiver or modification is first published unless the Secretary of HHS extends the waiver by notice for additional periods of up to 60 days, up to the end of the emergency period. Waivers for EMTALA (for public health emergencies that do not involve a pandemic disease) and HIPPA requirements are limited to a 72-hour period beginning upon implementation of a hospital disaster protocol.

Waiver of EMTALA requirements for emergencies that involve pandemic diseases last until the termination of the pandemic-related public health emergency. The 1135 waiver authority applies only to Federal requirements and does not apply to State requirements for licensure or conditions of participation.

Other Flexibilities: In addition to the 1135 waiver authority, Section 1812 (f) of the Social Security Act (the Act) authorizes the Secretary to provide for skilled nursing facility (SNF) coverage in the absence of a qualifying hospital stay, as long as this action does not increase overall program payments and does not alter the SNF benefit's "acute care nature" (that is, its orientation toward relatively short-term and intensive care).

Determining if Waivers Are Necessary: In determining whether to invoke an 1135 waiver (once conditions precedent to the authority's exercise have been met), ASPR with input from relevant Operations Divisions (OPDIVS) determines the need and scope for such modifications. The information considered includes requests from the Governor's office, feedback from individual healthcare providers and associations, and requests to regional or field offices for assistance.

Waiver Request Process

Once an 1135 waiver is authorized, health care providers can submit requests to operate under that authority or for other relief that may be possible outside the authority to the Centers for Medicare and Medicaid Services (CMS) Regional Office with a copy to the State Survey Agency. Requests can be made by sending an email to the CMS Regional Office in their service area. The Midwest Consortium email address is listed below. Information on your facility and justification for requesting the waiver will be required.

Review of 1135 Waiver requests: CMS will review and validate the 1135 waiver requests utilizing a cross-regional Waiver Validation Team. The cross-regional Waiver Validation Team will review waiver requests to ensure they are justified and supportable.

Contact for CMS Regional Office, Midwest Consortium: ROCHIS@cms.hhs.gov
Midwest Consortium services: Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin, Iowa, Kansas, Missouri, and Nebraska.

Sample EMTALA Policy Language on Section 1135 Waivers

1. This amendment should be written at the end of a hospital's hospital wide EMTALA policy.
2. Conditions of Amendment to EMTALA Policy: it applies when a major disaster or emergency is declared and the Secretary of HHS has declared a public health emergency.
   a. Hospital must implement its disaster protocol.
   b. Hospitals must notify CMS through the appropriate State Survey Agency when it implements its disaster protocol.
   c. The Secretary exercises his/her waiver power under Section 1135 to cover the area in which the hospital is located.

d. The waiver is either limited to a 72-hour period beginning with the implementation of the hospital's disaster protocol or, in the case of a pandemic infectious disease, until the termination of the declaration of the public health emergency.

3. Amendment Language: "This EMTALA policy does not apply when the Secretary of HHS declares a public health emergency and a waiver of EMTALA requirements for the area in which the hospital is located. The waiver of the of the hospital's EMTALA requirements applies only for the period during which the waiver is in effect."

Emergency and disaster-related policies and procedures that may be implemented only with a 1135 Waiver: https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/MedicareFFS-EmergencyQsAs1135Waiver.pdf.

Appendix C — Acronyms

ACS	Alternate Care Site		ICS	Incident Command System
ASPR	Administration for Strategic Preparedness and Response		LEOC	Local Emergency Operations Center
BEPESoC	Bureau of Emergency Preparedness, EMS and Systems of Care		MAC	Multi-Agency Coordination
CHECC	Community Health Emergency Coordination Center		MCC	Medical Coordination Center
DEPR	Division of Emergency Preparedness and Response		MDHHS	Michigan Department of Health and Human Services
DESoC	Division of EMS and Systems of Care		MIMORT	Michigan Mortuary Response Team
DMAT	Disaster Medical Assistance Team		MI-TESA	Michigan Transportable Emergency Surge Assistance Medical Unit
DMORT	Disaster Mortuary Operational Response Team		MOU	Memorandum of Understanding
ECMO	Extracorporeal Oxygenation Membrane		MRC	Medical Reserves Corps
EMAC	Emergency Management Assistance Compact		MRC	Medical Reserves Corps
EMAC	Emergency Management Assistance Compact		NBHPP	National Bioterrorism Hospital
EMS	Emergency Medical Services		NDMS	National Disaster Medical System
EOC	Emergency Operation Center		NICU	Neonatal Intensive Care Unit
EOP	Emergency Operation Plan		NIMS	National Incident Management System
ESF	Emergency Support Function		NMRT	National Medical Response Team
FEMA	Federal Emergency Management Agency		NVRT	National Veterinary Response Team
GLHP	Great Lakes Healthcare Partnership		PICU	Pediatric Intensive Care Unit
HCC	Healthcare Coalitions		SBCC	State Burn Coordinating Center
HCO	Healthcare Organization		SEOC	State Emergency Operations Center
HHS	U.S. Department of Health and Human Services		SNS	Strategic National Stockpile
HPP	Hospital Preparedness Program		TRACIE	Technical Research Assistance Center, and Information Exchange