

Hurricane Season
Louisiana/Federal Joint ESF #8
Response Plan

Revised April 2012

Promulgation Statement and Preface

The 2011 Hurricane Season Louisiana/Federal Joint ESF #8 Response Plan provides the mechanism for coordinated Federal assistance to supplement Louisiana state, local, and tribal resources in response to public health and medical care needs (to include veterinary and/or animal health issues when appropriate) in response to tropical storm and hurricane force winds that make landfall in the State during the 2011 hurricane season. This plan is in observance of the Governor's Office of Homeland Security's (GOHSEP) Basic Plan. The Basic Plan can be found online at www.ohsep.louisiana.gov. The roles and responsibilities of the various state agencies are outlined in the basic plan. These roles and responsibilities are promulgated by Executive Order BJ 08-32 and Executive Order BJ 08-94. The ESF-8 Operations Plan builds upon the basic plan and documents in further detail the roles, responsibilities and planning considerations and contingency activities for a state and federal level ESF-8 response to assist/supplement local efforts when local resources are no longer adequate for response.

The plan is the product of a series of workshops, meetings, and discussions held with emergency planners in EMS, hospitals, public health and supporting ESF representatives, subject matter experts, and other State and Federal ESF #8 partners throughout the entire State. This collaborative effort produced the working draft of the plan, which has been refined and reviewed by State and Federal officials.

Planning is continuous. Recipients of this Plan are expected to develop detailed plans, procedures, arrangements, and agreements for their agencies and/or organizations; train their personnel to implement those plans, procedures, arrangements and agreements regularly; and make changes as needed. Changes to this plan will be issued as appropriate. Supplements to this plan may be issued as needed.

This plan presents guidelines for Federal, State, and local response. However, at time of execution the responsible officials retain the prerogative to adjust procedures as required to accomplish the mission.

The chapters in this plan cover the ESF#8 functional responsibilities outlined in the National Response Framework (NRF), draft emergency management compact agreements and action request forms. The introductory chapter contains general guidance regarding the mission, situation, responsibilities, incident management responsibilities, and a general concept of logistics.

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Chapter 1

Introduction

A. PURPOSE AND SCOPE

The Basic Plan identifies that ESF 8 provides public health and sanitation, emergency medical and hospital services, crisis counseling and mental health services to disaster victims and workers, to supplement and support disrupted or overburdened local medical personnel and facilities and relieve personal suffering and trauma. (See ESF8 Public health and Medical Services Annex of the Basic Plan). In addition, ESF 8 provides coordination of the State's Catastrophic Mass Fatality Plan which may be enacted during a state declaration. The purpose of the Louisiana/Federal Joint ESF #8 Operations Plan is to describe the joint activities that will take place in the event Louisiana is affected by a tropical storm or hurricane and to detail the organizational structure that will provide unified command and control over these activities. It also delineates the responsibilities of State and Federal partners in accomplishing these activities.

ESF #8 Louisiana hurricane response and recovery planning will be focused on developing and coordinating collaborative interagency and multi-jurisdictional operational activities and capabilities to provide for:

- Patient and Medical Special Needs Evacuations
- Life-Saving Operations
- Life-Sustaining Operations
- Restoration of Public Health, Medical Infrastructure and Medical Special Needs

The activities in this plan are based on the 18 ESF #8 actions outlined in the National Response Framework (NRF); however State and Federal planners have expanded or focused the breath of each activity to develop an executable plan centered on Louisiana emergency preparedness processes and procedures.

Response and initial recovery planning and operational activities will be anticipatory and proactive as allowed by federal and applicable state statutes and avoid being passive and reactive.

Louisiana ESF #8 response and initial recovery planning and operational activities will consider and incorporate:

- Unique geographic, socio-economic, and demographic features and characteristics.

- Identification and use of medical evacuation options and resources for individuals with special medical needs in any of the following, but not limited to, hospitals, nursing homes, assisted living facilities, and persons living at home.

- Individuals with disabilities that do not require medical support/intervention but do require other means of support such as the assistance of an interpreter, the assistance of a personal caregiver to accomplish activities of daily living, and/or the assistance of a caregiver to provide guidance in daily decision making is a shared responsibility between ESFs #1, #6, and #8.

Hurricane Preparedness, Response and Recovery Operational Concepts and Components:

Recognize that Local Parishes and the State of Louisiana assume Lead Agency responsibilities.

Parish and State Government officials are the primary decision makers within the Unified Command.

Recognize that Parish and State Government will work in cooperation with disability service providers and advocacy organizations as decisions regarding special populations are made.

Recognize that Tribal governments have sovereignty and special authorities within the emergency management framework in most instances.

The Tribal Chief Executive is the primary decision maker within the Unified Command in respect to Indian Country, in most instances.

B. SITUATION

During the 2012 hurricane season, public health and medical support may be required to support prevention actions (evacuation, sheltering, and health surveillance), response actions (needs assessment, patient care, victim identification, and worker safety), and recovery actions (drug, blood, water, food, and agricultural safety) as the southern Louisiana parishes are affected by this season's tropical storms and hurricanes. Southern Louisiana parish citizens could potentially need State and Federal assistance to evacuate a large portion of the special needs population and general populations. The path and intensity of storms and hurricanes will determine which segment of the population is most affected, but it is very likely that some, potentially large, portion of the Southern Louisiana population will need assistance in the coming months.

C. MISSION

Emergency Support Function (ESF) #8 partners at Federal, State, and Parish levels must proactively prepare for hurricane season in Louisiana. This is critically important every year due to the catastrophic nature of the 2005 season that created unique challenges for Louisiana citizens. If this plan is executed, State and Federal ESF #8 partners will provide technical assistance in the 18 ESF #8 functions outlined in the National Response Framework (NRF) as required in support of disaster victims and workers in order to supplement and support local services, personnel and facilities.

The U.S. Department of Health and Human Services (HHS) provides supplemental assistance to the State of Louisiana Department of Health and Hospitals (DHH) in identifying and meeting the needs of the citizens of Louisiana in the event of a tropical storm or hurricane that affects the State. HHS along with the support of its ESF #8 partners will coordinate all Federal public health, medical and medical special needs support to prepare for, respond to, and recover from the effects of the hurricane season in Louisiana.

D. OPERATIONAL PRIORITIES AND DECISION POINTS

(Under Construction)

E. RESPONSIBILITIES

On behalf of the Governor of Louisiana, DHH has the lead role for providing leadership for planning, directing and coordinating the overall State efforts to provide public health and medical assistance to the affected parishes.

On behalf of the Federal government, the DHHS, Office of the Assistant Secretary for Preparedness and Response (ASPR), is responsible for the federal coordination and execution of this plan.

F. INCIDENT MANAGEMENT PROCEDURES

The command and control of operations described in this plan are consistent with the National Response Plan and compliant with National Incident Management System requirements. One important new provision is the establishment of a Federal ESF #8 Technical Assistant in the DHH Emergency Operations Center (EOC). This position will enhance the common operating picture and expedite action requests from the State Emergency Operations Center to the Federal Joint Field Office and mission assignments to Federal ESF #8 partners.

Joint ESF #8 State and Federal planning and preparation will facilitate a highly integrated and simultaneous response to health and medical threats to Louisiana during the hurricane season. The diagram in Figure 1 depicts the State (blue) and Federal (yellow) reporting chains for reporting and disseminating information for this highly complex relationship.

The joint Louisiana and Federal operations detailed in this plan are based on the 17 ESF #8 functions outlined in the National Response Framework (NRF). A separate chapter is provided for each function.

G. PLAN DESIGN

Following the introductory chapter of this plan there are 17 chapters that cover the ESF#8 functional responsibilities outlined in the National Response Framework (NRF).

In many of the chapters that detail the functional ESF #8 responsibilities Chapters (2-18), there are references to pre-scripted general request forms found in Addendum 1.

Chapters 2 through 18 in most cases describe ESF #8 critical activities through use of a common activity template. The template organizes activity components in a clear and consistent manner. Each activity template includes the following components:

- A brief paragraph describing the scope of the element
- A listing of assets and functions of each relevant jurisdictional level (i.e., Local/Parish, State, and Federal); many Local/Parish comments refer specifically to New Orleans
- Details of command and control mechanisms to coordinate joint State and Federal operations
- Operational scope and guidance for emergency response
- Logistics and communications support required for successful mission accomplishment

- Reporting and planning requirements that will result in a common operating picture for cohesive joint operations.

H. LOGISTICS

ESF-8 teams supporting either evacuations or medical response will process requests for supplies and services through their respective Logistics chiefs.

Logistical support for sheltering in place, Medical Special Needs Shelters and medical care facilities supported by the NDMS will be supported through a combination of State and federal contracts for supplies and services. These contracts include, but are not limited to, ice, water, food, linens, fuel, generators, portable air conditioners, medical supplies, pharmaceuticals, and various services. Coordination for support will be done through Louisiana (DHH) to allow the state to fulfill the requirement locally. If the requirement exceeds the states capability a request will be processed through the ESF-8 liaison to Governor's Office of Homeland Security and Emergency Preparedness (GOHSEP). ESF-8 will satisfy the requirement internally, or pass to FEMA. FEMA will fill the requirement through their internal logistics system, or through their Inter-agency Agreement (IAA) with Defense Logistics Agency (DLA).

Evacuation of patients from hospitals and nursing homes will be supported through a combination of state and federal transportation contracts. The ambulances will be coordinated through Louisiana Bureau of Emergency Medical Services (BEMS) out of the Louisiana State Department of Health & Hospitals' (DHH) Emergency Operations Center (EOC) and Emergency Support Function #8 (ESF-8) will provide a liaison to assist. Buses will be coordinated through LA State Department of Transportation & Development (DOTD) and ESF-8 will provide liaisons for assistance. Aeromedical transport of patients will be coordinated through the National Disaster Medical System (NDMS) utilizing Department of Defense (DoD) aircraft.

I. COORDINATING INSTRUCTIONS.

Direct coordination of activities described in this plan is authorized between Federal and State officials. Any proposed changes to the plan should be brought to the attention of the respective State and Federal plan leads at DHH and HHS respectively.

CHAPTER 2

ASSESSMENT OF PUBLIC HEALTH AND MEDICAL NEEDS (APHM)

In collaboration with DHS, HHS mobilizes and deploys ESF #8 personnel to assist the State of Louisiana in assessing public health and medical needs. This function includes the assessment of the public health care system and facility infrastructure.

Assets and Functions

Local/Parish

- Local public health teams and/or EMS in each Parish perform initial assessments.
- Parish emergency managers formulate needs and forward them through their Emergency Operations Centers (EOCs) to the State EOC.

State

- Designated Regional Coordinators (DRC) - which are HHS grant-supported positions - relay local hospital needs to State ESF #8.
- The Office of Public Health (OPH) assesses epidemiological, environmental, and infectious disease threats and immediate needs.
- Regional OPH medical directors collect and forward information to State ESF #8 through the DHH Emergency Operations Center (EOC)DHH Emergency Operations Center (EOC).

Federal

- Regional Response Activities. The FEMA Regional Administrator deploys a liaison to the State EOC to provide technical assistance and also activates the Regional Response Coordination Center (RRCC). Federal department and agency personnel, including ESF primary and support agency personnel, staff the RRCC as required.
- The Regional Response Coordination Center (RRCC):
 - • Coordinate initial regional and field activities.
 - • In coordination with State, tribal, and local officials, deploy regional teams to assess the impact of the event, gauge immediate State needs, and make preliminary arrangements to set up operational field facilities. • Coordinate Federal support until a JFO is established.
 - • Establish a JIC to provide a central point for coordinating emergency public information activities.
- Incident Management Assistance Team (IMAT). In coordination with the RRCC and the State, FEMA may deploy an IMAT. IMATs are interagency teams composed of subject-matter experts and incident management professionals. IMAT personnel may be drawn from national or regional Federal department and agency staff according to established protocols. IMAT teams make preliminary arrangements to set up Federal field facilities and initiate establishment of the Joint Field Office (JFO).

- The Governor is responsible for requesting Federal assistance for incidents within his or her State. Overall, Federal incident support to the State is generally coordinated through a Joint Field Office (JFO). The JFO provides the means to integrate diverse Federal resources and engage directly with the State.
- HHS coordinates ESF #8 field response activities according to internal policies and procedures. HHS may designate a Senior Health Official to serve as the senior Federal health official in the JFO. Regional ESF #8 staff are ready to rapidly deploy, as the Incident Response Coordination Team – Advance (IRCT-A) to provide initial ESF #8 support to the affected location. As the situation matures, the IRCT-A will receive augmentation from HHS and partner agencies transitioning into a full IRCT capable of providing the full range of ESF #8 support to include medical command and control. The regional ESF #8 staff includes representatives to staff the RRCC and/or JFO, as required, on a 24-hour basis for the duration of the incident.

Command and Control

- The Local health jurisdiction is responsible for local command and control.
- Assessment teams report to the State ESF-8 and FEMA ESF #5.
- The State EOC communicates with Federal ESF #8 (IRCT) through the IMAT/JFO.
- The SMO communicates with state and ESF #8 regarding initial actions and serves as a liaison with IMAT/JFO.
- The IMAT transitions into a JFO, once a facility is located.
- The MNAT will remain under control of the command structure at the ERT and/or JFO.
- The JFO communicates with the RRCC if it is still operational or the NRCC.
- Deployed Federal ESF #8 representatives in the field communicate through normal chains of command (DHS/FEMA) but they also report to the State EOC and the ESF #8 IRCT.

Operations

- The IRCT conducts public health and medical assessments as an extension of the IMAT
 - The IMAT coordinates assessment activities with ESF #8 supporting agencies and the State.
 - Transportation and security for Federal and State staff.
- Initial security and worker safety issues are addressed by the assessment teams.

Logistics and Communications Support

- Unless other arrangements are made, logistic and communications support is the responsibility of the parent organization.
- HHS will provide satellite (SAT) phones, GPS equipment, and cell phones to ESF #8 representatives if necessary.
- DHH/OPH may support DRCs with 700MHZ as available.
- FEMA logistics will provide IMAT members with communications and logistics support if necessary.
- The NDMS regional office or MST will provide logistics and communications support to NDMS personnel if necessary.

Reporting and Planning

- The JRCT identifies and validates public health and medical needs.
- ESF #8 reports to the State Coordinating Official/Federal Coordinating Official (SCO/FCO) through ESF #8 IRCT at the IMAT/JFO, which then reports to the RRCC if it is still operational or the NRCC.
- The JRCT continues to reassess and report the effectiveness of interventions.
- The JRCT coordinates planning efforts with all ESF #8 supporting agencies to avoid duplication.
 - The RNA/MNAT prepares and distributes a single situation report (SITREP).
 - SITREPs are sent by the RNA/MNA teams to the ESF 8 IRCT which distributes them to the DHH Emergency Operations Center (EOC)DHH Emergency Operations Center (EOC), State EOC, HHS SOC, NDMS OSC, and ERT/JFO Planning Section.
- The RNA/MNAT establishes one uniform reporting template for assessing hospitals and public health infrastructure and issues.
- The following essential elements will be reported to maintain a Common Operating Picture (COP):
 - Number and location of hospitals damaged
 - Status of other critical medical infrastructure (e.g., urgent care facilities, EMS services, public health departments)
 - Fatalities
 - General damage in the affected area
 - Hospital bed capacity
 - Environmental impact issues (e.g., water, air, chemical exposure, hazards)
 - Infectious disease risk assessment
 - Status of NDMS
 - Public health communications about exposure risks
 - Reports/outbreaks of abnormal diseases or disease rates
 - Priorities
 - Weather forecast
 - Status/results of transportation assessments
 - Status/results of environmental assessments
 - Status of supply systems
 - Local partners with capacity to deliver critical health/safety information to the affected individuals/areas
 - Federal resources needed
 - Status of requests for Federal resources

CHAPTER 3

HEALTH SURVEILLANCE (HS)

Existing surveillance systems will be enhanced to monitor the health of the general population and special high-risk populations, carry out field studies and investigations, monitor injury and disease patterns and potential disease outbreaks, and provide technical assistance and consultations on disease and injury prevention and precautions.

Assets and Functions

Local/Parish

- Local public health surveillance personnel have day-to-day surveillance responsibilities.

State

- Operating at the (Department of Health and Hospitals/ Office of Public Health (DHH/OPH) Command Center, the State Epidemiologist is responsible for health surveillance.
 - The State Epidemiologist's staff includes regional epidemiologists and regional disease surveillance specialists.
 - Responsibilities include injury and worker safety surveillance and initial epidemiology.
 - The State web-based surveillance and monitoring system (i.e., hospital reporting system) includes symptom surveillance and disease reporting.
 - Regional hospital nurse coordinators serve as liaisons between hospitals and disease surveillance specialists.
- DHH/OPH/Center for Environmental Health Services (CEHS) environmental health officers and epidemiologists conduct surveillance activities.
- The DHH/OPH/Center for Community Preparedness Injury Prevention Program monitors injuries.
 - The Injury Prevention Program staff conducts injury surveillance activities.

Federal (See Addendum 1)

- Epidemiology teams from the CDC and Agency for Toxic Substances and Disease Registry (ATSDR) augment State surveillance efforts.
- The CDC has public health laboratories available to support State efforts.
- U.S. Public Health Service (PHS) Applied Public Health Teams (APHTs) have surveillance personnel.
- The Environmental Protection Agency (EPA) has surveillance resources that can be tasked.

Command and Control

- The State Epidemiologist and appropriate Center Directors manage surveillance activities through the DHH Emergency Operations Center (EOC)DHH Emergency Operations Center (EOC).

- All health surveillance and epidemiology responders are tasked by and report to the State Epidemiologist or appropriate Center Director.
- The DHH Emergency Operations Center (EOC) reports to the State Health Officer (SHO) in the State EOC.
- The SHO communicates with Federal ESF #8 through the ESF #8 Liaison in the State EOC.

Operations

- Conduct shelter surveillance to include disease and environmental health surveillance.
 - Perform additional surveillance of potable water, food supplies, and food preparation facilities, as well as any other emergency sites identified by the SHO.
 - Perform surveillance of waste management/disposal sites.
- The CDC ascertains the status of vaccination/immunization requirements in potentially affected areas.
- The CDC determines the requirements for long-term post-event surveillance or investigation.
- The CDC/OD/ACF/SAMHSA assists the State with surveillance efforts, including outbreak reports of abnormal disease/injury in affected areas and surveillance of “pockets of special needs.”
- Perform health surveillance of responders.
- Provide information sheet on local geographic medicine, local health hazards, and cultural considerations to responders.

Logistics and Communications Support

- Parent agencies will provide necessary communications and information technology (IT) equipment to deployed surveillance personnel.
- Additional support will be requested through FEMA logistics (e.g., transportation, security, and workspace) if necessary.
- DHH/OPH will provide surveillance teams with access to previous data needed for trend analysis.

Reporting and Planning

- Local surveillance personnel report findings to DHH Emergency Operations Center (EOC) through their respective Parish EOC.
- State teams report surveillance information and results to the DHH Emergency Operations Center (EOC).
- Federal teams report surveillance information and results to the ESF #8 Incident Response Coordination Team (IRCT).
- The State DHH Emergency Operations Center (EOC) communicates with Federal ESF #8 IRCT through the ESF #8 IRCT Liaison Officer.
- State and Federal ESF #8 produce consolidated surveillance reports.
- The following essential elements will be reported to maintain a Common Operating Picture (COP):
 - Region and territory assessed
 - Number, type, and location of assessments conducted
 - Number and size of outbreaks, location, and type
 - Environmental health investigations

- Location and type of sources identified and remediated
- Number, location, and type of public health interventions
- Health statistics (e.g., illness, injuries, fatalities)
- Demographics of the affected population

Note: Chapter 19 provides additional detail on the elements of information for reporting and maintaining a COP.

CHAPTER 4

MEDICAL PERSONNEL (MP)

Medical personnel will be required to staff shelters, augment staff at hospitals and medical care facilities, and staff temporary sites established to support emergency response operations. .

Medical personnel will also be required to assist local health departments to conduct public health functions such as disease surveillance, food inspection, and sanitation and vector control. Behavior health is also an area where augmentation of medical personnel will be required.

Assets and Functions

Local/Parish

- Local medical providers and hospital staff
- Medical Reserve Corps (MRC) (Caddo/Bossier, Calcasieu, Livingston, East Baton Rouge, Plaquemines, Jefferson, City of New Orleans and Acadian).

State

- DHH can staff up to 8 MSNSs for 3-5 days with the following resources
 - Louisiana State University (LSU) hospital staff.
 - Nursing, pharmacy, and EMS volunteers, who are listed in a database maintained by DHH
 - DHH Work as Employed (WAE) employees
 - DHH will augment MSNS health and medical staff through EMAC.
 - See Addendum 1
- Volunteers are available through the State's Emergency System for Advance Registration of Volunteer Health Professionals (ESAR VHP) known as Louisiana Volunteers in Action (LAVA).

Federal (See Addendum 1)

- The US. Public Health Service has the following ESF #8 response personnel:
 - Rapid Deployment Force (RDF) teams
 - Applied Public Health Teams (APHT)
 - Mental Health Teams (MHT)
 - Health and medical personnel
 - Undefined number of Inactive Reserve Corps
- NDMS has DMATs and other specialty teams/groups.
 - DMAT personnel can be configured into strike teams.
- Medical Reserve Corps (MRC) personnel can be federalized.
- The FEMA Voluntary Agency (VOLAG) type manages volunteer offers.
- ESF #8 partners (VA, DOD) have medical personnel to augment local and state resources.
- HHS/civilian clinical staff.

Command and Control

- The State Health Officer or their designee has primary responsibility for medical personnel.
- The DHH/OPH manages (functions include staffing, deployment, and operations) State medical teams.
- The DHH/OPH communicates with the Office of Emergency Preparedness (OEP) through the State EOC.
- The DHH Emergency Operations Center (EOC) forwards requests for Federal assistance to the State EOC.
- The State OEP EOC communicates with Federal ESF #8 through the ESF #8 Liaison at the Joint Field Office (JFO) and Emergency Operations Center (EOC).
- The PHS has an enhanced team structure that includes a command and control element.
- Assets shall coordinate with local officials requesting the asset in accomplishing mission assignments.

Operations

- The DHH maintains a roster of available medical and non-medical DHH personnel.
- The DHH/OPH maintains a volunteer database for nurse, pharmacy, and EMS personnel through LAVA – Louisiana Volunteers in Action.
- The Secretary’s Operations Center (SOC) rosters staff augmentation teams through the OFRD/PHS.
- The NDMS Emergency Coordinator/Management Support Team (MST) provides field command and control for NDMS assets.
- The ESAR-VHP System will provide a readily available pool of health care volunteers (nurses, physicians, pharmacists, EMTs, etc.) to assist in an emergency situation. Volunteers may be requested and deployed through the Department of Health Hospitals. During a declared emergency, medical boards have the authority to suspend licensure rules and regulations without the need for Governor issued Executive Orders. The following briefly describes the process for onsite license verification and/or credentialing to be done by designated authorities.(www.lava.louisiana.gov)
 - View and copy volunteer’s driver’s license and professional license.
 - Volunteer completes *Registration Form* and *Agreement to Volunteer Services Form*.
 - Give assignment and make copy of *Assignment Form*.
 - Write assignment (deployment site) on top of *Registration Form*.
 - Record assignment on shelter schedule. (Updated schedules should be faxed to shelters. If no fax is available at shelter, updated schedule should be phoned to shelter at 3 pm daily.)
 - Enter information into *ESAR-VHP Database* and place a hard copy into appropriate binder/file.

Logistics and Communications Support

- The State provides limited communications equipment to deployed State personnel.
 - Personnel use a mix of State-provided and personal cell phones, email, blackberries, etc.
- State shelter Incident Commanders communicate with the DHH/OPH and account for assigned personnel.

- OPHEP Logistics provides logistics (i.e., travel) and communications support to deployed PHS personnel.
 - Personnel use agency-issued and personal cell phones and blackberries.
- FEMA logistics provides logistics and communications support to NDMS personnel.
 - NDMS team communications include two-way radios, NEXTEL/cell phone/blackberries, standard email, and SAT phones.

Reporting and Planning

- Reporting and planning occur for specific mission operations (e.g., operating a Medical Special Needs Shelter).
- The State reports on personnel staffing daily or every shift as needed.
- Team leaders report locations and status of deployed personnel to the ESF #8 IRCT daily or every shift as needed.
- The SOC reports reload personnel status and expected arrival date to the ESF #8 IRCT.
 - Send separate personnel report daily or every shift as needed. The ESF #8 IRCT OFRD Liaison provides this report to the IC.
 - The ESF #8 IRCT forwards this information to Team Leaders.
- DHH Emergency Operations Center (EOC) DHH Emergency Operations Center (EOC) communicates and funnels medical personnel requests to State ESF #8 at the State EOC.
- State ESF #8 at the State EOC receives and validates requests for medical personnel.
- The State communicates with Federal ESF #8 through the ESF #8 Liaison at the State EOC.
- SHO and Federal ESF #8 partners develop IAP and tactical objectives to ensure adequate support, location, re-supply, etc.
- The JFO (ESF#8) disseminates this information to Federal partners through daily IAP and SITREPs.
- Maintaining a Common Operating Picture (COP):
 - Report daily updates of medical personnel needs at hospitals, mobile medical units, primary care facilities
 - Report daily status of medical personnel requests
 - Report daily status of Federal medical personnel rotations, including expected departure and arrival dates for personnel
 - Number and status of personnel staged and in the field
 - Projected demobilization dates for deployed personnel
 - Personnel/team locations and missions

CHAPTER 5

HEALTH/MEDICAL/VETERINARY EQUIPMENT AND SUPPLIES (HMES)

Medical equipment and supplies (e.g., medical diagnostic equipment, radiation-emitting devices, pharmaceuticals, and biologic products) will be needed to support immediate medical response operations and to restock healthcare facilities in the affected area.

Assets and Functions

Local/Parish

- Regional contracts for oxygen supplies are available for the 2011 hurricane season.

State

- Louisiana's ESF-8 Network maintains medical countermeasures and responsible for its contents, location, and distribution.
- Assets from Fire Marshal State Agency for hygiene / showering / decontamination.
- Potential Receiving, Staging, and Storing (RSS) sites are located at several locations across the state.
 - The Louisiana National Guard normally operates warehousing functions, but assistance through EMAC may be needed.
 - **See Addendum 1.**
 - Local and State Police normally operate security functions, but assistance through EMAC may be needed.
 - **See Addendum 1.**
 - The Louisiana National Guard normally operates distribution functions, but assistance through EMAC may be needed.
 - **See Addendum 1.**
 - ESF #7 has crossover responsibilities; the Governor's Office of Homeland Security and Emergency Preparedness (GOHSEP) has the lead.
 - DHH will augment MSNS health and medical equipment through local, state and/or federal assets as needed.
 - **See Addendum 1.**

Federal

- HHS headquarters maintains contracting mechanisms for medical equipment and supplies, including pharmaceuticals.
- Additional procurement mechanisms exist through VA and DOD prime vendor contract for pharmaceuticals and supplies.

Command and Control

- The DHH/OPH operates the RSS with assistance from assets obtained through general requests (e.g., personnel, transportation) and local, state and federal assets as needed.
- The State DHH and GOHSEP maintain communications with Federal ESF #8 at the JFO through ESF #8 Liaison at the State EOC.
- Federal ESF #8 functions under the ESF #8 IRCT.

Operations

- The SERT works with the ERT-N/A and RRCC/NRCC to pre-identify and prioritize assembly areas of pre-deployment of medical supplies to strategic locations.

Logistics and Communications Support

- The State logistics cell provides support through the State EOC.
- ESF #8 logistics support is coordinated through FEMA logistics at the JFO.

Reporting and Planning

- The Federal ESF #8 Technical Assistant to the DHH Emergency Operations Center (EOC) will track requests for and deliveries of medical equipment and supplies and report this information to State and Federal ESF #8 leadership.
- The following essential elements will be reported to maintain a Common Operating Picture (COP):
 - Requests for medical equipment and supplies, including quantity and types of items requested, purpose, source, and location of request
 - Quantities of medical equipment and supplies ordered, enroute, and delivered

CHAPTER 6

PATIENT EVACUATION

In times of emergency, due to limited resources of state and local authorities, Federal assets may be required to assist with the evacuation and subsequent medical support of the special medical needs population.

Due to their proximity to the Gulf of Mexico, Louisiana's 12 coastal parishes are particularly vulnerable to hurricanes. Patient evacuation covers the coastal parishes' evacuation in regards to hospital and nursing home evacuations, and the medical and public health support to those in the general populations that are forced to evacuate.

Assets and Functions

Local/Parish

- Hospitals and nursing homes are responsible for developing and maintaining their own evacuation plans. NH and Hospital plans can be requested by DHH anytime. Only NH in the 22 parishes named in R.S. 40:2009.25 are required to submit plans yearly to DHH.
- In the event that hospitals request assistance for evacuation and State and/or federal assets are required, the evacuating hospital patients will first be transported from the medical institution to an aeromedical marshalling point (AMP)
- Hospital evacuations rely on ambulances, ambulance buses and rotary-wing aircraft. NH's rely on these resources as an alternative when required primary contracted resources fail.

State

- For transport from hospital to airhead
 - Ambulances
 - Buses and/or Para transits (contingency contracts established for surge supply)
- For transport to out of State hospitals
 - Ambulances
 - Rotary-wing aircraft crews
 - LA National Guard assets will provide LNOs for coordination between DOD personnel airlift control and ESF 8.
- Will require assistance through EMAC and Federal ESF #8

Federal

- NDMS
 - DoD with Air Evacuation (AE) crews
 - HHS with contract AE crews
 - Federal Coordinating Centers (FCCs) staffed by VA, DoD
 - Destination hospitals

Command and Control

- Unified command
- GPMRC liaison will be co-located with state representatives at the state EOC in Baton Rouge.

- The State will work through Federal ESF #8 for all medical resource requests.
 - The State OEP communicates with Federal ESF #8 through the ESF #8 IRCT liaison at the State EOC.
 - ESF #8 will be responsible for actual ambulance contracting.

Operations

- See Annex 3 for details of hospital evacuation CONOPS.
- See Annex 4 for details of nursing home CONOPS
- See Annex 5 for details of New Orleans evacuation CONOPS

Logistics and Communications Support

Reporting and Planning

- SHO and Federal ESF #8 partners develop IAP and tactical objectives to ensure adequate lift capability and ground support.
- The JFO (ESF #8) disseminates this information to Federal partners through daily IAP and SITREPs.
- Reports are provided through on-scene liaisons and the Patient Movement Cell
- Maintaining a Common Operating Picture (COP):
 - Location and number of patients needing evacuation
 - Number of patients evacuated and evacuation locations

CHAPTER 7

PATIENT CARE

Patient care services includes inpatient hospital care for those who shelter in place, provision of medical services to individuals in temporary special needs or general population shelters, and urgent medical services to others whose normal sources of care are not available due to the affects of the storm.

Medical Special Needs Shelters (MSNS) refer to shelters set up for vulnerable populations who require assistance with disabilities or other special needs (e.g., limited mobility, medical conditions).

Federal Medical Stations (FMS) are caches of medical equipment and supplies that are set up and staffed in buildings of opportunity. They are similar to a Medical Special Needs Shelter.

General shelters are set up for the general population. All types of shelters require some form of medical care (e.g., outpatient nursing station, mobile care clinic, bedside care).

Assets and Functions

Local/Parish

- Some institutions may shelter in place while others may be expected to support evacuees from other facilities

State

- Department of Children and Family Services (DCFS) is tasked to identify and secure Medical Special Needs Shelters
- Department of Health and Hospitals (DHH) is tasked with coordinating medical care at Medical Special Needs Shelters

Federal

- Federal Medical Stations (FMS)
 - 1000 FMS beds are designated for Louisiana
 - With the current warehouse arrangement, FMS assets can be on-site¹ within 48 hours of request; partial capability can be set up and operational within 4-6 hours of arrival if adequate staffing is available
 - Federal ESF-8 has a staffing plan to staff the 1000 FMS beds.
- Mobile hospitals
 - Private units are available by contract (e.g., Carolinas Med-1)
 - DoD EMEDs (25-bed units), Combat Support Hospital (CSH) takes 2 weeks, large space to set up
 - USN Hospital Ships

¹ SNS advises they can be deployed within 48 hours (as opposed to onsite)

Command and Control

- Deployed medical teams report through team leaders to local authorities (hospital or health) and to Federal ESF #8 via the IRCT at the JFO.
- Coordination of requirements and assignments occurs through ESF #8 IRCT Liaison at the State EOC and the ESF #8 Technical Assistant in the DHH Emergency Operations Center (EOC).

Operations

- Staff at hospitals and primary care facilities will be augmented with local medical providers, MRC volunteers, and volunteer health professionals from across the state through the ESAR VHP as available.
- Additional Federal medical personnel from USPHS, VA, DoD, or other ESF #8 support agencies will also augment hospital and local primary care clinic staff as available.
- Federal ESF #8 medical personnel may be used as support staff to augment special needs sheltering duties.
- For additional details see Annex VI for details of the shelter in place population. Additional details for provision of medical services to individuals special medical needs shelters are at Annex X.
- The concept for support for mass prophylaxis is at Annex XII.

Logistics and Communications Support

- Personnel and patient care sites require security, food, water, sanitation, waste disposal, medical waste disposal, redundant communications, etc.

CHAPTER 8

SAFETY AND SECURITY OF HUMAN DRUGS, BIOLOGICS, MEDICAL DEVICES

Following a disaster, ESF #8 is responsible for ensuring the safety, efficacy, and security of regulated human and veterinary drugs, biologics (including blood and vaccines), medical devices (including radiation emitting and screening devices), and other products regulated by HHS or State agencies.

Assets and Functions

Local/Parish

- None

State

- The OPH/CEHS field survey and assessment teams.
- The OPH/CEHS field inspection teams.
- The DHH Pharmacy Board regulates pharmacists and pharmacies.
- OPH/CEHS may request assistance from PHS for pharmacy teams.

Federal (See Addendum 1)

- FDA regional laboratories perform testing.
- FDA can assist in performing sample collections of human and/or animal drugs, biologics and medical devices for subsequent analyses.
- FDA can assist states with inspections of pharmacies and other establishments offering human and/or animal drugs, biologics and medical devices at retail.
- FDA can assist with laboratory analysis of human and animal drugs, cosmetics and medical devices
- FDA can assist in conducting assessments (field tests) of facilities where diagnostic x-ray and mammography equipment are installed to help assure the equipment is operating within acceptable radiation emission limits.
- FDA can provide subject matter experts to address issues that impact whether human and/or animal drugs, biologics and medical devices are appropriate for use and provide guidance on what steps can be taken to restore such products to a condition whereby they would be fit for use.
- FDA can assist with inspections of establishments which prepare, pack or hold human and/or animal drugs, biologics, cosmetics and medical devices.

Command and Control

- The OPH/CEHS and FDA are jointly responsible for managing drug safety and security operations.
- FDA Liaison Officers are located with the ESF #8 IRCT and OPH/CEHS.
- OPH/CEHS and FDA coordinate requests for additional Federal Assistance through the DHH Emergency Operations Center (EOC)DHH Emergency Operations Center (EOC), which forwards requests to the State EOC.
- The DHH Emergency Operations Center (EOC)DHH Emergency Operations Center (EOC) communicates with the State EOC.

- OPH/CEHS and FDA maintain communications with Federal ESF #8 through the ESF #8 IRCT.

Operations

- OPH/CEHS and FDA conduct surveys and assessments of drug manufacturers, wholesale distributors, and retail facilities.
- OPH/CEHS and FDA conduct inspections of drug manufacturers, wholesale distributor and retail facilities.
- OPH/CEHS issues permits to manufacturers and distributors, obtains voluntary corrections, and takes appropriate actions to ensure drug safety (e.g., seizures).
- FDA conducts laboratory testing at regional labs.
- The CDC helps secure research threats, such as the release of lab primates.
- HHS provides funding for HIV and psychological medication.

Logistics and Communications Support

- GSA provides cars to FDA survey and inspection teams.
- FEMA logistics provided communications equipment and GPS locators to FDA survey and inspection teams.

Reporting and Planning

- State teams report survey information and results to the State Food and Drug Central Office.
- The State Food and Drug Central Office reports to the FDA Area Operations.
- The FDA Area Operations reports to the HHS ESF #8 IRCT.
- FDA disseminates information to and through the ESF #8 IRCT.
- FDA Area Operations will report accomplishments related to the following essential elements:
 - Number of firms assessed
 - Operational status of firms (open or closed)
 - Type of product and dollar amount and quantity of drug seizure and/or destruction
 - Employee labor hours
 - Contact of most responsible person

CHAPTER 9

BLOOD AND BLOOD PRODUCTS (BBP)

Following a disaster, ESF #8 monitors the need for blood, blood products, and the supplies used in their manufacture, testing, and storage; the ability of existing supply chain resources to meet these needs; and any emergency measures needed to augment or replenish existing supplies.

Assets and Functions

Local/Parish

- Hospital blood banks and regional providers in the blood bank system.

State

- The State Health Officer (SHO) coordinates requests for Federal assistance through the DHH Emergency Operations Center (EOC) and the State EOC.

Federal

- Through a liaison in the HHS Secretary's Operations Center (SOC), HHS monitors blood availability and maintains contact with the American Association of Blood Banks (AABB) Inter-organizational Task Force on Domestic Disasters and Acts of Terrorism and, as needed, its individual members.
 - The American Red Cross (ARC) coordinates blood drives.
 - FDA can assist in performing sample collections of human and/or animal drugs, biologics and medical devices for subsequent analyses.
 - FDA can provide subject matter experts to address issues that impact whether human and/or animal drugs, biologics and medical devices are appropriate for use and provide guidance on what steps can be taken to restore such products to a condition whereby they would be fit for use.
 - FDA can assist with inspections of establishments which prepare, pack or hold human and/or animal drugs, biologics, cosmetics and medical devices.
-

Command and Control

- The DHH Emergency Operations Center (EOC) forwards requests for assistance to the State EOC.
- The State EOC communicates with Federal ESF #8 at the JFO.
- The AABB Task Force coordinates with Federal ESF #8 through the HHS SOC.
- FDA Liaison Officers are located with the ESF #8 IRCT and OPH/CEHS
- OPH/CEHS and FDA maintain communications with Federal ESF #8 through the ESF #8 IRCT.

Operations

- Hospitals are responsible for monitoring blood supplies.
- FDA conducts assessments of blood banks, donor centers, and plasma centers.
- The SHO coordinates requests for assistance through the DHH Emergency Operations Center (EOC) which forwards requests to the State EOC.

- HHS coordinates blood drives and blood issues through the AABB Task Force representative in the SOC.

Logistics and Communications Support

- Fuel and/or transportation support are provided by ESF #1 and FEMA logistics.
- GSA provides cars to FDA survey and assessment teams.
- FEMA logistics provides communications equipment and GPS locators to FDA survey and inspection teams.

Reporting and Planning

- The JFO (ESF #8) disseminates this information to Federal partners through daily IAPs and SITREPs.
- The following essential elements will be reported to maintain a Common Operating Picture (COP):
 - Blood supplies
 - Status of assessments of blood banks and plasma centers
 - Status of requests for Federal blood support

CHAPTER 10

FOOD SAFETY AND SECURITY (FSS)

Following a disaster, ESF #8 is responsible for ensuring the safety and security of federally regulated foods. (Note: HHS, through the Food and Drug Administration (FDA), has statutory authority for all domestic and imported food except meat, poultry, and egg products, which are under the authority of the USDA/Food Safety and Inspection Service.)

Assets and Functions

Local/Parish

- Parish food safety inspectors assist during recovery

State

- OPH/CEHS field survey and assessment teams to conduct rapid assessment via telephone of establishments serving food to ascertain loss of power and refrigeration of potentially hazardous food products, as well as any physical damage to the establishment which would make it impossible to open for business as usual.
- OPH/CEHS field inspection teams to conduct on-site inspections of establishments serving food at retail. Examples include restaurants, school and hospital cafeterias, day care center food service establishments, temporary shelters, etc.
- OPH Food and drug inspectors to conduct rapid assessment via telephone of establishments preparing, packing or hold food products to ascertain loss of power and refrigeration of potentially hazardous food products, as well as any physical damage to the establishment which would make it impossible to open for business as usual.
- OPH Food and drug inspectors to conduct onsite inspections of establishments which prepare, pack or hold food

Federal (See Addendum 1)

- FDA can assist in performing inspections of establishments serving food at retail. Examples include restaurants, school and hospital cafeterias, day care center food service establishments, temporary shelters, etc.
- FDA can assist in performing sample collections of food for subsequent analysis.
- FDA can assist with laboratory analysis of food and water as necessary.
- FDA can provide subject matter experts to address issues that impact whether food products are appropriate for consumption; and provide guidance on what steps can be taken to restore food products to a condition whereby they would be fit for consumption.
- FDA can assist with food safety expertise; provide training in food safety preparations, handling and storage to volunteers and/or other appropriate disaster response personnel.
- FDA can assist with inspections of establishments which prepare, pack or hold food.

Command and Control

- OPH/CEHS and FDA are jointly responsible for managing food safety and security operations.
- FDA Liaison Officers are located with the ESF #8 IRCT and OPH/CEHS.
- OPH/CEHS and FDA coordinate requests for Federal assistance through the DHH Emergency Operations Center (EOC) and the State EOC.
- OPH/CEHS and FDA maintain communications with Federal ESF #8 through the ESF #8 IRCT at the JFO.

Operations

- OPH/CEHS and FDA conduct surveys and assessments of food manufacturers, wholesale distributor, and retail facilities.
- OPH/CEHS and FDA conduct inspections of food manufacturers, wholesale distributors, and retail facilities
- OPH/CEHS issues permits, obtains voluntary corrections, or takes appropriate actions to ensure food safety (e.g., seizures, recondition goods).
- FDA labs analyze water as it affects FDA-regulated products.

Logistics and Communications Support

- GSA provides cars to FDA survey and inspection teams.
- FEMA logistics provides communications equipment and GPS locators to FDA survey and inspection teams.

Reporting and Planning

- State teams report survey information and results to the State Food and Drug Central Office.
- The State Food and Drug Central Office reports to FDA Area Operations.
- The FDA Area Operations reports to the HHS ESF #8 IRCT.
- The FDA disseminates information to and through the ESF #8 IRCT.
- FDA Area Operations will report accomplishments related to the following essential elements:
 - Number of firms assessed
 - Operational status of firms (open or closed)
 - Type of product and dollar amount and weight of food seizure and or destruction
 - Employee labor hours
 - Contact of most responsible person

CHAPTER 11

AGRICULTURE SAFETY AND SECURITY (AGSS)

HHS coordinates with ESF#11 to ensure the safety and security of food-producing animals, animal feed, and therapeutics. (Note: HHS, through the FDA, has statutory authority for animal feed and for the approval of animal drugs intended for both therapeutic and non-therapeutic use in food animals as well as companion animals.)

Assets and Functions

Local/Parish

- None

State

- Through the Louisiana Department of Agriculture and Forestry, Office of Animal Health Services, the Louisiana State Veterinarian is responsible for ensuring the safety and security of the animal livestock industry.

Federal (See Addendum 1)

- FDA has statutory authority for animal feed and for the approval of animal drugs.
- The U.S. Department of Agriculture (USDA) is the coordinating agency for ESF #11 – Agriculture and Natural Resources – under the NRF.

Command and Control

- ESF #8 coordinates with ESF #11 through the JFO.

Operations

- Operations are initiated and conducted by ESF #11.
- ESF #11 coordinates assistance from ESF #8 as needed.
- The CDC and ATSDR assess risks from exposure to agricultural pesticides.

Logistics and Communications Support

- None

Reporting and Planning

- Reporting and planning for agriculture safety and security is the responsibility of ESF #11.
- The following essential elements will be reported to maintain a Common Operating Picture (COP):
 - ESF #8 activities in support of ESF #11

CHAPTER 12

ALL HAZARD PUBLIC HEALTH AND MEDICAL CONSULTATION, TECHNICAL ASSISTANCE AND SUPPORT (AHZ)

HHS may task its components to assist in assessing public health and medical effects resulting from all hazards. Such tasks may include assessing exposures on the general population and on high-risk population groups; conducting field investigations, including collection and analysis of relevant samples; providing advice on protective actions related to direct human and animal exposures, and on indirect exposure through contaminated food, drugs, water supply, and other media; and providing technical assistance and consultation on medical treatment, screening, and decontamination of injured or contaminated individuals.

CHAPTER 13

BEHAVIORAL HEALTH CARE (BHC)

Behavioral health care includes assessing mental health, substance abuse and developmental disabilities needs; providing disaster behavioral health training and materials for workers; providing liaison with assessment, training, and program development activities undertaken by Federal, State, and Local mental health, substance abuse and developmental disabilities officials; and providing additional consultation as needed.

Assets and Functions

Local/Parish

- Local Emergency Management structures are organized by parish in Louisiana. Local jurisdictions are responsible for initial response to a disaster. Each parish has a Local Emergency Operations Plan (LEOP). The local plan should contain information about how that parish intends to meet the psychological and social needs of people in that area after a disaster.
- Regional Behavioral Health Authorities will designate staff or volunteers to serve as Regional Disaster Behavioral Health Coordinators. These coordinators will serve as a link with emergency management, public health, and other agencies and organizations within communities, and with State agencies. The State will look to the Regions to provide local behavioral health information needed to prepare a FEMA Crisis Counseling grant application if a disaster occurs that makes the area eligible.

State (See Annex VIII for DHH Behavioral Health Plan)

- Personnel are available from:
 - Office of Behavioral Health
 - Office of Citizens with Developmental Disabilities
- The workforce is identified as persons available for either:
 - Medical Special Needs Shelters and other identified sites as available personnel will allow.
 - Behavioral Health interventions for disaster victims and/or response personnel.
- Request additional Behavioral Health teams for shelters and to relieve State personnel.

Federal (See Addendum 1)

- The Substance Abuse and Mental Health Services Administration (SAMHSA) administers grants for assistance both independently and through an interagency agreement with FEMA.
- 5 PHS Mental Health Teams (MHTs) are available.
- The VA has Mental Health personnel.
- 2 NDMS crisis teams exist (primarily for Force Protection but potentially available for crisis intervention).
- The FEMA VOLAG manages volunteer offers.

Command and Control

- A State Behavioral Health Branch will be established in the DHH Emergency Operations Center (EOC).
- The Behavioral Health designee assigned to the DHH Emergency Operations Center (EOC) has reach back to program offices and regional managers and communicates with the State EOC.
- In-patient and out-patient behavioral health service providers (state and contracted) maintain control of the delivery of their services using prescribed disaster and or evacuation plans as dictated by the event.
- The State EOC communicates with Federal ESF #8 through the JFO.
- ESF #6 and #8 will coordinate with the ARC to augment its normal mental health staff if necessary.

Operations

- The DHH Emergency Operations Center (EOC) receives requests for assistance and will look first to the region to meet those needs.
- The State will establish behavioral health functions in Medical Special Needs Shelters, including:
 - Stress management care for staff
 - Behavioral Health Specialists (multiple)
 - Quiet beds / quiet area
- PHS MHTs will provide behavioral health support at FMSs as available.
- The State will establish mobile crisis behavioral health support to general shelters as available.
 - Mobile group augmented by shelter volunteers
 - Establish teams of 4-6 persons from regional and Federal personnel
 - Plan for providing medication onsite (teams can prescribe)
 - Plan for providing care for substance abuse patients
 - Medical care for acute withdrawal
 - Arrangement for continuity of 12-step programs in shelters
 - Case management including take-out doses if approved by the State Methadone Authority.

Logistics and Communications Support

- Psychiatric and substance abuse treatment medications will be requested.
 - This includes pharmaceuticals to manage alcohol and/or drug dependencies and withdrawals
 - Pursue State stockpile first
- Support for mobile general shelter group will include:
 - Medications to be provided by existing HHS contracting mechanisms
 - Vehicle (van or RV): 3 NDMS medically configured RVs are potentially available.

Reporting and Planning

- Shelter personnel report to regional representatives.
- Regional representatives report daily to DHH via conference calls.
- The following essential elements will be reported to maintain a Common Operating Picture (COP):

- Behavioral health bed status
- Medical Special Needs Shelters and FMSs
 - Number of residents with behavioral health diagnoses
 - Shelter density (occupied and vacant beds) and demographics
- General shelter statistics
- Statistics on volunteer credentialing
- Requests for Federal behavioral healthcare assistance
- Transition plan for State and Local resumption of behavioral healthcare support
- Federal behavioral healthcare assets available and deployed
- Applications for FEMA crisis counseling grants
- Forecasted need for behavioral health resources
- Location and type of behavioral health services
- Status of behavioral healthcare infrastructure (e.g., hospitals, clinics)
- Procedures for behavioral health surveillance and intervention

CHAPTER 14

PUBLIC HEALTH AND MEDICAL INFORMATION (PHMI)

Public health, disease, and injury prevention information will be provided through Pre-Scripted Announcements as described in the All-Hazard Public Health and Medical Consultation, Technical Assistance, and Support section.

CHAPTER 15

VECTOR CONTROL (INSECTS AND RODENTS) (VC)

Vector control includes assessing the threat of vector-borne diseases; conducting field investigations, including the collection and laboratory analysis of relevant samples; providing vector control equipment and supplies; providing technical assistance and consultation on protective actions regarding vector-borne diseases; and providing technical assistance and consultation on medical treatment of victims of vector-borne diseases.

Assets and Functions

Local/Parish

- Local entities: Mosquito Abatement Districts, Police Juries, and/or municipalities are responsible for monitoring rodent/mosquito populations.

State

- The Office of Public Health (OPH) Center for Environmental Health (CEHS)
 - Provides technical advice to Parishes (OPH/CEHS entomologist).
 - Coordinates public information about DOD's adulticide applications and the adulticides to be utilized (OPH/CEHS entomologist / OPH Public Information Officer / Environmental Epidemiology and Toxicology).
 - Requests support from LSU (laboratory testing) and the LA Animal Disease Diagnostic Lab.
 - In Parishes without surveillance based abate programs, may assist in emergency surveillance. (OPH/CEHS entomologist).
 - For rodents, provides technical advice (OPH/CEHS entomologist).
 - Coordinates with local entities and Federal agencies (CDC / DOD) in surveillance, design of application plans and application oversight (OPH/CEHS entomologist).
 - Approves surveillance counts for FEMA funded abatement applications (OPH/CEHS entomologist).
 - Selects adulticides utilized by DOD in all emergency applications (OPH/CEHS entomologist).
 - Communicates with Federal ESF #8 at the JFO (OPH/CEHS entomologist).
 - Contacts Parish officials in those Parishes where DOD applications may occur.

Federal (See Addendum 1)

- Federal agencies assist with vector surveillance and mosquito testing:
 - The DOD may conduct mosquito spraying.
 - The CDC provides technical assistance in vector control methods.
 - The CDC provides vector control teams.
- For rodents, CDC assistance from Fort Collins may be available.

Command and Control

- The SHO has the lead for operations relating to vector control. The SHO is responsible for the communication of requests and coordination of response operations through the DHH EOC and the State EOC.

- The CDC SMO advises State officials on environmental health and vector control options.
- The Team Leader (OPH/CEHS entomologist) for mosquito spraying or vector control team receives tasking from OPH/CEHS at EOC, and reports activities, findings, and recommendations to both the OPH/CEHS representative at the EOC and to ESF #8 desk at JFO.
- The State OEP through the State EOC communicates with Federal ESF #8 at the JFO through the Federal ESF #8 Liaison.

Operations

- Louisiana Animal Disease Diagnostics Lab tests mosquito pools, sentinel chicken bloods, wild bird bloods and dead birds.
- The OPH/CEHS entomologist provides technical advice to Parishes.
- The OPH/CEHS entomologist approves all surveillance based applications with local entities (assumption: no State assets for mosquito spraying).
- The SHO coordinates public messaging with CDC, OSHA, ATSDR and other entities through the JIC.
- The SHO coordinates requests for Federal assistance through the OPH/CEHS at the DHH Emergency Operations Center (EOC) and the State EOC.
- DoD may conduct mosquito spraying.
- CDC provides vector support (e.g., surveillance) through environmental health teams.
- The OPH/CEHS entomologists may coordinate with those local entities without surveillance based abatement programs to approve emergency surveillance and areas for applications of adulticides by contractors.

Logistics and Communications Support

- Once requested, DoD will coordinate vector control operations with OPH/CEHS entomologist, State (OPH/CEHS at EOC), OPH Public Information Officer, Environmental Epidemiology and Toxicology, and Parish officials.

Reporting and Planning

- The SHO and Federal ESF #8 develop the IAP and tactical objectives to ensure vector control.
- The JFO (ESF#8) disseminates this information to Federal partners through daily IAP and SITREPs.
- The following essential elements will be reported to maintain a Common Operating Picture (COP):
 - Report individual and cumulative test results
 - Report spraying schedule and areas that have received applications of adulticides

CHAPTER 16

POTABLE WATER, WASTEWATER AND SOLID WASTE DISPOSAL (WWSW)

In coordination with ESF #3, ESF #8 is responsible for assessing potable water, wastewater, solid waste disposal issues, and other environmental health issues; conducting field investigations, including collection and laboratory analysis of relevant samples; providing water purification and wastewater/solid waste disposal equipment and supplies; and providing technical assistance and consultation on potable water and wastewater/solid waste disposal issues.

Assets and Functions

Local/Parish

- Parish Boards are responsible for the testing and maintenance of water supplies, sewage treatment, and solid waste disposal.
- Following a hurricane or flooding, Parish Boards may request assistance from DHH/OPH with assessment of water quality and/or damage to infrastructure through Parish OHSEP EOCs.

State

- The OPH/ CEHS:
 - Responds to threats or reports of compromised water supply with testing in State Labs and technical advice
 - Coordinates public information and emergency messaging regarding the safety of water
 - May request additional resources through General Request Forms

Louisiana Dept of Environmental Quality (LDEQ)

- Monitors lakes, rivers, reservoirs, etc for contamination of water
- Coordinates environmental clean-up following spills

Federal (See Addendum 1)

- ATSDR supports EPA and State officials with issues regarding hazardous materials, contaminations, exposures, and other environmental issues.
- Environmental Health Officers (EHOs) on Environmental Health Teams (CDC/ATSDR) or Applied Public Health Teams (PHS/OFRD) deploy to assist the State evaluate water supplies.
- FDA mobile lab unit
- If the remediation of sewage treatment plants and/or water supply is necessary, the engineering tasks are requested through ESF #3 (Public Works).
- FDA labs analyze water as it affects FDA-regulated products.

Command and Control

- The SHO is responsible for coordinating the assessment of the water supply and related emergency messaging.

- The SHO is responsible for communicating requests for assistance from other State agencies, through EMAC, and from the Federal government through the CEHS at the DHH Emergency Operations Center (EOC) and the State EOC.
- EHOs or Team Leaders for EHTs or APHTs involved in water assessment receive tasking from OPH/CEHS at the EOC, and reports activities, findings, and recommendations to both the OPH/CEHS representative at the EOC and to ESF #8 desk at the JFO.
- If requested by the parish via WebEOC, GOHSEP is responsible for operations relating to the procurement and delivery of potable water to areas without safe drinking water, or as requested by city or Parish officials

Operations

- The OPH/CEHS performs engineering assessments on the sewage system and water quality testing.
- If the supply is potentially compromised:
 - The SHO coordinates public messaging and ongoing monitoring and evaluation through OPH/CEHS
 - The State GOHSEP supplies potable water.
 - The State GOHSEP takes actions to remediate water system
- The SHO coordinates requests for Federal assistance through the CEHS in the DHH Emergency Operations Center (EOC) and the State EOC.
- The CDC DEQ/ATSDR performs engineering assessments on sewage systems and performs water assessment/testing.
- FEMA supports requests for potable water through ESF #3/USACE.

Logistics and Communications Support

- GOHSEP may task an ESF with transportation of potable water to affected site(s).
- The State may also request potable water supplies through FEMA, which may utilize ESF #1 for transportation assets.
- The Parish coordinates sampling of donated water with regional environmental health personnel.

Reporting and Planning

- The SHO and Federal ESF #8 develop IAP and tactical objectives to ensure potable water and facilitate remediation.
- The JFO (ESF #8) disseminates this information to Federal partners through daily IAP and SITREPs.
- The following essential elements will be reported to maintain a Common Operating Picture (COP):
 - Report testing schedule (OPH/CEHS)
 - Report individual and cumulative results from all affected sites
 - Track supply, demand and any challenges associated with water availability (GOHSEP)
 - Report engineering assessments of water supply infrastructure and timetables/milestones for remediation

CHAPTER 17

MASS FATALITY MANAGEMENT, VICTIM IDENTIFICATION AND DECONTAMINATING REMAINS

Victim identification and mortuary services include establishing temporary morgue facilities; performing victim identification by fingerprint, forensic detail, and/or forensic pathology/anthropology methods; and processing, preparation, and disposition of remains.

Assets and Functions

Local/Parish

- Parish Coroners have primary authority and responsibility for victim identification and mortuary services.
- Local assets include volunteer coroners, search and recovery assets, refrigerated truck contracts, and contracts with forensic anthropologists and other technical experts.

State

- Depending on the status of the affected local coroner, the size of the event and the number of fatalities, and the availability of assistance from other coroners in Louisiana, the State may submit an Executive Order establishing the position of a State Medical Examiner to oversee victim recovery, processing, identification, and family assistance activities.
 - If multiple jurisdictions are affected, a joint command of the jurisdictional Coroners will be established at the State EOC.
- The State has a Family Assistance Center (FAC) plan in place that relies on NDMS and DMORT support for staffing, equipment, supplies and other resources.
 - If local coroner resources are overwhelmed, LSP will coordinate missing persons operations at the FAC. The State Medical Examiner will function as the Incident Commander at the FAC.
 - The LSP Crime Laboratory will coordinate DNA identification efforts at the FAC and in concert with the centralized morgue facility; if established and if local coroner resources are overwhelmed.
 - The Louisiana Forensic Anthropology and Computer Enhancement Services laboratory (FACES) at LSU will also be available to assist in victim identification tasks.
- The State may use a volunteer network of regional coordinators and volunteer strike teams staffed by the Louisiana Coroner's Association, the Louisiana Funeral Directors Association, EMAC requests, and/or emergency contracts for body recovery assistance.
- The State will request refrigerated trucks, drivers, fuel supplies and maintenance resources for a sufficient number of trucks depending on the number of fatalities and the location of the necessary processing and storage facilities.
- The State has a small cache of body bags and other PPE necessary for victim recovery.

Federal (See Addendum 1)

- The State will potentially request support from NDMS Disaster Mortuary Response Teams (DMORTs) (one per region)
 - 10 DMORT regions

- Contain a variety of personnel; team composition varies based on need
 - Typically deploy in 25-member teams
- Includes search and recovery capability (WMD DMORT) as of 2006
- The State will potentially request NDMS Disaster Portable Morgue Units (DPMU)
 - Can process 144 victims/24 hours using 1 DPMU and associated DMORT staff members
 - NDMS can mobilize up to 5 DPMUs (3 Federally-owned and 2 contracted)
 - NDMS can assist in identifying and mobilizing a suitable site to deploy DPMU operations and other morgue facilities.

Command and Control

- The jurisdictional Coroner will coordinate local operations and report to the State Medical Examiner, if this position is established.
 - If the State Medical Examiner Executive Order is not invoked, ESF 8 will establish a joint command at the State EOC including the affected jurisdictional Coroners.
- The joint command and/or the State Medical Examiner will request and coordinate Federal assets and operations through the DHH Emergency Operations Center (EOC) and the State EOC.
- The joint command and/or State Medical Examiner will coordinate public information with the JIC to ensure consistency.
- The joint command and/or State Medical Examiner will coordinate operations through the State EOC.
- The NDMS MST establishes command and control of DMORT operations in coordination with the appropriate State representative(s).
- The State Medical Examiner will function as the Incident Commander at the FAC, if established.
- The State EOC communicates with Federal ESF #8 through the JFO and the ESF #8 Liaison.

Operations

- Pre-stage NDMS assets with a DPMU at a site near potential impact areas that can support post-disaster mortuary and victim recovery/identification operations.
- The State Health Officer will augment joint command or State Medical Examiner staffing and establish an ICS structure.
- Search and recovery teams will use standardized USAR search markings
 - The State will provide a fact sheet with USAR markings to non-USAR teams.
- Search and recovery teams will consult with the local jurisdiction having authority for a policy for forced entry.
- Body recovery teams will use standard forensic procedures (including documentation) for criminal events.
 - The jurisdiction Coroner, joint command, or Medical Examiner will establish a standard procedures
 - Body recovery teams will perform field documentation using HHS-provided GPS data entry units or other procedures as defined by the joint command and/or the State Medical Examiner.
- The State will establish field collection points with security.
 - Staff will document the receipt time of remains and store them in refrigerated trucks.

- Remains will be transported in refrigerated trucks to designated collection points and/or the central morgue processing facility by end of day with security.
- Federal assistance will be requested if necessary (See VIMS Requests for Information/ARFs).
- The State or Federal ESF #8 will establish mobile morgues at pre-determined State sites.
 - If federally supported, NDMS will use a site or sites identified with the assistance of the State ESF 8 Incident Commander and/or his designee.
 - The jurisdiction Coroner, joint command, or State Medical Examiner will establish specific protocols (e.g., identification and autopsy protocols).
 - Non-storm fatalities will not be processed by the Federal site.
 - The affected Parish will establish a process for non-storm fatalities with local mutual aid and Federal Public Assistance if necessary.
 - The local jurisdiction has responsibility for the disposition of remains regardless of where and by whom the processing/mortuary services were provided.
- The State will conduct searches for disinterred remains with Federal assistance using helicopter support.
 - Incorporate initial search into Rapid Needs Assessment (RNA) process (report coordinates of remains to jurisdictional Coroner and ERT-A or JFO ESF #8)
- Casketing of disinterred is the responsibility of the jurisdiction coroner.
 - May request assistance from NDMS for casketing of unidentified remains
 - The Stafford Act does not cover re-interment in community cemeteries.
- The joint command or State Medical Examiner will coordinate public information activities.
 - Create joint fact sheets for all field assets to use
 - Refer all requests for information to the State Medical Examiner
- The State will establish a Family Assistance Center (FAC) with Federal assistance.

Logistics and Communications Support

- Coordinate security support through local command and control, or JFO if stood up
 - Local Police, State Police ESF 13.
 - Federal Protective Service (FPS), contract security
- Coordinate helicopter support for search and recovery, and to retrieve disinterred remains through JFO
- GOHSEP will provide radio communications support to Parish Coroners, joint command, and State Medical Examiner.
- FEMA logistics will provide enough SAT phones for the ESF #8 IRCT and NDMS field teams.
- FEMA logistics will provide equipment, supplies, communications lines, IT and telecom support, and physical locations for the FAC if activated.
- USAR teams use the standard communications link to the JFO.

Reporting and Planning

- Federal Search and Recovery teams and Parish Coroners report for coordination through their command channels, to the State Medical Examiner.
- The joint command and/or the State Medical Examiner provides information (e.g., missing persons) to the JFO.
- The JFO conducts daily ESF #8 IAP meetings to set planning activities, identify issues, and report data.

- The following essential elements will be reported to maintain a Common Operating Picture (COP):
 - Number of residences searched by USAR teams
 - Cumulative statistics on recovery of remains, remains processed, disposition of remains
 - Cumulative statistics on relevant activities at the FAC

CHAPTER 18

VETERINARY MEDICAL SUPPORT

In coordination with ESF #11, ESF #8 supports the protection of livestock and companion animals by ensuring the safety of the manufacture and distribution of foods and drugs given to animals used for human food production, as well as companion animals. The sheltering of companion animals is a State ESF #11 responsibility.

Assets and Functions

Local/Parish

- None

State

- Through the Louisiana Department of Agriculture and Forestry, Office of Animal Health Services, the Louisiana State Veterinarian is responsible for protecting the livestock industry.
- The State Veterinarian reports to the State Epidemiologist.

Federal

The U.S. Department of Agriculture (USDA) is the coordinating agency for ESF #11 – Agriculture and Natural Resources – under the NRF.

- NDMS has Veterinary Medical Assistance Teams (VMATs).
- Technical veterinary expertise is available through the PHS.
- FDA can assist in performing sample collections of animal food and drugs for subsequent analysis.
- FDA can assist with laboratory analysis of animal food and drugs.
- FDA can provide subject matter experts to address issues that impact whether animal food and drug products are appropriate for use; and provide guidance on what steps can be taken to restore animal food and drug products to a condition whereby they would be fit for consumption.
- FDA can assist with inspections of establishments which prepare, pack or hold animal food and drugs.

Command and Control

- ESF #8 coordinates with ESF #11 through the JFO.

Operations

- Operations are initiated and conducted by ESF #11.
- ESF #11 coordinates assistance from ESF #8 if necessary.

Logistics and Communications Support

- None

Reporting and Planning

- Reporting and planning for animal health protection is the responsibility of ESF #11.
- The following essential elements will be reported to maintain a Common Operating Picture (COP):
 - ESF #8 activities in support of ESF #1

CHAPTER 19

Essential Elements of Information for Reporting and Maintaining a Common Operating Picture

ESSENTIAL ELEMENT	Report	Source
Assessment of Public Health and Medical Needs		
- Hospitals damaged	Assessment Report	State/MNAT
- Hospital needs	Assessment Report	State/MNAT
- Status of other critical medical infrastructure	Assessment Report	State/MNAT
- Fatalities	Assessment Report	State/MNAT
- General damage report	Assessment Report	State/MNAT/ERT
- Hospital bed capacity	Assessment Report	State/MNAT
- Environmental impact issues	Assessment Report	MNAT/ERT
- NDMS Status	Assessment Report	NDMS
- Public health implications	Assessment Report	State/MNAT
- Weather forecast	IAP/IRCT SITREP	IRCT
- Status of transportation	Assessment Report	State/MNAT/ERT
- Status of supply systems	Assessment Report	MNAT/ERT
- Priorities	IAP/IRCT SITREP	State/IRCT
- Federal resources needed	IAP/IRCT SITREP	State
- Status of requests for Federal resources	IAP/IRCT SITREP	IRCT
Health Surveillance		
- Region and territory assessed	Surveillance Report	Surv. Teams
- Number and location of assessments conducted	Surveillance Report/ IAP/IRCT SITREP	Surv. Teams Surv. Teams
- Number and size of outbreaks, location and type		Surv. Teams
- Environmental health investigations	Surveillance Report	Surv. Teams
- Location and type of sources identified and remediated	Surveillance Report	Surv. Teams
- Number, location, and type of public health interventions	Surveillance Report	Surv. Teams
- Health statistics (illness, injuries, fatalities)	Surveillance Report	Surv. Teams
- Demographics of the affected area	Surveillance Report/ IAP/IRCT SITREP	Surv. Teams Surv. Teams
Surge Medical Care Personnel		
- Number and status of personnel staged and in the field	SOC Logs Report/ IAP/IRCT SITREP	SOC Logs
- Projected demobilization dates for deployed personnel	SOC Logs Report	SOC Logs
- Personnel/team locations and missions	IRCT SITREP	IRCT
Health and Medical Equipment and Supplies		
- Requests for medical equipment and supplies, including quantity, items, purpose, source, and location of request	Equipment and Supply Report	ESF#8 LNO to State
- Quantities of medical equipment and supplies ordered, enroute, and delivered	Equipment and Supply Report	ESF#8 LNO to State
Patient Care		

ESSENTIAL ELEMENT	Report	Source
- Medical Support for Evacuation and Sheltering of Special Needs Populations		
- Report location and status of State or Federal Medical Special Needs Shelters	IAP/IRCT SITREP	State/IRCT
- Report location and status of FMS caches	IAP/IRCT SITREP	IRCT
- Report daily patient census and patient breakdown	Shelter Report	State/IRCT
- Report daily expected discharges and arrivals to Medical Special Needs Shelters and FMSs	Shelter Report	State/IRCT
- Medical Support for Hospital Evacuation		
- Location and number of patients needing evacuation	Evacuation Report	State/NDMS
- Number of patients evacuated and evacuation locations	Evacuation Report	State/NDMS
- Hospital Staff Augmentation and Primary Care		
- Daily updates of medical personnel needs at hospitals, mobile medical units, and primary care facilities	IAP/IRCT SITREP	State/IRCT
- Daily status of medical personnel requests	IAP/IRCT SITREP	State/IRCT
- Daily status of Federal medical personnel rotations, including expected departure and arrival dates for personnel	IAP/IRCT SITREP	State/IRCT
Safety and Security of Human Drugs, Biologics, Medical Devices and Veterinary Drugs		
- Number of firms assessed	FDA SITREP	FDA
- Operational status of firms (open or closed)	FDA SITREP	FDA
- Type of product and dollar amount and quantity of drug seizure and/or destruction	FDA SITREP	FDA
- Employee Labor Hours	FDA SITREP	FDA
- Contact of most responsible person	FDA SITREP	FDA
Blood and blood products		
- Blood supplies	IRCT SITREP	State
- Status of assessments of blood banks and plasma centers	FDA SITREP	FDA
- Status of requests for Federal blood support	IRCT SITREP	IRCT
Food Safety and Security		
- Number of firms assessed	FDA SITREP	FDA
- Operational status of firms (open or closed)	FDA SITREP	FDA
- Type of product and dollar amount and weight of food seizure and or destruction	FDA SITREP	FDA
- Employee Labor Hours	FDA SITREP	FDA
- Point of Contact	FDA SITREP	FDA
Agriculture Safety and Security		
- ESF #8 activities in support of ESF #11	IRCT SITREP	IRCT
All Hazard Public Health and Medical Consultation, Technical Assistance, and Support		

ESSENTIAL ELEMENT	Report	Source
- Planning based on public health surveillance and medical needs assessment	IAP	IRCT
Behavioral Health Care		
- Medical Special Needs Shelters: - Number of residents with behavioral health diagnoses	Shelter Report	State/IRCT
- Shelter density and demographics	Shelter Report	State/IRCT
- Skill levels of shelter staff	Shelter Report	State/IRCT
- Statistics on volunteer credentialing	IRCT SITREP	IRCT
- Behavioral health bed status		
- Requests for Federal behavioral healthcare support	IRCT SITREP	State/IRCT
- Federal behavioral healthcare assets available and deployed	IAP	State/IRCT
- Applications for FEMA crisis counseling grants	IRCT SITREP	State/IRCT
- Forecasted need for behavioral health resources		
- Location and type of behavioral health services	IRCT SITREP	State/IRCT
- Status of behavioral healthcare infrastructure		
- Procedures for behavioral health surveillance and intervention	IRCT SITREP	State/IRCT
Vector control (insects and rodents)		
- Report individual and cumulative test results	IAP/IRCT SITREP	State/IRCT
- Report spraying schedule and areas that have been sprayed	IAP/IRCT SITREP	State/IRCT
Potable water, wastewater and solid waste disposal		
- Report testing schedule (OPH/CEHS)	IAP/IRCT SITREP	State/IRCT
- Report individual and cumulative results from all affected sites	IAP/IRCT SITREP	State/IRCT
- Track supply, demand and any challenges associated with water availability (GOHSEP)	State SITREP	State
- Report engineering assessments of water supply infrastructure and timetables/milestones for remediation	State SITREP	State
Victim Identification and Mortuary Services		
- Number of residences searched by USAR teams	USAR Report	State
- Cumulative statistics on recovery of remains, remains processed, disposition of remains	Mortuary Report	State/Mortuary Task Force
Protection of Animal Health		
- ESF #8 activities in support of ESF #11	IRCT SITREP	IRCT

ANNEX I

Acronym Listing

Abbreviations and Acronyms

Abbreviation	Meaning
ACS	U. S. Administration for Children and Families
ADLS	Advanced Disaster Life Support
AELT	Aero-medical Evacuation Liaison Team
AFO	Area Field Office
AHRQ	U. S. Agency for Healthcare Research and Quality
ALS	Advanced Life Support
AMP	Aero-Medical Marshalling Point – the airport and associated incident command staff and equipment used for hospital evacuations. Also referred to as an “Air Head”.
AoA	U. S. Administration on Aging
APD	Amtrak Police Department. Responsible for security once citizens are onboard an Amtrak train. Supports the City and Parish Assisted Evacuation Plans
ARC	American Red Cross. Generally responsible for managing parish-based general population shelters.
ARF	Action Request Form. An Excel™ spreadsheet used to submit a resource request to FEMA. Based on the GOHSEP form, “Requesting Information Form.”
ASAR	Animal Search and Rescue
ASH	Assistant Secretary for Health (Federal HHS)
ASPHEP	Assistant Secretary for Public Health and Emergency Preparedness
ASPR	Assistant Secretary for Preparedness and Response (Federal HHS)
BDLS	Basic Disaster Life Support
BEMS	Louisiana Bureau of Emergency Medical Services (DHH)

Abbreviation	Meaning
BLS	Basic Life Support
CAEP	City Assisted Evacuation Plan (New Orleans). Residents using this plan are taken to Critical Transportation Needs Shelters across the state (CTNS)
CASF	Contingency Air Staging Facility. Supports AMP operations
CCATT	Critical Care Air Transport Teams. Arrive on the first evacuation plane at an AMP
CDC	U. S. Centers for Disease Control and Prevention
CMS	U.S. Centers for Medicare and Medicaid Services
CONOPS	Concept of Operations plan
COP	Common Operating Picture. Usually part of a briefing to an Incident Command Team.
COW	Commercial cellular on wheels. Units owned and deployed by GOHSEP to implement local communications post-event
CTNS	Critical Transportation Needs Shelter. Used for those persons evacuated by local governments from affected areas. These are not general population shelters for those who self-evacuate.
DCE	Defense coordinating element
DCO	Defense Coordinating Officer
DEQ	Department of Environmental Quality (ESF 10)
DHH	Department of Health & Hospitals (ESF 8)
DHH EOC	The DHH Emergency Operations Center located at the Bluebonnet Boulevard Office of Public Health complex.
DHHS	U.S. Department of Health and Human Services
DHS	U.S. Department of Homeland Security
DMAT	Disaster Medical Assistance Team. Part of NDMS that assists in staffing Medical Special Needs Shelters and other critical healthcare sites.
DMORT	Disaster Mortuary Operations Response Team. Part of NDMS that assists states and local governments in mass fatality incidents.
DOA	Division of Administration

Abbreviation	Meaning
DOAg	Department of Agriculture (ESF 11)
DOC	Louisiana Department of Corrections or U.S. Department of Corrections
DoD	U.S. Department of Defense
DOE	U.S. Department of Energy
DOI	U.S. Department of the Interior
DOJ	U.S. Department of Justice
DOL	U.S. Department of Labor
DOS	U.S. Department of State
DOT	U.S. Department of Transportation
DOTD	Department of Transportation and Development (ESF 1)
DPMU	Disaster Portable Morgue Unit
DRC	Designated Regional Coordinator. There are DRCs for hospitals, nursing homes, and EMS.
DCFS	Department of Children and Family Services (ESF 6)
DVA	U.S. Department of Veterans Affairs
EARS	Emergency Animal Rescue Service
EJGH	East Jefferson General Hospital
EMAC	Emergency Mutual Assistance Compact. Through EMAC, a disaster impacted state can request and receive assistance from other member states, resolving two key issues: liability and reimbursement. An EMAC request originates with the GOHSEP "Requesting Information Form".
BEMS	Bureau of Emergency Medical Services. Provides the incident command for medical transportation assets.
EMSystem/ EMSTAT	The primary information system used by the hospitals in Louisiana and ESF 8 to report bed availability and evacuation needs. It is a web-based application maintained by LHA through a contract with DHH.

Abbreviation	Meaning
EOC	Emergency Operations Center. GOHSEP EOC is referred to as the State EOC. As with other state agencies, DHH also maintains a free-standing EOC that coordinates with the State EOC. ESF 8 Incident Command is housed at the State EOC.
EPA	U.S. Environmental Protection Agency
ESAR-VHP	Emergency System for Advance Registration of Volunteer Health Professionals (Known in Louisiana as LAVA – Louisiana Volunteers in Action)
ESF	Emergency Support Function. Organized into Branches at GOHSEP. See listing of ESF functions and agencies at end of this document.
FAC	Family Assistance Center. Part of the mass fatality response that assists families of victims and collects ante-mortem information used in identification of victims.
FCC	<ul style="list-style-type: none"> ▪ Federal Coordinating Center. Sites usually associated with VA Hospitals that receive evacuated hospital patients and transfer those patients to NDMS hospitals across the country. Part of the MIEP. ▪ U.S. Federal Communications Commission
FCO	Federal Coordinating Officer. Usually housed at the Joint Field Office (JFO).
FDA	U. S. Food and Drug Administration
FIRST	Federal Incident Response Team
FIT	Federal Medical Station Installation Team
FMS	Federal Medical Station. Refers to the equipment and medical staffing provided by NDMS for Medical Special Needs Shelter beds.
FPS	Federal Protective Service. Usually provides security to a variety of federal operations and offices. Can support local law enforcement post-event.
GOHSEP	Governor’s Office of Homeland Security and Emergency Preparedness. The formal incident command organization for emergency management in Louisiana.
GPMRC	Global Patient Movement Requirements Center. The federal Department of Defense system used in the evacuation of hospital patients. The GPMRC coordinates the evacuation need with the Department of Defense aircraft requirements and the destination hospitals

Abbreviation	Meaning
GSA	U.S. General Services Administration
HAN	Health Alert Network
H-HOUR	The time at which tropical storm force winds hit the coast of Louisiana. H-0 is set by GOHSEP.
HRSA	U. S. Health Resources and Services Administration
HSIN	Homeland Security Information Network
HURREVAC	Hurricane Evacuation (computer program)
IAP	Incident Action Plan. A NIMS document outlining the overall concept of operations for an entity.
IC	Incident Commander
ICE	U. S. Immigration and Customs Enforcement
ICS	Incident Command System
IED	Improvised Explosive Device
IHS	U.S. Indian Health Service
INS	U. S. Immigration and Naturalization Service
IRCT	Incident Response Control Team (Federal HHS)
JFO	Joint Field Office. Usually the headquarters of local FEMA operations. Currently located in Baton Rouge in the former Godchaux's department store on Florida Blvd.
JIC	Joint Information Center. Usually established at GOHSEP during an event.
JPMT	Joint Patient Movement Team. Part of the MIEP.
JRMP	Joint Regional Medical Planner. Military medical planners assigned to specific regions in the country. Coordinate activities with HHS and US NORTHCOM.
LANG	Louisiana Army National Guard. (ESF 16)
LAVA	Louisiana Volunteers in Action. Louisiana's version of ESAR-VHP
LAVOAD	Louisiana Voluntary Organizations Active in Disasters

Abbreviation	Meaning
LDWF	Louisiana Department of Wildlife & Fisheries
LHA	Louisiana Hospital Association
LNHA	Louisiana Nursing Home Association
LNO	Liaison Officer
LSP	Louisiana State Police (ESF 13)
MA	Mission Assignment
MASF	Mobile Aero-medical Staging Facility. Supports AMP operations
MCC	<ul style="list-style-type: none"> ▪ Morial Convention Center (New Orleans) ▪ Movement Control Center (part of DOTD)
MIEP	Medical Institution Evacuation Plan
MNAT	Medical Needs Assessment Team (Federal)
MRC	Medical Reserve Corps
MSCC	Medical Surge Capacity Capability
MSNS	Medical Special Needs Shelter. serve the community homebound citizens who have no available care giver/s.
MST	Management Support Team (Federal)
NAS	Naval Air Station (i.e. Belle Chasse NAS)
NDMS	National Disaster Medical Service. Part of the federal HHS that supplies medical equipment and staff to support state ESF 8 operations in an event.
NICCL	National Incident Communications Conference Line
NIH	U. S. National Institutes of Health
NOAA	U. S. National Oceanic and Atmospheric Administration
NOPD	New Orleans Police Department
NORTHCOMM	U.S. Northern Command
NRCC	National Response Coordination Center (FEMA)

Abbreviation	Meaning
NRF	National Response Framework (to replace the NRP)
NRP	National Response Plan
OAAS	Louisiana Office of Aging and Adult Services (DHH)
OAD	Louisiana Office of Addictive Disorders (DHH)
OCDD	Louisiana Office of Citizens with Developmental Disabilities (DHH)
OEP	Office of Emergency Preparedness. Usually refers to a parish-level agency.
OMCP	U. S. Office of Mass Casualty Planning (Federal HHS)
OMH	Louisiana Office of Mental Health (DHH)
OPH	Louisiana Office of Public Health (DHH)
OPHEP	HHS Office of Public Health Emergency Preparedness
OSHA	U. S. Occupational Safety and Health Administration
PAEP	Parish Assisted Evacuation Plan (usually refers to Jefferson Parish)
PDAT	Preliminary Damage Assessment Team
PIO	Public Information Officer. Generally works in or in concert with the JIC.
PFO	Principal Federal Official. For Louisiana, the PFO is Gil H. Jamieson, FEMA Deputy Director for Gulf Coast Recovery. Usually housed at the Joint Field Office (JFO).
PHERC	Public Health Emergency Response Coordinator
PHS	U. S. Public Health Service
PHS – CC	U. S. Public Health Service - Commissioned Corps
POD	Point of Dispensing
PPE	Personal Protective Equipment
PPP	Parish Pickup Point
PSMA	Pre-scripted Mission Assignment
REC	Regional Emergency Coordinator (Federal HHS)

Abbreviation	Meaning
RHA	Regional Health Administrator (Federal HHS)
RNA	Rapid Needs Assessment
RRCC	FEMA Regional Response Coordination Center. Each FEMA region has an RRCC.
RSS	Receiving, Staging and Storage Site
SAR	Search and Rescue
SAT	Satellite Phones
SAMHSA	U.S. Substance Abuse and Mental Health Services Agency
SARBOO	Search and Rescue Base of Operations
SERT	Secretary's Emergency Response Team (Federal HHS)
SHO	<ul style="list-style-type: none"> ▪ State Health Officer, Dr. Jimmy Guidry, M.D. ▪ Senior Health Official (Federal HHS)
SIP	Shelter in Place
SMART locations	A listing of pre-designated search sites for Search and Rescue (SAR) teams post-event
SME	Subject Matter Expert
SMO	CDC Senior Management Official
SNS	Strategic National Stockpile. Managed by the Office of Public Health Center for Community Preparedness.
SOC	U.S. HHS Secretary's Operations Center
SOPs	Standard Operating Procedures
SOW	Statement of Work, usually part of a contract document or purchase order
SSO	Site Safety Officer
SUP	Shelter for Unique Populations. A 250 bed tent shelter set up for the evacuation of convicted sex offenders. For 2008, this acronym/name has been changed to Sex Offender Shelter.
TARU	Technical Advisory/Assistance Response Unit (Federal HHS)

Abbreviation	Meaning
TMOSA	Temporary Medical Operations and Staging Area
TRANSCOMM	U.S. Transportation Command
TSA	U.S. Transportation Security Administration
UPT	Union Passenger Terminal (New Orleans)
USACE	U.S. Army Corps of Engineers
USAID	United States Agency for International Development
USCG	U.S. Coast Guard
USDA	U. S. Department of Agriculture
USFS	U. S. Forest Service
USFWS	U. S. Fish and Wildlife Service
USPHS	United States Public Health Service
USPS	U. S. Postal Service
USSS	United States Secret Service
USTRANSCOM	U. S. Transportation Command
VMAT	Veterinary Medical Assistance Team
VOAD	Voluntary Organizations Active in Disaster
VTC	Video Teleconference
WebEOC	The primary information system used by GOHSEP, the 64 parish EOCs, and all ESFs to request and track resources and missions. It is a web-based application maintained by GOHSEP.
WJGH	West Jefferson General Hospital

Listing of ESFs for Louisiana

ESF	State Emergency Support Function	State Agency Lead
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ESF 1	Transportation	DOTD
ESF 2	Communications	GOHSEP
ESF 3	Public Works and Engineering	DOTD
ESF 4	Firefighting	DPS/OSFM
ESF 5	Emergency Management	GOHSEP
ESF 6	Mass Care, Housing, and Human Services	DCFS
ESF 7	Resources Support	GOHSEP
ESF 8	Public Health and Medical	DHH
ESF 9	Search and Rescue	DWF
ESF 10	Oil Spill, Hazardous Materials, and Radiological	DEQ
ESF 11	Agriculture	DOAg
ESF 12	Energy	DNR
ESF 13	Public Safety and Security	DPS/LSP
ESF 14	Community Recovery, Mitigation and Economic Stabilization	GOHSEP
ESF 15	Emergency Public Information	GOHSEP
ESF 16	Military Support to Civil Affairs	LANG

ANNEX II

ESF 8 MNA Assessment Form

The following form is formatted to facilitate brief reporting of Rapid Medical Needs Assessments (MNA) by phone, when reports cannot be faxed, e-mailed or manually turned in.

GUIDANCE ON USE OF TRAFFIC LIGHT COLOR CODES

Green:

Operational status or structural integrity intact.

Yellow:

Operational status capable of providing basic services however in need of staff, repair, equipment or supplies within 3-5 days.

Structural status damaged though functional pending repairs within 3-5 days.

Red:

Operational status is severely impaired or non-functional. If impaired, requires staff, repair, equipment or supplies within 1-2 days to continue minimal to basic operational capability.

Structural Status: Damaged severely or minimally functional pending emergency repairs within 1-2 days.

ANNEX III

HOSPITAL SHELTER-IN-PLACE (SIP) AND EVACUATION

Louisiana hospitals must provide a multi-faceted emergency response to hurricanes that includes: reduction in census, evacuation of certain patients and sheltering-in-place. Congressional criticisms post-Katrina/Rita has facilitated an effort to develop BOTH evacuation plans (movement of patients and staff out of the affected area) and shelter-in-place plans. This Annex addresses both SIP and EVAC Plans.

SHELTER-IN-PLACE (SIP) PLANNING ASSUMPTIONS:

1. The center of gravity for hospitals has been to shelter-in-place. State and federal partners support the strategy of sheltering-in-place (SIP) provided it can be done so safely. Hospitals must evaluate hardening structures and increasing supply assets so that unnecessary movement of critical patients is minimized.
2. Having SIP plans and supplies will strengthen the ability of a hospital to recover more quickly. In addition, it has been discussed in exercises such as Hurricane Pam and demonstrated in events such as Katrina/Rita 2005 that 7 days is the estimated time search and rescue planners felt they could get to hospitals in flooded conditions to replenish supplies. For Louisiana's SIP plans for hospitals, the state has (conveniently) pointed to the CMS requirements for 7 day's worth of supplies.
3. Communications pre and post storm remain critical. The Louisiana Department of Health and Hospitals participates in the Governor's Interoperable Communications Task Force. The State of Louisiana and FEMA developed a Communications Plan to address interoperable communications networks in each parish.
4. In a survey conducted by federal partners in 2006, hospitals identified several areas of concern related to hospital sheltering-in-place:
 - Availability of staff to support on-going operations;
 - Availability of generators to support HVAC systems;
 - Fuel for generators; and
 - Security

CONCEPT OF OPERATIONS FOR SIP:

Hospitals in potentially impacted areas should:

- Maintain call-out list for staff; encourage staff to complete “personal and family” plans; and assure that staff has necessary re-entry information and documentation.
- Maintain seven (7) days of supplies such as potable/non-potable water, food, linen, oxygen, pharmaceuticals, etc.
- Know the size and needed capabilities of their existing generators as generators are in very limited in supply and availability.
- Provide or make arrangements with vendors for fuel supplies.
- Provide or make arrangements for adequate internal and perimeter security.

Requests for assistance

If adequate **medical personnel** are not available, hospitals should contact their Designated Regional Coordinator. The Designated Regional Coordinator will work with unified medical command to request resources through the Emergency System for Advanced Registration of Volunteer Health Professionals (ESAR VHP) and with federal resources. It is very important that hospitals specifically identify the skill sets and number needed. Hospitals should be able to provide housing, orientation, and medical liability for volunteers.

If **supplies** are insufficient, hospitals should contact the Hospital DRC who will attempt to identify potential resource(s) amongst the hospitals in the region. If not available, the DRC refers the request to the appropriate parish Office of Emergency Preparedness for assistance. If independent plans fail, supplies may be made available through relationships with vendors established by federal partnerships. Hospitals should contact their Designated Regional Coordinators to request assistance from federal partners. Federal partners will assist in obtaining and arranging delivery of needed supplies. Hospitals will be billed for delivered supplies. Additionally, supplies may be available through other federal resources including the Strategic National Stockpile (SNS). Hospitals should contact their Designated Regional Coordinators to request assistance to access the SNS. The DRC will work with regional medical command and State Health Officer to request assistance through the SNS.

If **generators** should fail, hospitals should work with their Parish Office of Emergency Preparedness to identify alternatives for generator requirements to assist with back-up support.

If **generator fuel supplies are insufficient**, hospitals should contact their Parish Office of Emergency Preparedness for assistance. The Louisiana Department of Agriculture (LDOA) has developed alternative fuel resources for hospitals and other critical infrastructures. The Office of Emergency Preparedness will assist in requesting fuel support from the LDOA.

If **security arrangements** are inadequate, hospitals should contact their parish Office of Emergency Preparedness for assistance.

HOSPITAL PRE-STORM EVACUATION MEDICAL INSTITUTION EVACUATION PLAN

This document has been developed to provide detailed information regarding the pre-storm evacuation of the medically fragile population from southern Louisiana. It is part of the larger State and Federal ESF 8 Response plan, and has been modified from that format slightly to allow for expedited Federal support to meet the evacuation needs of the citizens of Louisiana.

The general approach of this document is to execute activities to move the medical population of Southern Louisiana out of harms' way prior to landfall of a hurricane. There is some application of the information contained in this document to all-hazards and no-notice events, but obviously some modifications of the assumptions and actions identified in this plan would need to be done.

This document identifies the local, State and Federal actions required to move hospital admit patients. In order to properly frame and support evacuation plans, this plan:

- 1) identifies the census of the medical population in the lower 12 Parishes
- 2) the transportation resources required to move the medical population
- 3) the personnel and materiel resources required
- 4) staging, sheltering and evacuation locations
- 5) the timeline for action to meet with success

This document will be modified on an annual basis, in agreement and coordination with local, State, and Federal ESF 8 partners, prior to each official hurricane season. The last date of modification of this plan is listed on the title page. The exception to this rule is that the FEMA Warm Cell Planning Section formatted this document after final content changes were made.

Background: It is a possibility that some hospitals will SIP and some will EVAC – or partially EVAC - given the threats (both direct and indirect) to the respective facilities in a given area. The following plan identifies the State/Federal response plan entitled “Medical Institution Evacuation Plan – Hospitals.” This MIEP is the back-up plan for facility’s failed evacuation plan. The MIEP is for hospitalized patients and has been developed in light of Hurricanes Katrina and Rita – 2005 season storms wherein 37 hospitals were evacuated post-storm for Hurricane Katrina and 21 hospitals were evacuated pre-storm for Hurricane Rita.

The center of gravity for hospitals’ response during a hurricane threat is to shelter-in-place. However, in the event it is found necessary to evacuate patients at-risk and/or institutions, this plan addresses the considerations for activating this plan, the assets required to activate and operationalize this plan, as well as the timeline, reporting, command, control and communications activities.

Preference: From a provider perspective, Louisiana continues to support the fact that patients should not be moved on a “maybe” event (prior to a storm) as it is not in the best interest of the patient to move critical care patients unless absolutely necessary. The federal government

(Chertoff) also endorses this preference to harden structures so that unnecessary movement of critical patients is minimized.

Risks: Because of the lack of precise predictability of a storm's land-fall 48-72 hours pre-event, movement of critical patients in this timeframe poses an increased risk. Movement of any critical care patient from a hospital to any other venue increases morbidity and mortality risks. Information has been provided from many hospitals which indicate that they have adequately prepared to shelter patients in place. State and federal support will be focused on assisting hospitals to care for the most vulnerable in hardened facilities. Support will also be provided to assist hospitals with moving those patients that can be safely evacuated.

The risk of staying in place with critically ill and electrically dependent patients will be weighed based on known information and conditions at that time; and what is in the best interest of the patients and staff. The plans for hospital evacuations were developed with "worst case" scenario conditions in mind. Direction, size, speed and intensity of the hurricane, and supporting infrastructure are factors that may cause a facility to partially or completely evacuate regardless of the hardened structural ability to shelter in place for most storms. The weakened levees, fragile infrastructure, the weakened response capabilities, and overburdened staff add to the indirect factors that may facilitate hospital evacuations regardless of structural ability to shelter-in-place. Although hospitals are required to have their own evacuation plans, it is expected that some facilities may not be able to execute their plans without State and/or federal assistance. The Louisiana DHH will need assistance evacuating hospital patients in the event of a coastal parish evacuation if hospitals are unable to self-evacuate and several hospitals across the area choose not to shelter-in-place.

ASSUMPTIONS

- This plan may be activated only during times of state declared emergencies.
- This plan primarily addresses the 12 coastal parishes that are particularly vulnerable to hurricanes, specifically: Calcasieu, Cameron, Vermillion, Iberia, St. Mary, Terrebonne, Lafourche, St. Tammany, Jefferson, Orleans, Plaquemines, and St. Bernard.
- This plan does not assume the evacuation of medical institutions in all 12 coastal parishes simultaneously. Depending upon the scope, severity, as well as other direct or indirect threats will determine the patient/institution evacuation (which types of patients will be evacuated and which airheads will be activated).
- Due to limited resources of state and local authorities, federal assets will be required to assist with the evacuation and subsequent medical support of this specific plan.
- Hospitals are responsible for developing their own evacuation plans.

CRITERION FACTORS TO ACTIVATE THE PLAN

The following criteria should be considered when making the decision to trigger the Medical Institution Evacuation Plan.

- Strength of the Storm – The storm can have many characteristics including size of the storm and slow/ fast-moving characteristics. This characteristic shall be considered when making a decision.
- Direction of the storm – The sensitivity of the instrumentation to predict the direction of the storm is not accurate. The storm's cone of error is broad at 70-60 hours before landfall. The cone of error becomes narrower as the storm approaches landfall. The trade-off to be considered: greater predictability closer to landfall with less time to enact

assets. Likewise, moving assets for a mass evacuation with greater time factor increases the likelihood of moving assets on a “maybe” event.

- Indirect or Direct threats to the facility (and/or patient) – Additional threats – direct or indirect –include incomplete work on levees and hurricane protection systems, loss of wetlands, vulnerable Parish infrastructure and/or other already weakened levee structures, the vulnerable structures as a result of previous storms, the flooding potential as a result of weakened pump structures and/or other threats yet unknown.
- Local Factors – Local parishes may have declared voluntary or mandatory evacuations. Such decisions have an impact on this plan. More specifically, such declared evacuations may impact the staff of hospitals that may facilitate an evacuation of the institution.

CONCEPT OF OPERATIONS

In the event that hospitals request assistance for evacuation and State and/or federal assets are required, the evacuating hospital patients will first be transported from the medical institution to an aeromedical marshalling point (AMP) and then from the AMP to a National Disaster Medical System (NDMS) destination hospital. Upon first alert of circumstances that could necessitate hospital evacuations, NDMS will initiate a nationwide bed count within NDMS hospitals

Patients will be transported to one of five AMPs by ground ambulances/air ambulance, wheel chair vans, and buses (AMPs are listed in Table 1). Specific hospitals and the AMP that they will be using can be found in Annex 7 of this document. Travel from the receiving FCC to receiving NDMS sites will be accomplished via ambulance. Once the aircraft arrives at the destination airport, patients are assigned to participating NDMS hospitals by the local Veterans Administration or Department of Defense Federal Coordinating Centers (FCCs).

Table 2: Louisiana’s Five Public Health Regions that Contain Coastal Parishes

Region Area	Region Number	Coastal Parishes
New Orleans	1	Jefferson, Orleans, Plaquemines, and St. Bernard
Houma	3	Lafourche, St. Mary, and Terrebonne
Lafayette	4	Iberia and Vermillion
Lake Charles	5	Calcasieu and Cameron
Hammond/Slidell	9	St. Tammany

Table 3. - Identified Aeromedical Marshalling Points

Region Area	Region Number	Aeromedical Marshalling Point Location
New Orleans	1	Scrubbed Data
Houma	3	Scrubbed Data
Lafayette	4	Scrubbed Data
Lake Charles	5	Scrubbed Data

Private hospitals that have contracted for private air and ground ambulance assets and can execute their plan without state and/or federal assistance will use a pre-designated airport. Private-evacuation-patients from these hospitals will be transported via commercial aircraft to pre-identified hospital locations.

EVACUATION OF NEONATAL INTENSIVE CARE UNITS (NICU) AND HIGH-RISK MOTHERS

Louisiana hospitals have been planning for patient evacuation in the event that Shelter-in-Place (SIP) is not possible. Early in response phase, hospitals evacuate their OB, NICU and Nursery units (~200 patients). This evacuation will be accomplished using private and contracted transportation resources to bring patients to pre-designated receiving facilities. The remaining patients that hospitals decide to evacuate will be moved through the sub-tasks outlined in Table 1.

Table 4 - Hospital Evacuation Subtasks

Sub-task	Agencies
A. Provide back-up to hospitals with plans, receiving facilities, and transportation to move themselves	<ul style="list-style-type: none"> • Individual hospitals/DRC • Private ground and air ambulances companies • ESF 8 Federal and State
B. Assist hospitals that need transportation assets to get to their pre-designated reception facility	<ul style="list-style-type: none"> • Individual hospitals/DRC • State ESF-8 and ESF-1 • Private ground and air ambulances, para-transit, and coach buses • State/Federally contracted ambulances, para-transit, and buses (with GSA)
C. Assist patient evacuation through NDMS	<ul style="list-style-type: none"> • Individual hospitals/DRC • State ESF-8 • Federal ESF 8 and NDMS partners

PATIENT EVACUATION

In times of emergency, due to limited resources of state and local authorities, Federal assets may be required to assist with the evacuation and subsequent medical support of the special medical needs population.

Due to their proximity to the Gulf of Mexico, Louisiana's 12 coastal parishes are particularly vulnerable to hurricanes. Patient evacuation covers the coastal parishes' evacuation in regards to hospital and nursing home evacuations, and the medical and public health support to those in the general populations that are forced to evacuate.

Responsibilities**Local/Parish****Parish Executive/Chief Elected Official**

- Provide overall command and control of local emergency response
- Declare and files state of emergency to the governor
- Issue evacuation order

Parish Office of Emergency Preparedness

- Activate and manage the parish EOC
- Coordinate EOC response and recovery operations
- Coordinate information and operations with LA Governor's Office of Homeland Security
- Identify shortfalls in local capabilities and conduct community EMS operations and evacuate medically fragile patients from their homes and request augmentation from Regional EMS Coordinator as required
- Incorporate into operations the notification by State Designated Regional Coordinator (DRC) for Hospitals and EMS of evacuation plans, progress and outcome
- Provide space, communications and internet connectivity for DRCs, Regional EMS Coordinators, and Public Health Emergency Response Coordinators (PHERCs)

Parish Law Enforcement (Local Police and Sheriff's Department)

- Provide security at disaster site, parish EOC, hospitals, medication dispensing sites, and shelters
- Coordinate security with the Louisiana State Police ESF 13 for medical transportation assets and staff
- Establish primary and alternate evacuation routes
- Provide traffic control

Local Fire / Rescue

- Assist with emergency medical services at disaster scene, shelters, and medical facility

Local Emergency Medical Services

- Maintain 911 emergency medical services response
- Provide mutual aid assistance to neighboring jurisdictions when able
- Provide triage, treatment and transport
- Provide triage support at Parish pickup points (PPP)

Local Hospitals

- Provide medical guidance for EMS units and field triage teams

- Complete and transmit ESF-8 Portal/EMSTAT and At-Risk Registry information as requested
- Implement hospital emergency management plans
- Have agreements with vendors / contractors to provide adequate inventory of essential personnel and resources in the event of a disaster should be in place.
- Designate Patient Load Officer for their facility
- Decision to evacuate staff and patients or to SIP made by individual hospital boards and / or CEO
- Notify DRCs on the numbers and types of patients that require evacuation
- Notify DRCs on the numbers and types of patients that are sheltering in place
- Activate existing memoranda or contracts to augment SIP staffing and resources
- Notify DRCs of staffing and resource shortfalls

State

Governor, State of Louisiana

- Declare State of Emergency
- Executive Order for mandatory evacuation
- Executive Order permitting non-Louisiana licensed medical providers to practice in the State for a prescribed period of time
- Request Federal Emergency/Disaster Declaration

Louisiana Department of Health and Hospitals

- State ESF 8 Lead
- Coordinates resources with and between medical institutions, EMS, and other critical healthcare operations and functions.
- Provide medical surveillance and patient tracking.
- Coordinates Special Needs Shelters through its regional Offices of Public Health and the Department of Children and Family Services (DCFS).
- Notify GOHSEP and HHS Region VI Regional Emergency Coordinator of possible evacuation of medical facilities by activation of this plan
- Coordinate evacuation needs and progress with the DRC manager onsite at the LA State Operations Center GOHSEP
- Request assets and assistance from other ESF functions in GOHSEP, both state and Federal
- Coordinate with Louisiana State University (LSU) Systems to provide medical personnel to augment urgent care support at the Union Passenger Terminal and the NOCC during evacuation operations
- Coordinate medical care for MSNS and GP shelters
- Report information flow/processing to maintain a medical common operating picture (COP)
- Forward medical COP to GOHSEP/Federal ESF 8

- **Bureau of Emergency Medical Services (BEMS)**
 - Track all ground medical transportation assets
 - Request Federal medical transportation assets as needed
 - Credential and placard medical transportation assets
 - Establish and staff regional coordination cells at the parish EOC
 - Dispatch transportation assets to retrieve the patients from hospitals and nursing homes
 - Monitor dispatch plans and mission completion
 - Estimate and coordinate mission discontinuation of evacuation transports

- **Designated Regional Coordinators (Hospitals):**
 - Monitor ESF-8 Portal/EMSTAT and At-Risk Patient Registry
 - Form 1 and 1A: Federal Evacuation Assistance
 - Form 2: Private Patient Movement Report
 - Form 3: SIP Form
 - Coordinate inpatient evacuations with hospitals, EMS DRC and AMP personnel
 - Receive hospital information for Resource Tracking
 - Update Parish OEPs, State ESF-8 on hospital SIP and evacuation status

- **Designated Regional Coordinators (Nursing homes):**
 - Coordinate Nursing home evacuations with hospital and EMS Regional Coordinators
 - Receive and report all nursing home SIP and evacuation status
 - Forward all information to State ESF 8
 -

- **Designated Regional Coordinators (EMS):**
 - Execute coordination of transportation assets within the region
 - Coordinate with State ESF 8 through the Bureau of Emergency Medical Services
 - Coordinate with local EMS and Parish/City EOCs
 - Assist in the coordination of transportation assets

- Establish local command at the forward staging area through a Medical Transportation Staging / Dispatch Officer

Governor's Office of Homeland Security and Emergency Preparedness

- Activate and manage the State EOC
- Provide logistical support to ESF 8
- Notify hospitals and nursing homes through the Hospital and Nursing Home Emergency Information Network of activation status, evacuation option deadlines, evacuation request finalization deadlines, and if appropriate, discontinuation of evacuation operations
- Transmit requests for assistance to the JFO when notified by State ESF 8 of need to evacuate

Louisiana State Police

- State ESF 13 lead
- Assist in the selection and announcement of primary and alternative evacuation routes, contraflow coordination, and provide the information to GOHSEP
- Provide credentials for emergency response personnel
- Assist in providing security for mass care centers, special needs shelters, medical treatment facilities, and other critical healthcare infrastructure operations
- Provide escort of ESF 8 assets upon request

Louisiana Department of Transportation and Development

- State ESF 1 lead
- Activate and conduct contra-flow evacuation operations.
- Maintain in-transit visibility on buses through the MCC
- Fulfill ESF 8 transportation requirements for ambulatory patients from hospitals, nursing homes, health care facilities and residents with special needs

Louisiana Department of Fisheries and Wildlife

- State ESF 9 lead
- Provide water rescue evacuation for medical treatment facilities, long term care facilities, and other medical institutions
- Execute search and rescue operations beginning with at risk facilities (Smart-SAR)

Louisiana Military Department/Louisiana National Guard (LANG)

- State ESF 16 lead for military support for civil affairs.
- Provide damage assessment assistance for medical institutions immediately after the storm
- If available, provide medical personnel to augment ESF 8 upon request
- May provide security in support of ESF 13 if available.

Louisiana Department of Agriculture and Forestry

- State ESF 11 lead
- Provide fuel for all ESF 8 transportation assets, including ambulances at staging areas
- Provide fuel for critical medical infrastructure operations including hospitals, long-term acute care facilities, nursing homes, and MSNS

Louisiana Department of Children and Family Services

- ESF 6 lead
- Establishes and manages MSNS and other mass care shelters
- Track evacuee information and locations in coordination with other responding agencies

Federal

Department of Health and Human Services (HHS)

- Federal ESF 8 lead with oversight of all ESF-8 activities.
- Assist State of LA Department of Health and Hospitals in coordinating response activities
- Deploy ESF-8 personnel appropriate to the response requirements which may include Region Six Regional Emergency Coordinators (RECs), other RECs, SMEs, the Incident Response Coordination Team (IRCT) to coordinate ESF 8 requests and missions, and a Senior Health Official, contractors, and others deemed appropriate.
- Request appropriate ESF 8 partners to activate and deploy health and medical personnel, equipment, and supplies in response to requests for Federal public health and medical assistance
- Coordinate with other primary and supporting departments, agencies, and governments throughout the incident including sending Liaison Officers where appropriate
- Provide staffing for urgent care at special needs and general population shelters, and (potentially) at aeromedical marshalling points and hospitals that are sheltering in place with its partner agencies
- Augment state and local evacuation efforts upon request
- Directs the activation of NDMS as necessary to support medical response operations.
- Activates and deploys teams of NDMS health / medical personnel, equipment, and supplies in coordination of HHS
- Activates the NDMS Medical Interagency Coordination Group (MIACG), composed of NDMS partner representatives (DHS, DOD, VA, and HHS), to support hospital evacuation and placement of patients in NDMS hospitals for care

Department of Homeland Security (DHS)

- Establishes Federal response operations structures in Presidentially declared disaster/emergencies including: the deployment of Emergency Response Teams, establishing of Joint Field Office(s), overall incident coordination, provision of funds and issuance of Mission Assignments.
- Provide communication support in coordination with ESF 2
- Assist in providing information/liason with emergency management officials in NDMS FCC areas
- Provide logistics support as appropriate.
- Identifies and arranges for use of U.S. Coast Guard aircraft and other assets in providing urgent airlift and other transportation support through ESF 1

Department of Defense (DOD)

- Alert DOD NDMS Federal Coordinating Centers (FCCs) (Army, Navy, Air Force) and provide specific reporting/regulating instructions to support incident relief efforts

- Alert DOD NDMS FCCs to activate NDMS patient reception plans in a phased, regional approach, and when appropriate, in a national approach
- Coordinate with ESF 1, at the request of HHS, to provide support for the evacuation of seriously ill or injured patients to locations where hospital care or outpatient services are available and provide general aviation and airhead support to compromised airports including emergency lighting and air traffic control.
- Utilize available DOD transportation resources, in coordination with the NDMS MIACG to evacuate and manage victims/patients from the patient collection point in or near the incident site to NDMS patient reception areas
- Provide available medical personnel for casualty clearing / staging and other missions as needed including aeromedical evacuation and medical treatment
- Mobilize and deploy available Reserve and National Guard medical units, when authorized and necessary to provide support
- Coordinate patient reception, tracking, and management to nearby NDMS non-federal hospitals, VA hospitals, and DOD military treatment facilities that are available and can provide appropriate care
- Provide non-DoD lift as required or requested as the lead for federal patient evacuation support under NDMS.

Department of Transportation (DOT)

- Assist in identifying and arranging for all types of transportation, such as air, rail, marine, and motor vehicle in collaboration with DOD, GSA, and other transportation providing agencies
- Provide patient movement assistance from DOT resources subject to DOT statutory requirements, at the request of HHS
- Coordinate with the Federal Aviation Administration (FAA) for air traffic control support of priority medical missions

American Red Cross (ARC)

- Provide support to Federal ESF 6 functions with DHS.
- Coordinate with LA DCFS regarding shelteree identification, and family reunification.

Department of Veterans Affairs (VA)

- Conduct and provide bed availability reporting for NDMS hospitals.
- Identify and recommend receiving FCCs based on staffing and bed counts.
- Designate and deploy available medical, surgical, and other health support assets, as requested, including Federal Medical Station augmentation packages (105 personnel).
- Coordinate with participating non-Federal NDMS hospitals to provide incident related medical care to authorized NDMS beneficiaries
- Provide logistics support and wraparound services as requested.

Command and Control

- Unified command

- NDMS Patient Movement Cells will be located at various airheads
- The State will work through Federal ESF #8 for all medical resource requests.
 - The State OEP communicates with Federal ESF #8 through the ESF #8 IRCT liaison at the State EOC.
 - ESF #8 will be responsible for actual ambulance contracting.

Operations

The following are guidelines to facilitate coordination, interagency communications, and operational functionality during the four phases related to hurricane response, including awareness, preparedness, response, and recovery. Medical institutions are responsible for having evacuation plans, including contracts or agreements in place to execute them. However, large-scale medical evacuation of an entire Region or multiple Regions will require private, local, State, and Federal assets to accomplish the mission. Individuals with special medical needs have the responsibility to self-evacuate whenever possible. Those who cannot self-evacuate will require assistance from the parish and other local entities. If local parishes are overwhelmed by the demand for medical evacuation, assistance from the State and Federal ESF 8 partners will be required. State and Federal assistance includes those elements required to successfully execute a medical evacuation and sheltering plan.

Awareness Phase

This phase begins with the start of hurricane season. During this phase, State and Federal ESF 8 partners review current hurricane plans, with a focus on identifying and filling resource gaps. Transition out of the awareness phase is contingent upon multiple factors: a tropical depression/storm enters the Gulf of Mexico, the storm's five day cone touches Louisiana coast, or the intensity reaches a category three while having the potential to impact the Gulf Coast.

Preparedness Phase

This phase begins when a tropical depression/storm enters the Gulf of Mexico, the storm's five day cone touches Louisiana coast, or the intensity reaches a category three while having the potential to impact the Gulf Coast. Once an emergency declaration is made by local, State, or Federal officials, and resources and assets will begin to be staged and deployed to parish locations in order to assist the affected areas. The intensity and projected track of the storm will determine the amount of ESF 8 assets deployed.

The JFO coordination group and JFO situation unit elevate to hot status, and the Federal ESF-8 Personnel come forward. These may include the Emergency Response Team A ESF-8 Liaison Officer in support of FEMA Region Six and to assist the LA DHH leadership, the HHS Region Six Regional Emergency Coordinator(s), a Senior Health Official to advise the JFO leadership and coordinate/oversee ESF-8 Federal Operations and the HHS Incident Response Coordination Team members.

- The ESF-8 Incident Response Coordination Team members will be determined by response requirements and validated state requests.

- Medical institutions review their evacuation plans and determine which patients can be discharged if necessary, which patients may shelter in place, and which patients may require evacuation.
- They alert their predetermined transportation contractors to prepare to deploy assets to support evacuation. They alert and maintain communications with their receiving facilities.
- Local 911 providers continue to respond to 911 requests, identify assets they will need to augment their operations, and identify where outside augmentation will report.
- Health Regions initiate their phone triage procedures to communicate with Special Needs residents regarding requirements for medically appropriate transportation assistance from their residence, to a final evacuation facility with definitive care.
- The State activates their EOC at GOHSEP. State and federal ESF 8 provide appropriate staffing for to meet ESF-8 requirements for response coordination at the State Operations Center.
- Coordination with other ESFs is initiated in preparation for evacuation and sheltering, including sending a liaison to LDOTD's MCC. State ESF 8 stands up its EOC at BEMS.
- State ESF 8, in coordination with GOHSEP, determines which regional medical staging/dispatch points, AMPs, and MSNS will be activated.
- BEMS mobilizes ambulances from outside the possible zone of impact to medical staging/dispatch points and local 911 providers.
- DRCs report to their respective EOC(s). Medical staff members from the State deploy to MSNS and prepare to conduct operations.
- Federal ESF 8 will alert its partners to prepare for deployment to Louisiana to support evacuation and shelter operation.
- Contracts are activated for Federal ambulances, para-transits and coach buses. Once the State of Louisiana or Parish officials order a mandatory evacuation and after a Pre-Landfall Presidential Emergency Declaration, Federal assets (including Federal Medical Station materiel caches and personnel) deploy to augment State and local assets.
- State / Federal ESF 8 partners form a Unified Command at BEMS to conduct medical operations. LNO(s) from State and Federal ESF 8s will report to their designated locations.
- HHS will alert NDMS for: possible deployment of teams, forward movement of patients, and reception at FCC. Once deployment orders are issued, DoD, the lead agent for evacuation transportation within the NDMS, provides assets required to evacuate patients from AMPs to NDMS facilities as determined by the Global Patient Movement and Requirements Center (GPMRC).
- HHS will stage NDMS teams to assist at the MSNS AMPs, and FMS as required.

Response Phase

This phase begins with the mandatory order to evacuate. The storm intensity and location will dictate the extent of the evacuation and destination of evacuees.

- Medical institutions, including hospitals, will decide whether to evacuate, SIP, or a combination of both. Nursing Homes are required to evacuate when a mandatory order to evacuate is issued by the parish.
- The facilities will notify their respective DRC with key information, as outlined in Roles and Responsibilities.
- Obstetrics, neonatal and pediatric intensive care patients will be evacuated by rotary wing and / or ground evacuation assets to Women's Hospital in Baton Rouge if required. Rotary wing assets will be provided by the appropriate Ambulances and the LANG.
- MSNS and FMS are available to receive special needs population. Those living in the general populations who have medical needs will either self-evacuate or be evacuated from PPP utilizing local, State and Federal transportation assets. Those identified as homecare patients will notify their Parish 911 or 311 providers to request evacuation to a MSNS, FMS, or hospital depending on medical needs.
- Medical institutions request ground evacuation through their Hospital DRC, who passes it to the EMS DRC. This request is relayed to the Medical Transport Staging / Dispatch Officers at the Regional Staging / Dispatch Points who will dispatch mission ambulances to the requesting facility and onto their final destination.
- The Medical Transport Staging / Dispatch Officers will coordinate with their LDOTD counterparts for buses to pick up ambulatory patients as needed. When possible, ambulances and buses will depart simultaneously from the staging area.
- When medical evacuation transportation arrives at a medical institution, the designated Loading Officer will coordinate the loading of patients onto ambulances and buses, and notify all appropriate DRCs when the mission is complete. Patients will be transported to AMPs (for NDMS evacuation), MSNS, FMS, and receiving facilities. Once the mission is complete the ambulances will notify the Regional Staging / Dispatch Officer who will have them return to the staging area or dispatch to another location.
- Twelve hours prior to onset of tropical storm force winds touching the coast of Louisiana, State and Federal medical evacuation assets will begin to move to sheltered locations outside the projected impact area. All State and Federal supported evacuation stops once tropical storm force winds hit the coast of Louisiana.
- When the hurricane passes and it is presumed safe, evacuation and / or rescue operations will resume, if required.
- Search and Rescue of medical institutions needing evacuation after the storm will commence, with those most needing rescue retrieved first (Smart SAR).
- Damage and Medical Needs Assessments will be conducted for all medical institutions and in coordination with the state and remaining response requirements identified.
- See Annex IV for details of nursing home CONOPS
- See Annex VI for details of Region 1 Parish Assisted Evacuation CONOPS

Recovery

The recovery phase is not covered in this annex. Once the storm has passed and it is safe to do so, residents will be allowed to re-enter their parishes and recovery assets will be deployed to the affected areas to begin recovery and restoration activities. Other ESF 8 activities, such as those outlined in the 2006 Hurricane Season Louisiana/Federal Joint ESF 8 Response Plan, will also begin at this time.

Logistics and Communications Support

Reporting and Planning

- The IRCT Planning Section, in consultation with the State ESF 8 staff and the HHS EMG, develops the IAP and tactical objectives to ensure adequate lift capability and ground support.
- The IRCT disseminates this information to its State and Federal partners through daily IAP and SITREPs.
- Reports are provided through on-scene liaisons and the Patient Movement Cell
- Maintaining a Common Operating Picture (COP):
 - Location and number of patients needing evacuation
 - Number of patients evacuated and evacuation locations

Sub-task A: Provide back up for hospitals who can self-evacuate

Hospitals that have plans, receiving facilities, and transportation assets in place to self-evacuate should not need State/Federal support. However, if their contracted transportation assets are not available at the time of an evacuation, State and Federal ESF #8 partners will assist with ground transportation (see sub-task B). Support through the NDMS will also be available, in the unlikely event that planned receiving facilities cannot be utilized (see sub-task C).

Sub-task B: Provide transportation assets to get NH clients to their receiving facilities

The majority of nursing homes that need assistance with evacuation transportation have pre-designated receiving facilities. However, they may need state/Federally-contracted transportation assets (ambulances, buses, para-transit/wheelchair vans) to get to these facilities. State and Federal ESF #8 partners are ready to assist in this mission, using transportation assets outlined in Logistics and Administration.

If Nursing Homes are unable to evacuate with pre-identified assets, they will request evacuation assistance from their parish. Nursing Homes will inform the parish on the status of their facility, the number of clients that require evacuation, and whether they are ambulatory or non-ambulatory. With this information, the parish may utilize available transportation resources or – if unavailable - will contact GOHSEP via WebEOC to facilitate evacuation movement from the nursing home through ESF-1. ESF-1 and ESF-8 will deploy buses, ambulances and/or para-transit vehicles (state and Federal) from the staging/dispatch areas to provide assistance with a facility's failed evacuation plan.

Sub-task C: Patient Evacuation through the NDMS

In a catastrophic event wherein multiple hospitals are evacuating concurrently and normal transfer agreements cannot be honored; the state will request assistance for the evacuation of patients via NDMS.

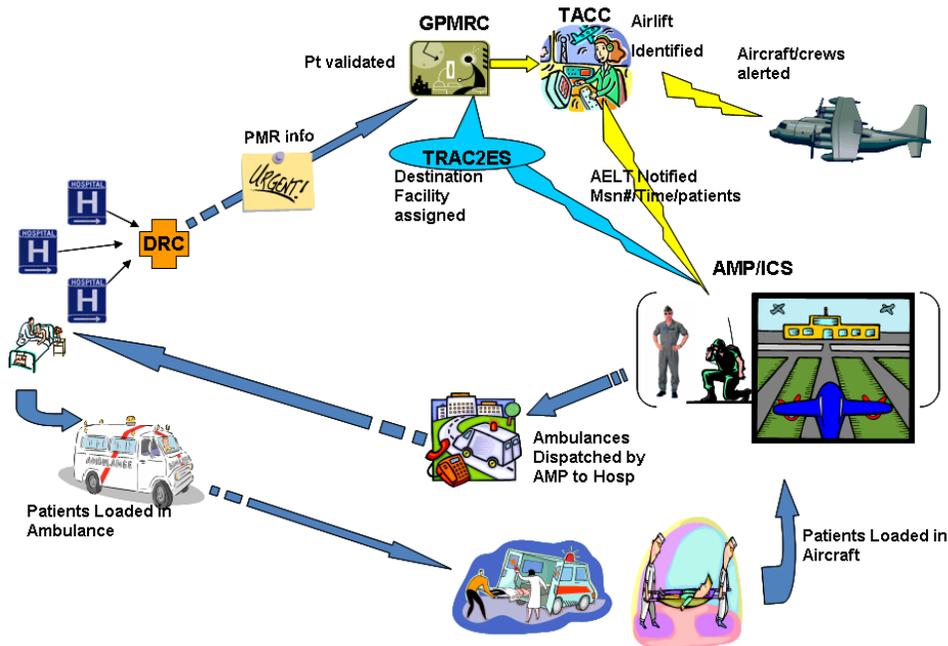
MIEP TIMELINES

H-Hour is the time of projected onset of tropical force winds striking the coast of Louisiana. It is NOT 12 hours before tropical storm force winds hit, nor is it the time of landfall.

Assumptions for H-Hour: 1) H-Hour is a guideline 2) H-Hour may be “recalibrated” to match the situational threat thereby compressing the time-frame to react to a given scenario. 3) As part of the protocol, GOHSEP should clearly establish the H-Hour and have the option to recalibrate the H-Hour to reflect the situational threat.

Please refer to the LHA website for updated version of timeline.

The following diagram provides a pictorial on the operational steps for MIEP.



PROCEDURES:

- Hospitals will contact their Designated Regional Coordinator for Hospitals (DRC), located at local or parish EOC with evacuation requirements beyond their capabilities.
- DRC will:
 - Collect and organize At-Risk Registry spreadsheets from hospitals
 - Forward At-Risk Registry spread sheets to GPMRC who is co-located with State ESF #8 at the State EOC (GPMRC is a component of the US Transportation Command, Scott AFB, IL.)
- GPMRC Liaison within State ESF#8 Cell will validate the request and DOD will task US TRANSCOM to execute
- State ESF #8/Department of Health and Hospitals will:
 - Notify GOHSEP and FEMA Region VI and Federal ESF #8 liaison of possible evacuation of medical facilities by activation of this plan
 - Obtain copy of State Declaration
 - Submit Action Request Forms for AMPs
 - Task BEMS to support the MIEP Plan which calls for ground ambulances at the AMP(s) to transport patients from the hospital to the airhead.
- The Louisiana Hospital Association / HHS Program will assist with information flow from hospitals via the DRC to DHH at the State Emergency Operations Center.

- GOHSEP will when notified by State ESF-8 (DHH) of need to evacuate, transmit requests for assistance to FEMA at JFO.
- FEMA will pass the request to the Defense Coordination Officer for Air Evacuation through NDMS
- GPMRC will:
 - Create a patient-bed-lift plan, matching patients' clinical needs and DHS/NDMS/Federal Coordinating Centers (FCC) beds, and regional NDMS hospital bed availability
 - Return a spreadsheet matching patients with aircraft tail numbers and destinations to:
 - DRC (who will pass it to EMS regional coordinators)
 - DOD Liaison team (if assigned),
 - Receiving FCC

Patient Care at AMP and Aboard Aircraft

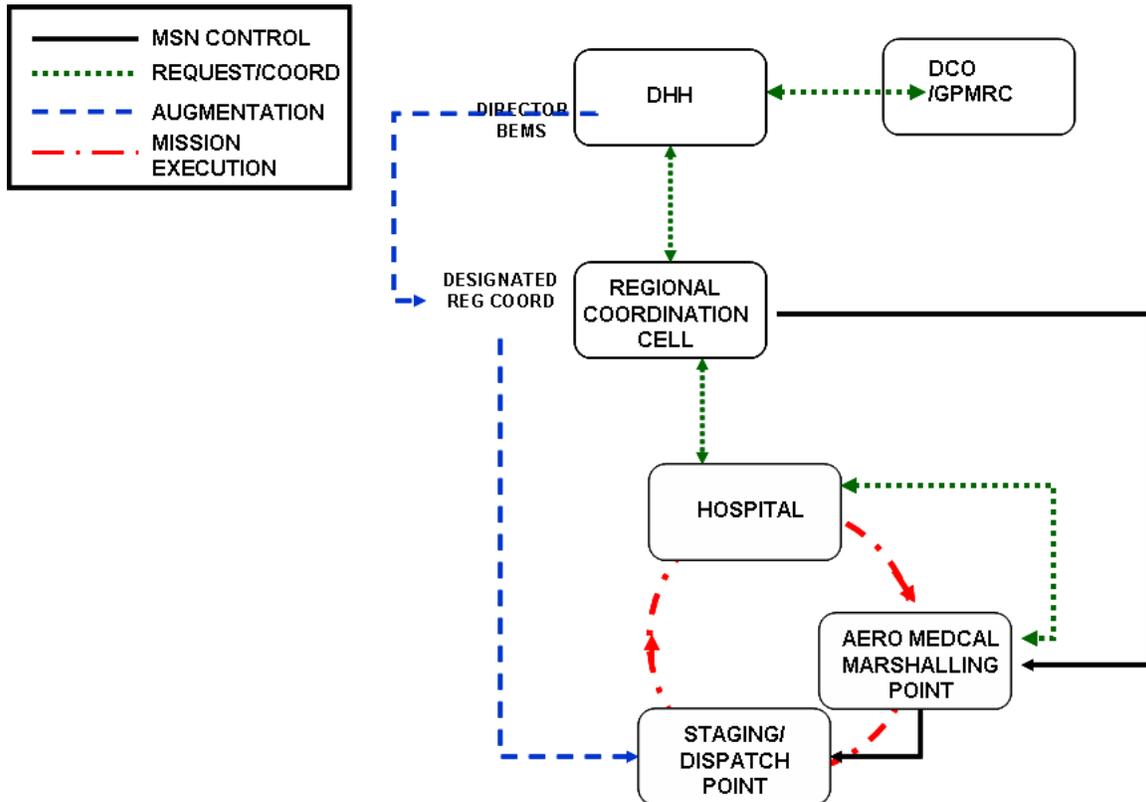
- Hospitals will identify critical patients who are electrically or ventilator dependent or require intensive care, and will pass this information to the DRC by submitting this information through the At-Risk Patient Registry.
- DRC will pass acuity information to GPMRC
- GPMRC will assign Critical Care Air Transport Teams to manage those needing critical care.
 - Each CCATT team is comprised of an intensivist, a critical care nurse and a respiratory technician.
- The EMS Regional Coordinator will request ambulances and/or buses from the Staging/Dispatch Officer who is located at the staging area(s). The Staging/Dispatcher officer will dispatch the regional assets to collect the patients from the hospitals and deliver them to the aeromedical marshalling point.
- NDMS partners will have in-place medical assets (DASF/DMAT) to care for patients at the AMP until they are loaded on the designated aircraft.
- The aeromedical evacuation (AE) crewmembers (nurses and technicians specially trained to care for patients in-flight) will take over patient care once patients are aboard the aircraft.

Arrival and Off Load

- Military personnel and aircraft (C-130, C-17) will transport patients to pre-designated NDMS/FCC airports of debarkation.

- The FCC will ensure that the patient reception area is ready to receive the aircraft and patients.
- The FCC will coordinate transportation for patients who are off-loaded at their destination airport to the designated FCC beds within the NDMS network.
- The FCCs will track patients from receiving until discharge in accordance with NDMS guidelines.

HOSPITAL EVACUATION OPERATIONS



The primary mission of the MIEP is to evacuate an identified group of patients from a specific hospital to the AMP via ambulance. The NDMS system will receive the patients and transport to other NDMS facilities across the nation. The diagram is a pictorial of coordinating transportation (ambulances) from hospitals to the AMP. An identified set up ambulances (~ 50) are pre-staged at the AMP with the mission to pick up specific patients from hospitals. If additional ambulances are required for the mission, The EMS DRC will “chop” additional ambulances from a staging area to the AMP.

Post Storm Evacuation Scenario

In the post-storm evacuation scenario, search and rescue operations water rescue could potentially occur depending upon the extent of weather conditions and flooding scenarios. The post-storm evacuation scenario can be explained in two phases. Phase 1 is water evacuation to an Aeromedical Marshalling Point. Phase 2 is the movement of patients from the Aeromedical Marshalling Point to receiving hospitals. The primary ESF for water evacuation operations is lead by ESF-9. Water evacuation and resources will be coordinated with ESF-9. Non-traditional medical transport may be used to effectively move bed-bound or critical patients such as modified-flat-bottom boats and high-water vehicles that can accommodate bed-bound patients. Once patients have been moved to the Aeromedical Marshalling Point (AMP), patients can be moved by ambulance, medically configured military craft, and/or fixed wing to receiving facilities. Movement of patients from the AMP to receiving facilities is outlined in detail under the Pre-Storm Evacuation Process.

The likelihood of Regions 4 and 5 to conduct a post-storm evacuation is minimal as flood waters are likely to quickly recede in these two regions. It is more likely that these two regions may experience power outages and fuel shortages and that providing these regions with such assistance (as opposed to relocating these institution's patients) would be a priority.

The likelihood of Regions 1 and 3 to be affected by storm surge and flood waters for an extended period of time is more probable as a scenario than in Regions 4 and 5. Regular assessments of institution "survivability" would be conducted to ascertain whether conditions would warrant sheltering-in-place by supporting with generators and other critical wrap-around services to continue operations or whether it would be more prudent to evacuate the institution. Critical information would be gathered at H+12 to determine strategy of SIP or evacuation. Critical information includes but is not limited to: damage to the institution, generator status, the longer term operational status of the life safety branches of the institution, accessibility of personnel to maintain the infrastructure of the institution, damage to the Parish water and sewerage system, anticipated weather conditions or threats that may cause additional damage to the vulnerable institution.

Phase 1: The location, accessibility, and resources needed to evacuate a flooded institution are factors that will determine timeline and priority of evacuation. Pre-storm, ESF 8 and ESF-12 Search and Rescue will identify a catalogue listing of those institutions including 1) their status (evacuated (i.e. full or partial) or sheltered-in-place and 2) an estimate of the number of occupants on site (patients, staff and guests). These SMART locations are pre-identified locations that may have been affected require a post-storm status check. As SMART locations hospitals will be prioritized for assistance from ESF 12 Search and Rescue.

To assist with post-storm evacuation hospitals are asked to complete the At-Risk Registry which includes:

- the number of patients, staff, and guests on-site;
- medical transport resources for patients (i.e. electrically dependent, litter bound, etc) and
- required ground and/or air transportation assets necessary to evacuate the facility.

Phase 2: The Aeromedical Marshalling Point will be determined based on proximity to the affected area. At the AMP, the resources to safely prepare patients for flight will be organized using the Medical Institution Evacuation Plan (MIEP). The footprint of resources at the AMP includes, but is not limited to: ambulances, DMAT, JPATS, and DASF.

Due to anticipated power outages and lack of communication methodologies, it may not be possible to manifest patients (generate a Reverse TUCS Form) prior to evacuation. It is highly probable that patients will be manifested on the ground as search and rescue is able to bring the patients to the AMP. The frequency and volume of the patients brought to the AMP is dependent on a number of unknown variables – extent of damage to the area, accessibility of hovering craft to evacuate from the affected facility, accessibility of search and rescue craft to get to the facility, distance from the site to the AMP, etc. For this reason, the personnel and wrap-around services operating at the AMP should anticipate following contingencies: having a “holding” area with enough robust capability to support patients for a time until the medically configured C-130 can be filled; having access to sufficient supply of ground/ air ambulances or fixed wing aircraft that can move the patient to a receiving site. The condition of the patient will determine which contingency action is conducted.

ANNEX IV

NURSING HOME EVACUATIONS

Nursing homes have transportation agreements in place to evacuate their residents in case of emergency. However, given a large-scale disaster affecting multiple Parishes in coastal-Louisiana, a portion of these nursing homes will not be able to procure their pre-arranged transportation. This relates to 109 nursing homes in the 22 high risk parishes.

Most nursing home patients will be transported to alternate facilities with which the nursing home has a pre-arranged agreement. The only nursing home residents that will not be transported to an alternate nursing home facility are those who decompensate, or whose current medical condition warrants transfer to the hospital evacuation process. This transfer will be done by ambulance. Non-ambulatory patients will be transferred to partner institutions via ambulance; ambulatory patients will be transferred via coach bus, and those who are wheelchair dependent will be transported via WCV. Table 1 displays the operations involved in accomplishing required sub-tasks.

Table 1 - Federal Support for evacuation of Nursing Home²

Sub-task	Agency
A. Transport ambulatory and non-ambulatory nursing home patients from institutions to alternate facilities via ambulance (point to point)	Individual nursing homes LA DHH –ESF #8 DOTD – Evac #1 Contracted: ambulances wheel chair vans and coach buses
B. Transport medically fragile nursing home residents to hospitals for SIP or to Aeromedical Marshalling Points	Individual nursing homes LA DHH – ESF #8 Contracted: ambulances

*Based on LDHHS Historical Experience

Buses

Currently, the state has a pool of 220 coach buses available for all special needs evacuation, of which a percent can be used for nursing home evacuations. A percentage of these buses will have wheelchair lifts. Each bus can hold approximately 40 nursing homes residents and staff members.

Wheelchair Vans (WCV)

For those who need to be transported in their wheelchairs but do not need to be on a stretcher (necessitating ambulance transport) can ride in WCV. Many nursing homes have their own WCV, and use them to transport their residents for routine trips. However, if a State-assisted evacuation is needed, federally contracted WCV will be available. The contract will allow for 4,000-5,000 trips, and will be used for the evacuation of nursing homes and hospitals.

² Numbers from HHS nursing home assessments done June 2007

Advanced Lifesaving Support (ALS) ambulances

Currently the state has a pool of approximately 100+ ambulances for special needs evacuations. These ambulances can carry two people per trip, and come with drivers and the necessary medical personnel to provide in-transit care.

Federal contracts add approximately 300 ambulances to the pool. These units include drivers and necessary medical personnel to provide in-transit care.

Evacuation staffing

Having available staff to loading, unload, and provide in-transit care for nursing home residents is a vital part of a safe and effective evacuation. In addition to nursing staff, augmentation will be required from the Parish and/or volunteers.

Nursing homes are responsible for making and resourcing their evacuation plans. There is an expectation that many nursing homes will succeed in their efforts to self-evacuate; however, those that cannot may request assistance from the Parish. If Parish transportation assets are not available, state assistance will be requested.

- Nursing homes, with input from Parish emergency personnel, will make the determination to evacuate or to shelter in place (SIP). Nursing Homes will:
 - Implement nursing home emergency management plans
 - Make decisions to evacuate staff and patients, or to shelter in place with input from Parish emergency personnel
 - Activate existing memorandums or contracts to evacuate patients to pre-identified facilities.
 - Notify their respective Parish on their decision to evacuate.
 - Should a nursing home require state assisted evacuation; a representative from the nursing home will notify the parish OHSEP. The parish OHSEP shall provide locally available resources and if locally available resources are exhausted the parish shall notify GOHSEP who in turn will task the appropriate state agencies.
 - Part of the information needed includes: name of the nursing home, the number of patients that require evacuation, the type of patients and whether they are ambulatory or non- ambulatory
- If tasked by GOHSEP to assist with a NH evacuation, the WebEOC request will be vetted with the ESF-8 branch, and transportation resources will be coordinated by the DOTD EOC. An ESF-8 rep will also assist DOTD with ensuring that the composition of transportation resources for a NH evacuation meets the need.
- Local Parish
 - Responsible for keeping situational awareness of this decisions, keeping accurate records of nursing homes in that have evacuated and nursing homes that have chosen to SIP.
 - Provide non-medical personnel to assist in the loading and off-loading of patients.
 - Provides transportation

If Parish or contracted transportation resources become overwhelmed, DHH will be asked to support the evacuation of the nursing homes. To do so, state EMS and DOTD will dispatch a portion of the 220 coach buses and 120 ambulances marked for special needs evacuation. However, if these assets proved to be unable to support the evacuation, DHH may require the use of federally contracted ambulances and buses.

If needed, federally contracted transportation will be used in support of the nursing home evacuations. Transportation will be coach buses with drivers and medical personnel on each bus, as well as federally contracted ambulances with drivers and medical personnel.

The following Tables (2a-2f) were compiled by the Health Standards Section. Act 540 charged the DHH/HSS to collect the Nursing Home Plans for 22 high-risk parishes. The data for these nursing homes are summarized below.

Table 2a: Region 1 - Nursing Home Evacuation Plans
Scrubbed Data

Table 2b: Region 2 - Nursing Home Evacuation Plans
Scrubbed Data

Table 2c: Region 3 - Nursing Home Evacuation Plans
Scrubbed Data

Table 2d: Region 4 - Nursing Home Evacuation Plans
Scrubbed Data

Table 2e: Region 5 - Nursing Home Evacuation Plans
Scrubbed Data

Table 2f: Region 9 - Nursing Home Evacuation Plans
Scrubbed Data

ANNEX V

SUPPORT FOR SHELTER IN PLACE (SIP)

This section discusses the concept of operations, intent of mission, and roles and responsibilities needed to shelter in place hospitalized individuals requiring continued medical management. Predicted needs will likely vary with time and region depending on hospital capacity, patient acuity and accessibility.

In the event that a medical institution designates itself as a facility that will shelter in place, resources of the federal government may be requested to augment state and local efforts in support of each institution.

Federal response will be directed at each facility and distributed by the number and types of patients at each institution.

Pre-deployment of resources will be dictated by the medical needs assessment developed by the federal ESF-8 task force (see Annex II-MNA Assessment). The federal response will encompass both the augmentation of medical personnel as well as medical supplies, depending upon the type of facility.

Federal response is designed to augment available state and local resources, allowing medical facilities to maintain acceptable standards of care for a period of 7 days. A number of assumptions guide the predicted needs assessment. These assumptions are as follows:

- Facility power supply will be intermittent
- Facility resources will be exhausted or severely compromised
- Facility personnel will be overwhelmed quickly
- Acceptable staffing ratios must be maintained
- Essential medical equipment (i.e. ventilators) must be able to function without electricity for undetermined periods of time

1. Hospital Support

Hospital staff will be requested by hospitals through their DRCs to LA DHH, who will forward to Federal ESF-8. If approved by GOHSEP, FEMA will mission assign hospital staff augmentation to HHS. These actions will occur in the H 96-72 hour time frame.

Immediately upon first alert from LA DHH, federal HHS will roster and arrange travel for medical care providers including physicians, nurses, respiratory therapists and pharmacists from ESF #8 partners including US Public Health Service, Veterans Administration, Dept of Defense and FEMA/NDMS. Staff should be in place at H 48-36 hours. A Team leader will be designated for the staff assigned to each hospital.

Upon arrival, federal providers will report to the team leader who is located at the requesting hospital(s). The hospital will be responsible for billeting and logistics for these providers on site from before the storm through the shelter-in-place operation. The team leader will also notify the IRCT of their arrival, location, status, and contact information for team members on all shifts.

During SIP operations, the federal medical providers will work regular rotations with the hospital's own staff. After a storm has passed, the team leader will work with the hospital's administration to assess consequences of the incident and determine ongoing and/or future requirements. These may include immediate demobilization of the federal staff, an estimate of duration of continued staffing, or a need to evacuate if circumstances warrant. All of these conditions will be communicated by the team leader to the IRCT.

Roles and responsibilities: private, parish, State and federal

- Hospitals
 - JCAHO mandates hospital disaster planning
 - Agreements with regional medical institutions and vendors to provide adequate inventory of essential personnel and resources in the event of a disaster should be in place. Efforts should be made on an institutional level to ensure adequate resources are available.
 - In the event these resources are not adequate, it is the responsibility of the appointed hospital administrator to notify the Designated Regional Coordinator (DRC) of their shortfalls.
- DRC for Hospitals
 - Once notified of a specific request from a hospital, the DRC will validate the request and forward it to the local OHSEP. The DRC is also expected to notify the LDHH of OEP requests.
- Local OHSEP will then create an WEBEOC request form for federal support and sends this document to the GOHSEP.
- GOHSEP
 - Will request the assistance of the Federal ESF-8 partners if the personnel and/or resources required exceed state capacity,
 - Submits an ARF for fed support to FEMA OPS
 - Upon initiation of this process, state officials should be prepared to provide federal officials with an accurate based census and bed capacity figure.
- FEMA OPS upon receipt of the ARF notifies ESF#8.
- HHS, in coordination with ESF #8 partners, will lead the federal shelter in place to support to hospitals.

STAFFING

Augmentation of Hospital Personnel

Some institutions may shelter in place while others may be expected to support evacuees from other facilities in addition. As a result, patient volume will be the independent variable driving

federal personnel deployments. Evidence suggests, increases in mortality occur with increasing patient/nursing ratios³. Every effort will be made by to maintain appropriate staffing ratios.

Suggested ratios were obtained from a number of different evidence based resources^{4,5,6} as well as accepted state models.

Recommended Staffing Ratios per **24 hour period** (used for SIP staffing calculations spreadsheet):

1. **Intensive Care Unit:**
 - a. 2RNs/1-3 patients
 - b. 2 ICU MDs/15 patients
 - c. 2 pharmacist/10-20 patients
 - d. 2 respiratory therapists/15 patients
2. **Medical/Surgical/Telemetry/Pediatric and Psychiatric Units:**
 - a. 2RNs/6-10 patients
 - b. 2MDs/10-20patients. If MLP (mid level practitioner)/MD ratio is 1:1, then MD/patient ratio can be increased to 2MDs/20 patients
 - c. 2 Pharmacists/15-25 patients
 - d. 2 Behavioral Health professionals / 15 psychiatric patients

Recommendation: If the staff/patient ratio is below the guidelines, re-allocation of personnel is suggested.

Augmentation of Essential Hospital Resources

Logistical support requirements have been identified to ensure SIP facilities have adequate essential supplies. The federal augmentation of such supplies will be provided based on the requirements identified by the SIP facilities. Coordination is being done to identify prime vendors and credential drivers to assure deliveries are not interrupted. In addition Federal and State contracts for supplies and services have been identified as backup for SIP facilities. Highlighted below is the needs specific to essential life maintaining equipment.

Emergency Ventilation Recommendations

- Evidence demonstrates hazards of manual vs. mechanical ventilation. Complications include hemodynamic instability, hypoxemia, hypercardia and significant acid base changes.
- Evidence supports the recommendation to increase hospital mechanical ventilatory capabilities by supplying the portable, battery run, rechargeable Uni-vent 754 ventilator^{7,8,9}.
 - The Strategic National Stockpile inventory of this model will be utilized

³ JAMA (23)30, October 2002

⁴ Online J Issues Nurs. 2003;8(3):5

⁵ Chest.2005;128:567-572

⁶ Crit Care Med 2005 V33, N10

⁷ Crit Care. 1999; 3(5): R83–R89

⁸ Crit care Med Volume 27(4), April 1999, pp 802-806

⁹ Respir Care 2002;47(10):1173-1183

- This portable unit has up to 12hrs of battery life,
- Is capable of running off DC power sources (i.e. car batteries)
- Can generate an independent source of concentrated oxygen
- Estimates predict need for approx. 250 units
- 1 rapid re-charger (re-charges within 4hrs with a rapid re-charger) should accompany every 3 Uni-vent 754s deployed

2. Nursing Home Support

Nursing Home patients are lodged in and cared for on a permanent basis in their nursing homes. The nursing homes have a custodial responsibility for their patients. Patients are not expected to leave their nursing homes in the normal course of events unless their condition deteriorates so much that it requires them to be admitted to a hospital or other serious care facility. Nursing homes are expected to make all arrangements to evacuate and shelter their patients in emergencies. DHH maintains a directory of nursing homes and the number of beds for which they are licensed. Nursing homes generally run at 70% capacity or higher. Nursing homes have facilities, on-site staff and some transportation.

Depending upon the event and the risks associated with both the event and its aftermath, local OHSEPs, nursing homes, ESF 8 State Command and other stakeholders may reach consensus on the ability of certain nursing facilities to SIP.

Roles and responsibilities: private, parish, State and federal

- Nursing Homes
 - State law mandates nursing home emergency preparedness planning.
 - Agreements with sister facilities, other institutions, and other vendors to provide adequate inventory of essential personnel and resources in the event of a disaster should be in place. Efforts should be made on an institutional level to ensure adequate resources are available.
 - In the event these resources are not adequate, it is the responsibility of the appointed nursing home administrator to notify the Designated Regional Coordinator (DRC) of their shortfalls.
- DRC for Nursing Homes
 - Once notified of a specific request from a nursing home, the DRC will validate the request and forward it to the local OHSEP. The DRC is also expected to notify the LDHH of OHSEP requests.
- Local OHSEP has first responsibility to fulfill the request and provide support to the facility. If not possible, the local OEP will then create a WebEOC request for state/federal support and send this document to the GOHSEP.
- GOHSEP
 - Will request the assistance of the Federal ESF-8 partners if the personnel and/or resources required exceed state capacity,
 - Submits an ARF for fed support to FEMA OPS

- Upon initiation of this process, state officials should be prepared to provide federal officials with an accurate based census and bed capacity figure.
- FEMA OPS upon receipt of the ARF notifies ESF#8.
- HHS, in coordination with ESF #8 partners, will lead any federal shelter in place effort to support nursing homes.

Augmentation of Essential Nursing Home Resources

Logistical support requirements have been identified to ensure SIP facilities have adequate essential supplies (See Nursing Home Emergency Preparedness Planning rules). The state and federal augmentation of such supplies will be provided based on the requirements identified by the SIP facilities. Nursing Home DRCs are responsible for identifying and vetting the requirements of local facilities for specific resources. Federal and State contracts for supplies and services have been identified as backup for SIP facilities.

ANNEX VI

REGION 1 PUBLIC ASSISTANCE EVACUATION PLAN

Note: This annex was developed as an outcome of a GOHSEP/ESF-8 meeting on March 6, 2008 to discuss Region 1 evacuation and Region 2 sheltering issues. Orleans, Jefferson, and Plaquemines representatives were present. St. Bernard was invited but did not attend.

The population density and topography of Region 1 poses logistical issues for a mass evacuation. Multiple agencies are required to ensure a well-coordinated and resourced plan. Region 1 is composed of 4 parishes: Jefferson, Orleans, St. Bernard and Plaquemines. St. Bernard and Plaquemines will be making earlier decisions for evacuations prior to Jefferson and Orleans as their populations must pass through Jefferson and/or Orleans. The majority of the population in the region 1 area resides in Jefferson and Orleans.

Assumptions

- Region 1 Parishes could experience disaster conditions that would require the evacuation of these parishes.
- Disaster conditions requiring publicly assisted evacuation could be brought on by natural phenomena such as hurricanes, floods, tornadoes, fires, storms, or any combination thereof.
- Other unforeseen occurrences that could necessitate publicly assisted evacuation would be hazardous material incidents either at a fixed site or in transit or acts of terrorism.
- Jefferson Parish (10-15K), Orleans (20-30K), St. Bernard (100) and Plaquemines (200-300) residents either do not own or cannot drive an automobile or do not have the financial means to evacuate without assistance from government.

Concept of Operations

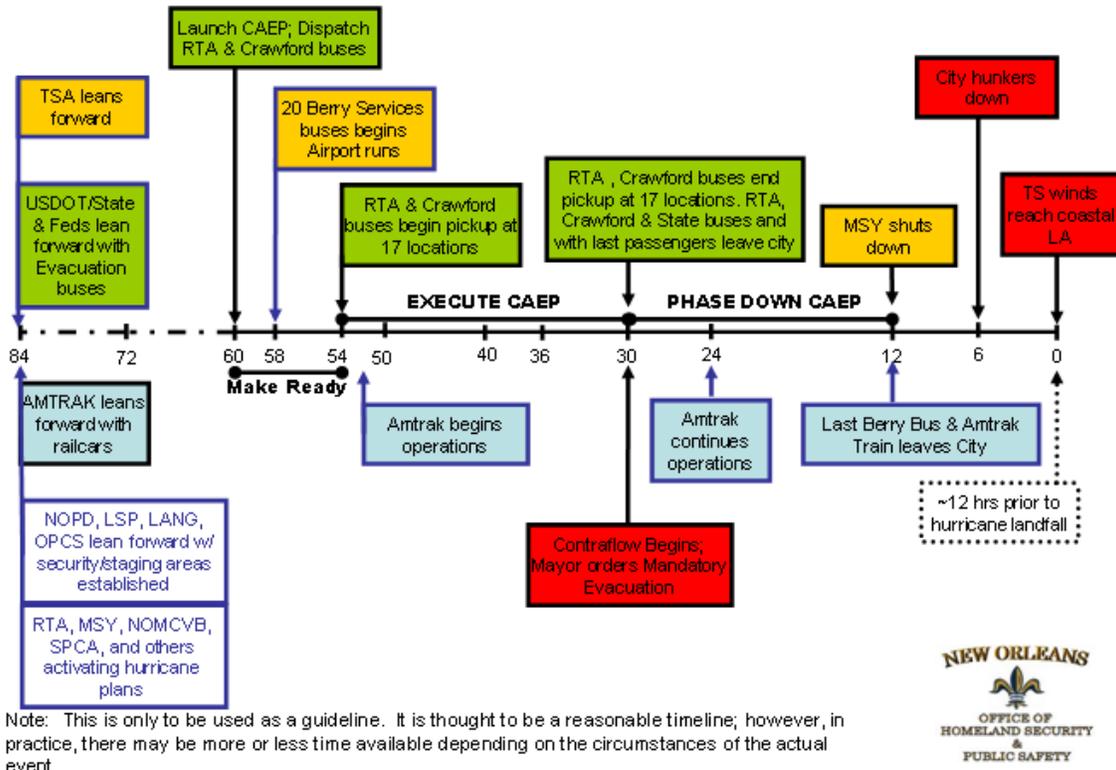
The publicly assisted evacuation plan is designed to provide evacuation transportation during disasters requiring the evacuation of large portions of the general public that do not own an automobile, members of the general public that do not have the financial means to pay for an evacuation; the elderly and handicapped that are not able to drive.

With a given threat matrix, the Parish Presidents will initiate evacuation procedures which conceptually includes the designation of Parish Pick-up Points (PPP). The Parish Pick-up Points are pre-designated areas where evacuees are received, registered and transported to shelter locations outside of the disaster impact area.

Upon arrival at a PPP site, evacuees will be processed by ESF-6 and placed on buses provided by ESF 1 (once local assets have been exhausted) to be evacuated to shelter locations outside of the disaster impact area.

<u>Parishes</u>	<u>Number of PPPs</u>	<u>Locations</u>
Plaquemines	1	Scrubbed Data
St. Bernard	1	Scrubbed Data
Jefferson	2	Scrubbed Data
Orleans	1	Scrubbed Data

A cornerstone to the Region 1 public assisted evacuation plan is the New Orleans City Assisted Evacuation Plan (CAEP). The CAEP identifies the timeline model below:



This timeline is for guideline purposes only and may be compressed or expanded based on the threat matrix at the time. The timeline is thought to be reasonable; however, in practice, there may be more or less time available depending on the circumstances of the actual event.

- H120 – H60
In short, “lean forward” activities of readiness will be conducted between H-120 to H-60.
- H60 – H54
This is the “make ready” phase wherein initial dispatch of buses and start-up activation activities may be conducted. At this H-hour, it is anticipated that Region 1 faces a credible threat and certain mitigation activities must be enacted. Encouragement by public announcements to self-evacuate will be made.
- H54 – H30
Public Assisted Evacuation Plans is executed.
- H30
Contraflow Begins
- H12
All operations cease due to anticipated landfall winds

The Evacuation timelines for St. Bernard, Jefferson, and Plaquemines are fairly synchronous with the CAEP.

The evacuation timelines for the execution of the Medical Institution Evacuation Plan (MIEP – see Annex 3) are synchronous with CAEP.

Transportation Triage Criteria

Gross triage will be conducted to sort individuals by transportation needs (i.e. Green patients, yellow patients, with red patients sent to Hospitals and/or MIEP evacuation procedures). Efforts will be made to place similar patients together on the same vehicle; although this may not always be possible. Green patients/ bus will be directed to a specific CTNS location as directed by ESF6. Red patients will be sent to hospitals as directed by the Hospital Designated Regional Coordinator (ESF-8). Yellow patients/bus will require a brief stop in Region 2 for a status check to determine whether evacuees on these specific buses will need to be checked off the buss and receive community assistance at the Region 2 Medical Special Needs Shelter or the Region 2 Federal Medical Station. These buses will be directed to a CTNS by ESF6.

New Orleans has developed Transportation Triage Criteria below. These criteria are not necessarily adopted by Jefferson, St. Bernard, and Plaquemines but the model holds some merit for anticipated needs of evacuees. In short, Blue or Green evacuees would evacuate in a Point-to-Point manner (PPP to CTNS). Yellow evacuees would evacuate in a 3-step process (PPP to Bus Triage Site in Baton Rouge to CTNS). Red evacuees would require hospital care and be directed to a Shelter-in-place hospital or slated for evacuation via the MIEP Plan. The Transportation Triage Criteria is found in Appendix 5b.

Bus Triage

Pre-designated Site: A Bus Triage site has been pre-designated in the Region 2 area, specifically at the Department of Agriculture Site off of E. Parker Road on the LSU Campus. This site has been established to evaluate at-risk individuals evacuating on buses and quickly determine if it is medically safe for them to continue on their journey on the bus to a designated Critical Transportation Needs Shelter or Medical Special Needs Shelter (MSNS).

Triage Strike Teams: A Triage Officer will direct the five (5) triage strike teams. The five (5) Triage Strike teams consist of three (3) team members. Each Team will consist of at least 1 EMT-Paramedic who is team leader and then 2 others (nurses or EMT-Paramedics)

Clinical Triage Guidelines: Clinical triage guidelines for triage strike teams to remove patients from the bus those with any clinical signs that would suggest that remaining on the bus would result in a high likelihood of material deterioration from their baseline condition.

For Example: Adult Parameters:

Heart Rate sustained above 120 bpm

Sustained systolic BP less than 100 or diastolic BP greater than 120.

Respiratory Rate greater than 30 per minute

Patient Transfer Forms: Department of Children and Family Services (DCFS) representative will maintain the list of patients that have been removed from a bus. DCFS completes Patient Transfer Forms for each patient and keeps them secured.

ANNEX VII

HOSPITAL EMERGENCY PREPAREDNESS AND RESPONSE

Please refer to the LHA website for the Updated Version.

ANNEX VIII
EMERGENCY MEDICAL SERVICES
EMERGENCY PREPAREDNESS AND RESPONSE

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Appendices

Appendix A– Designated Regional Coordinators

Appendix B – Operational matrix

Appendix C – EMS disaster response talk groups

Appendix D – Regional response teams

Louisiana Emergency Medical Services (EMS)

Emergency Preparedness and Response

I. Introduction and Background

The Louisiana Department of Health and Hospitals, Office of Public Health, Bureau of Emergency Medical Services (**BEMS**) is the lead state agency for EMS disaster preparedness and response.

During all emergency responses, the medical and health components will normally utilize the same processes and personnel to address local and public needs. These process and personnel will be coordinated by the Bureau of Emergency Medical Services.

The Bureau of EMS uses a multi-hazard approach to medical-disaster planning that gives high priority to new threats such as pandemic disease outbreak, weapons of mass destruction and terrorism and loss of logistics that support medical operations. The Bureau's planning efforts also reflect Louisiana's change in Emergency Response coordination philosophy based on Louisiana's disaster medical response experience and the response to September 11, Hurricanes Katrina and Rita and other disasters nationwide that demonstrated the importance of a state capability to rapidly augment local response with EMS assets and provide sustained coordination for disaster medical operations.

To meet these challenges, BEMS and its federal, state, and local partners have increased their collective capacity to meet the disaster medical needs of its citizens. Resultant enhancements include:

- Improved State and regional coordination for preparedness and response.
- Adoption of new communications and information technology systems.
- Expanded catastrophic event medical planning with local, state, regional and federal partners.
- Enhanced cooperation and coordination between EMS and the state and local partners resulting in more effective medical and health operations at the state, regional and local levels.
- Strengthened state and DHH/OPH Emergency Operations Center (**EOC**) functioning.
- Coordination of elements of the mutual aid system for medical and health resources including support, and oversight of Designated Regional Coordinators (**DRC**).
- Expanded EMS capabilities and operational response role through the development of the Emergency System for Advanced Registration of Volunteer Health Personnel (ESAR-VHP).

II. EMS Emergency Preparedness and Response

A. Infrastructure

i. Adoption of National Incident Management System (NIMS)

NIMS was developed as a comprehensive national approach to incident management, applicable at all jurisdictional levels and across functional disciplines, to further improve the effectiveness of emergency response providers and incident management organizations across a full spectrum of potential incidents and hazard scenarios.

Louisiana has adopted NIMS at all government departments and agencies as well as in the private public partnership of health care providers. All EMS providers receiving Federal grant funds are required to be NIMS compliant.

ii. Regional structures

To facilitate the multi-layered response, nine (9) planning regions for EMS Providers were identified. These regions correspond with those used by Louisiana Department of Health and Hospitals Office of Public Health.

All ambulance providers “belong” to a region and have a responsibility to be involved in the development of regional plans.

Leadership for Louisiana EMS Emergency Preparedness and Response is provided thru ambulance provider volunteers known as **Designated Regional Coordinators (DRCs)**. The primary responsibilities for the EMS DRCs are:

Serve as the voice of regional EMS in real-time decision-making:

- Regional Coordinators will respond to a declared state of emergency to the OEP office designated for response.
- Regional Coordinators will serve as the voice of all participating EMS in the region and make decisions about the deployment of regional EMS resources during the incident.
- Regional Coordinators will communicate with the EOC critical information concerning the availability of EMS resources within the region. In turn, the EOC will disseminate critical information to the coordinator that will be shared with designated EMS coordinators.
- Regional Coordinators will collect vital facility information on all EMS in their region to pass on to the EOC and/or to the State Emergency Operations Center during an incident.
- Regional Coordinators will develop and maintain regional EMS response organizational charts.

Coordinate the delivery of essential supplies, including pharmaceuticals within the region:

- Regional Coordinators will facilitate the delivery of resources needed for individual EMS Providers within the region. Regional Coordinator will coordinate with the local EOC according to plans developed for the region.

Appendix A provides a listing of current Designated Regional Coordinators.

Appendix B outlines the operational matrix.

iii. State and Federal Interface

The Louisiana Department of Health and Hospitals, Office of Emergency Preparedness provides coordination on behalf of the State of Louisiana and all other state agencies, to the federal government through Emergency Support Function (ESF) 8 - Health and Medical Services, and the Louisiana EMS Emergency Preparedness and Response.

B. Critical Initiatives

Several critical initiatives have been developed by the Louisiana Hospital Emergency Preparedness and Response to support emergency preparedness:

- Development and refinement of the EMS Designated Regional Coordinator Network
- Communications infrastructure
- Regional Response Teams
- Development of regional response plans
- Development of regional EMS planning councils
-

EMS Designated Regional Coordinator Network:

The Louisiana EMS Network was developed to assist state licensed EMS services to more effectively and efficiently exchange services and resources in response to declared disasters and emergencies.

The EMS network is a partnership between local EMS services and the State of Louisiana. The network provides a framework to facilitate a coordinated response to a local request for state assistance. The network is supplemental to, and does not affect day to day mutual aid agreements between EMS services.

Communications infrastructure:

Louisiana ambulance providers have been awarded grant funding to purchase radios that can provide statewide communications. Talk groups have been assigned specifically for EMS disaster response.

Appendix C provides a list of the current talk groups that have been assigned for EMS disaster response.

Regional Response Teams:

The Bureau of EMS has supported the establishment of regional response teams. To date one regional response team has been established in Region 7.

Appendix D provides a list of current regional response teams.

Development of Regional Response Plans:

The Bureau of EMS has facilitated and supported the drafting of regional EMS response plans. A draft template has been created and planning is occurring at the regional level.

Development of Regional EMS Planning Councils:

The Bureau of EMS will assist in the development of Regional EMS Planning Councils. The regional councils will form the framework for regional cooperation, planning and coordination of local EMS resources.

ANNEX IX

SUPPORT FOR MEDICAL NEEDS IN CRITICAL TRANSPORTATION NEEDS SHELTERS (CTNS)

Louisiana's ESF-6 Mass Care primary lead agency, Department of Children and Family Services, has identified 5 Critical Transportation Needs Shelters. CTNS are state-operated shelters for the general population who require transportation and sheltering assistance. The state-operated buses will be directed to the CTNS shelter sites. These sites are activated by DCFS when the expected population to be evacuated exceeds local assets.

Site Locations:

- Region 6 – Scrubbed Data
- Region 7 – Scrubbed Data
- Region 8 – Scrubbed Data

RESPONSIBILITIES:

Primary ESF- Louisiana Department of Children and Family Services is the lead agency coordinating resources and staffing for up to 5 CTNS shelters.

ESF – 8 Support: Medical Special Needs Shelter(s) may be activated in conjunction with the activation of a CTNS to provide medical support. In addition, two ambulances with medical personnel will be staged at each CTNS that is activated. LSU Hospitals provide medical support to the CTNS sites in Region 7 and 8. A copy of the agreements are found in Appendix 9.

If the CTNS site(s) is activated for greater than 5 days, then Primary Care teams composed of medical personnel from the ESF 8 partners in a federalized team will be organized to provide medical assessment, triage and/or treatment at the CTNS. The primary care teams will cover a cluster based on population or geography of the general shelters on a rotational basis. The teams may be composed of one care provider (MD, PA, NP), one pharmacist, three nurses, and either an administrative assistant or EMT. The team will travel with a chronic medical cache. These teams will be able to write and fill prescriptions and provide care that exceeds what American Red Cross first-aid provider are authorized to provide. These teams will evaluate the patient's condition and either dispense appropriate medications or refer the patient to a higher level of medical attention. By performing these services, the primary care teams will decrease the adverse effect that the shelters may have on the local community health resources.

Ideally, mental health and SAMHSA counseling teams will accompany the medical teams. This will increase overall coverage of the shelters.

At request of the state authorities, medical personnel from Federal ESF-8 partners will provide the primary care teams. These personnel can be any mix from the following agencies:

- HHS (total of approximately 2,000 personnel)
 - Five applied public health teams
 - Five mental health teams
 - Tier 3 personnel (from PHS Rapid Deployment Forces)
 - Inactive Reserve Corps personnel.

- VA Medical System Staff
- NDMS
- Credentialed volunteers
- DoD providers

ANNEX X

MEDICAL SPECIAL NEEDS SHELTERING PLAN

For an impending hurricane threat where evacuation seems imminent, general shelters, Medical Special Needs Shelters and possibly Critical Transportation Needs Shelters may be slated for opening concurrently. The underlying purpose is for triage: For those individuals that are too critical, hospital placement may be necessary. For those that are not as critical, general shelters or Medical Special Needs Shelters may be appropriate options defined by medical need and community resources available.

PART 1: GENERAL

SUMMARY:

1. The Louisiana Medical Special Needs Plan provides a framework for both Parish and Regional Special Needs Sheltering Concepts within which parish and state government agencies, private industries, non-profit organizations, and volunteer groups can coordinate their actions to deal with the problems and situations associated with Medical Special Needs (MSN) people in emergencies and disasters.
2. There exists local Medical Special Needs Shelters and State Regional Medical Special Needs Shelters. The State Regional Special Needs Shelters are listed in [Appendix 10](#). Some parishes have pre-designated Parish-operated MSN shelters and the State has pre-designated Regional MSN shelters, primarily for medically dependant individuals who do not require care in a hospital setting, and whose pre arrangements have failed and left the patients with no other recourse. Regional Shelters will be used to support the Parish GOHSEP's only after Parish resources have been totally exhausted. Parish resources refer to the required parish operated minimal Medical Special Needs Shelter (MSNS).

There exists a growing vulnerable population in Louisiana. The vulnerable population is defined as being medically dependent.

The Medical Special Needs population is a subset of the vulnerable population. The Medical Special Needs population is eligible to receive care in pre-designated Medical Special Needs Shelters provided that appropriate skill set can be provided at the shelter. The Medical Special Needs population has difficulty evacuating, cannot arrange their own sheltering, have physical or mental conditions that limit their mobility and ability to function on their own, and have no other recourse to care.

3. Medical Special Needs Shelters are shelters pre-designated by state and local Offices of Homeland Security and Emergency Preparedness (OHSEP) to house individuals who have difficulties evacuating, cannot arrange their own sheltering, have physical or mental conditions that limit their mobility and ability function on their own, and have no other recourse to care.
4. All Parish and State government agencies, private, and non-profit organizations, and volunteer groups will cooperate to ensure that the most effective and efficient assistance possible is provided to the vulnerable populations in times of emergency.

5. In an emergency, Parish and State government authorities will encourage the evacuation of vulnerable populations with their families well before calling for mandatory evacuation of the general population

PART II: AT-RISK POPULATION PLANNING

Although Parish governments have overall responsibility for medical special needs shelters in their jurisdictions, the State-operated Regional Medical Special Needs Shelters provide support depending on the circumstances. The Department of Children and Family Services (DCFS), the Department of Health and Hospitals (DHH), the Louisiana State University (LSU) system, public and private hospitals, other state agencies, volunteer organizations, as well as other public and private entities, will be called upon to support the Parish and Regional MSN Concept as required.

There exists a growing vulnerable population in Louisiana. This population is seen in the health care facilities and agencies, such as Nursing Homes, Group Homes, Home Health, Assisted Living and other health care facilities. All such healthcare facilities will have emergency plans with provisions equaling or exceeding the provisions prescribed by licensure.

A. Nursing Homes

Nursing Home patients are lodged in and cared for on a permanent basis in their nursing homes. The nursing homes have a custodial responsibility for their patients. Patients are not expected to leave their nursing homes in the normal course of events unless their condition deteriorates so much that it requires them to be admitted to a hospital or other serious care facility. Nursing homes are expected to make all arrangements to evacuate and shelter their patients in emergencies. DHH maintains a directory of nursing homes and the number of beds for which they are licensed. Nursing homes generally run at 70% capacity or higher. Nursing homes have facilities, on-site staff and some transportation.

1. **PLANNING:** Nursing Home facilities will evaluate their patients and assign them to categories in accordance with the instructions in the Louisiana Model Nursing Home or Home Health Emergency Plan.
2. **PATIENT CARE:** Nursing home patients that meet hospital admit criteria will be evacuated, whenever possible, to hospitals or other health care facilities in which extensive care can be arranged. It is the responsibility of Nursing Homes to seek out the appropriate care from other providers to ensure the safety of their patients during disasters. Prearranged agreements shall be made as appropriate between Nursing Home facilities and/ or other health care providers to ensure their patients' safety.
3. **SHELTERING:** Nursing homes are responsible for alerting their residents and their families or responsible parties of the decision to evacuate/shelter. Nursing Homes shall not use Medical Special Needs Shelters as a planned option for patient care. Nursing Homes should not transfer to a higher level of care (only for those that meet admission criteria) but should have pre-arranged/pre-identified alternate sheltering locations – ie. Another NH, school or other properly equipped facility.

4. **TRANSPORTATION:** Nursing Homes are expected to make all arrangements to evacuate and shelter their patients in emergencies. Plans shall provide for professional staff to accompany evacuating Nursing Home patients so that care will continue to be provided by customary caregivers. Nursing homes will make arrangements to move their patients to host facilities according to the guidance in the Model Nursing Home Plan.
- a. Nursing homes have some transportation of their own. They may not, however, have sufficient transportation to move all their patients, staff and staff families at one time to a location outside the parish in an evacuation. Nursing homes will contract in advance with commercial carriers for emergency transportation for patients, staff and staff families. Ambulance companies may be consulted, but nursing home officials must be aware that, in an emergency, ambulances will be sought after by other nursing homes and health care agencies, as well as hospitals and clinics. Evacuation traffic accidents could produce enough injuries to tie up all of an area's ambulances.
- b. Parish authorities will instruct nursing homes and similar congregate care facilities to evacuate early in an emergency, well before they instruct the general population to evacuate. This will be done in order that the nursing homes will have ample time to confirm transportation arrangements and put their patients on the roads before road travel is slowed by congestion. This action will minimize the potential for physical and mental discomfort that would be caused by lengthy traffic jams.
5. **COMMUNITY TRANSPORTATION ASSISTANCE:** The Nursing homes, Home Health agencies, hospitals, and other organizations or agencies, which provide care to patients, but do not have enough transportation for all patients for all emergencies, will arrange for supplemental transportation. If their prearrangements fail, so that they cannot arrange for transportation, the agencies will report their shortfalls to the parish OHSEP in the parish in which the patients are located.

The Parish OHSEP will take in, collate, and report transportation needs in excess for their community capacity to the Governor's Office of Homeland Security and Emergency Preparedness (GOHSEP).

GOHSEP will consolidate transportation needs and report them to the ESF responsible for transportation. ESF-1 will compare the lists of transportation needs with organic assets, and, if the needs exceed assets, ESF-1 will arrange for supplemental transportation assistance from other state agencies, the Federal Government, private businesses, or other organizations, and volunteer groups.

Appendix 10c identifies the ESF-1 support Plan for the Transportation of Nursing Home Patients

B. HOME HEALTH PATIENT POPULATION:

Home Health patients receive treatment in their homes on a regular schedule from health care professionals and therapists. The patients may have mild or serious conditions. They may receive treatment or therapy on a short term basis after being released from a hospital stay caused by an illness or operation, or they may have a continuing physical condition. Home health agencies do not have facilities, numerous staff, or other physical resources, such as transport. Professional staff may treat people in several different parishes.

1. **PLANNING:** Home health agencies are required by the Home Health Model Plan to evaluate the condition of each patient. Based on the patients' condition, they will be categorized as Hospital Based Shelterees or Medical Special Needs shelterees. Home Health agencies shall report this information using TAB A of the Model Home Health Emergency Plan.

2. **MEDICAL SPECIAL NEEDS SHELTER ELIGIBLE PATIENTS:** The home health agencies are required to report only the Medical Special Needs Shelter eligible patients who would require public assistance in an emergency, to the Office of Homeland Security and Emergency Preparedness (OHSEP) in each parish in which patients in need are located. The reports are due yearly, in May, or more frequently if the agency can manage. Parish OHSEP's will use the reports of people who need community assistance to develop transportation and sheltering requirements. The information on individual patients' physical condition may change, but the reports will give the parish OHSEP a rough estimate of the numbers of Home Health Patients needing public assistance in an emergency.

3. **TRANSPORTATION:** Home Health agencies do not have facilities, equipment, or transportation for their clients. Home Health agencies serve patients in a fifty mile radius, which could include several parishes. The people who are responsible for the patient; family, caregivers, friends, or neighbors, will be informed of the need for transportation in emergencies. Home Health agencies will assist the patient or the patient's responsible people in making transportation arrangements.

a. **Pre-Disaster Communication:** Each year, in May, or more frequently if the agency can manage, the Home Health agency will inform the Parish OHSEP in which such patients reside of the location and condition of Special Needs Shelter eligible patients who need community assistance for evacuation. This information is communicated using TAB A of the Model Home Health Plan.

b. **Disaster Communication:** When an emergency arises, home health agencies are required to send updated lists of only those Special Needs Shelter eligible patients who need assistance from the community to the Parish OHSEP in each parish in which they have such patients. The list will consist of only those patients who cannot get assistance from any other source. It will not be a list of the agency's entire patient roster.

c. Parish authorities will instruct home health agencies, their patients, and their caregivers, to evacuate early in an emergency, well before they instruct the general population to evacuate. This will be done in order that home health agencies, patients, and their caregivers will have ample time to confirm transportation arrangements and get the patients on the roads before road travel is slowed by congestion. This action will minimize the potential for physical and mental discomfort that would be caused by lengthy traffic jams.

4. **COMMUNITY TRANSPORTATION ASSISTANCE:** The Nursing homes, Home Health agencies, hospitals, and other organizations or agencies, which provide care to patients, but do not have enough transportation for all patients for all emergencies, will arrange for supplemental transportation. If their prearrangements fail, so that they cannot arrange for transportation, the agencies will report their shortfalls to the parish OHSEP in the parish in which the patients are located.

The Parish OHSEP will take in, collate, and report transportation needs in excess for their community capacity to GOHSEP.

GOHSEP will consolidate transportation needs and report them to the state agency responsible for transportation, ESF-1. ESF-1 will compare the lists of transportation needs with organic assets, and, if the needs exceed assets, ESF-1 will arrange for supplemental transportation assistance from other state agencies, the Federal Government, private businesses, or other organizations, and volunteer groups.

PART III: MEDICAL SPECIAL NEEDS SHELTERING NETWORK

There are three (3) types of shelters. General shelters, medical special needs shelters and hospital-based shelters. These types of shelters provide a triage network of shelter care for vulnerable patients. Depending upon the acuity of the patient, potential patients can be triaged to a general shelter, special needs shelter or a hospital shelter.

Agencies with special needs patients/vulnerable populations – especially those providing residential service such as group homes, assisted living facilities, etc - are required to make every effort to secure emergency shelter for their patients for two types of emergencies, Parish and regional. MSN agencies are expected to arrange for shelter in nursing homes, other health care facilities, lodging facilities, business facilities, or other facilities that can support MSN patients with a minimum deterioration in the patients' conditions.

Parish emergencies, such as fires, tornadoes, hazardous materials incidents, or flooding, may require an evacuation of a few miles, possibly within the same city or parish. Regional emergencies, such as a catastrophic hurricane, or widespread flooding, may require an evacuation of fifty (50) or more miles.

A. MEDICAL SPECIAL NEEDS SHELTERING

There exists local pre-designated Medical Special Needs Shelters and State Regional Medical Special Needs Shelters. These shelters are listed in Appendix B. Parishes have designated Parish MSN shelters and the State has designated regional MSN shelters, primarily for medically dependant individuals who do not require care in a hospital setting, and whose pre arrangements have failed and left the patients with no other recourse. Regional Shelters will be used to support the Parish OHSEP's only after Parish resources have been totally exhausted. Parish resources refer to the required parish operated minimal Medical Special Needs Shelter.

Medical Special Needs Shelters are shelters pre-designated by state and local Offices of Homeland Security and Emergency Preparedness (OHSEP) to house individuals who have difficulties evacuating, cannot arrange their own sheltering, have physical or mental conditions that limit their mobility and ability function on their own, and have no other recourse to care.

All Parish and State government agencies, private, and non-profit organizations, and volunteer groups will cooperate to ensure that the most effective and efficient assistance possible is provided to the vulnerable populations in times of emergency.

In an emergency, Parish authorities will encourage the evacuation of medically vulnerable populations with their families well before calling for mandatory evacuation of the general population.

PARISH MEDICAL SPECIAL NEEDS SHELTER CONCEPT:

PARISH EMERGENCIES: When emergencies are localized and require an evacuation within one parish, or, at most, to an adjoining parish, Medical Special Needs people in hospitals, nursing homes, other health care organizations, and home health situations in that Parish will only need local evacuation to hospitals and shelters.

The Parish Medical Special Needs Shelter will be the primary responsibility of the Local Director and will be supported by the State if State assistance is requested and coordinated before the emergency.

If the Parish capacity or resources are exhausted, arrangements should be made with OHSEP to expand and support Parish operations. The State may initiate regional special need shelters if other approaches are not adequate.

REGIONAL MEDICAL SPECIAL NEEDS SHELTER CONCEPT:

Regional Medical Special Needs Shelters may be activated by Unified Command at the request of the Parish OHSEP Directors or when deemed appropriate by Unified Command, as it becomes evident that all Parish resources will become exhausted. Regional Medical Special Needs Shelters will be under the direction and control of the State.

Regional sites have been pre designated and consist of State Hospitals, State Universities, and other facilities as listed in Appendix 10b.

Regional medical special needs shelters will receive support from state agencies.

- a. ESF-6, DCFS will provide administrative control and support personnel.
- b. ESF-8, DHH will coordinate the medical operations and support within the Regional SNS. LSU will provide support as available.
- c. Other state agencies, private industries, non-profit organizations, and volunteer groups will be tasked by ESF-6 or ESF-8 to assist in setting up and running the shelters as needed.

Appendix 10 references the ESF-8 support plan to ESF-6.

B. HOSPITAL-BASED SHELTERING

Hospitals play a role in Medical Special Needs sheltering Plan. The condition of the patient determines which shelter the evacuee is referred to. There are general shelters, medical special needs shelters and hospital based shelters.

The LSU System is the lead state agency in the area of regional hospital emergency operations in support of MSN people. The LSU System will work with DHH and The Louisiana Hospital Association, the Metropolitan Hospital Council of New Orleans, and other hospital and health care organizations in order to formulate procedures for accepting and allocating evacuees during emergencies. Such procedures will become a part of this plan by reference.

The LSU System will be the core hospitals providing support to Hospital Based Evacuees who cannot be accommodated elsewhere.

Public and private hospitals may elect to be a part of the Medical Special Needs Sheltering network (Appendix 10e – Sheltering Memorandum of Understanding). The hospitals which elect to be part of the network will sign the Regional Memorandum of Understanding. The MOUs will be on file with the DHH/ Office of Public Health Regional Medical Director and the local and state OHSEP offices.

C. GENERAL SHELTERING

There is a need to have both general shelters opened as well as hospitals identified in those areas that have activated a Medical Special Needs Shelter. The underlying purpose is for triage: For those individuals that are too critical, hospital placement may be necessary. For those that are not critical, general shelters are appropriate. Having hospitals available and regular shelters available will decrease some of the volume of individuals seeking shelter and allow access to appropriate level of care.

- a. American Red Cross, other state agencies, private industries, non profit organizations, and volunteer groups will be tasked by local OHSEPs to assist in setting up and running local general shelters as needed.
- b. ESF-6, DCFS provides centralized reporting for sites and evacuees registered at each local shelter opened.
- c. Critical Transportation Needs Shelters are state operated shelters organized and resourced by ESF-6. CTNS are general shelters for individuals that do not have transportation assets and are dependent upon community resources for transportation and sheltering. CTNS concept of operations - and medical support to the CTNS – is found in Annex IX.

FEDERAL AUGMENTATION AND SUPPORT TO MEDICAL SPECIAL NEEDS SHELTERING

Although the State of Louisiana has the capability to care for a portion of the special medical needs residents in MSNS across the state, they may need assistance with sheltering special medical needs residents in a 12 coastal parish evacuation scenario. DHH and DCFS have identified staffing and resources to operate MSNS for 1400 special needs evacuees in state-operated MSNS using state resources.

The State would request Federal ESF-8 resources to assist in the shelter of the remaining 1,000 special needs population. Federal resources will be used when State care resources are exhausted. Each FMS provides a medical supplies and pharmaceutical cache to support 250 beds; the FMS kits are staged regionally and available within hours to three identified sites in Louisiana.

FMS are stand-alone, meaning they are not co-located with a MSNS or a general population shelter. The provision of support services such as meals, toilets, supplies, etc., will be through a combination of local, State, and Federal agencies.

Table 1. - Sub-tasks Special medical needs

Sub-task	Agency	Patients Affected
A. Establish, staff and support Medical Special Needs Shelters (MSNS)	State DHH & DCFS	1,400 Special medical needs population
B. Deploy, staff and support up FMS as MSNS	Federal ESF-8	Up to 1000 special medical needs population

Roles and Responsibilities for Medical Special Needs Shelters Medical Needs

All MSNS will be state-run or federally-run facilities; there is no direct local oversight. LA DHH and DCFS will set up and operate 1,400 beds in pre-designated MSNS. DHH state medical staff resources include Louisiana State University (LSU) hospital staff, supplies and other resources as available; nursing, pharmacy, and EMS volunteers (listed in a database maintained by DHH); and MSNS health and medical staff arranged through Emergency Management Assistance Compact (EMAC). If the personnel and/or beds available for medical special needs people exceeded state capacity, request for assistance will go to the Federal ESF-8 partners.

An ALS ambulance will be staged at the MSNS for transport to local hospitals in the event of a medical emergency. State EMS is responsible for command and control of federally contracted ambulances used at MSNS.

Ambulances staged at each FMS will be contracted by LDHH or the Federal Government and will have a contractor officer assigned for oversight of the contract.

Staffing at the FMS sites will be provided by Federal ESF 8. Additional staffing needs may be requested from volunteer programs such as MRC and ESAR/VP.

Operations

If requested by the State, Federal ESF-8 will provide personnel and medical equipment and supplies to support the state mission at the state-run MSNS. Personnel to augment the state-run shelters may be drawn from the Federal ESF 8 or the MRC.

Staffing for FMS will provide for a resident care staffing ratio of 1:10. If needed, an acute care team may be co-located at FMS sites to provide for the medical needs of patients that may decompensate beyond a level that can be safely managed by the FMS providers. An ambulance with either EMTs or paramedics will be staged at the MSNS-FMS.

The request for FMS will be made at H-72 hours, based on an anticipated medical special needs population in excess of State capability (1400 beds). The anticipated time to be operational is between H-54 to H-48 hours. Personnel for FMS will be alerted at H-96 hours. FMS require food service, sanitation, medical waste disposal, trash pick-up, security, water, and redundant communications. The provision of these support services has been agreed upon and is managed through a collaboration of local, State, and Federal agencies.

Table 2. - Louisiana Medical Special Needs Shelter Locations and Capability

Scrubbed Data

Appendix 10g further identifies Medical Special Needs Shelter locations and contact information.

ANNEX XI
FEDERAL MEDICAL STATION (FMS)

(Under Construction)

ANNEX XII

MASS PROPHYLAXIS

Mass prophylaxis is accomplished to protect the health of Louisiana citizens through the administration of drug prophylaxis or vaccination in response to a public health emergency. Mass prophylaxis is accomplished in a timely manner to prevent the development of disease among those exposed or potentially exposed. Mass prophylaxis planning includes the capability to provide follow-up and monitoring for adverse events in those receiving prophylaxis. Effective risk communication to the public is essential in mass prophylaxis campaigns.

In response to the affects of a tropical storm or hurricane it becomes necessary to have a mass prophylaxis campaign, the campaign will take place at the general and Medical Special Needs Shelter sites for displaced persons. All other potentially affected citizens will receive prophylaxis as indicated in the point of dispensing planning section of the Louisiana Strategic National Stockpile (SNS) Plan.

Assets and Functions

Local/Parish

- Regional planning has identified over 200 facilities that could serve as regional points of dispensing sites.

State

- The State maintains a cache of drugs to begin a prophylaxis campaign.
- Louisiana is scored by the Centers for Disease Control (CDC) for receipt of Federal assets from the Strategic National Stockpile.
- Louisiana is one of only a few states to have experienced a SNS deployment. This occurred during Hurricanes Katrina and Rita.
- There are several CDC approved receiving, staging, and storing (RSS) sites within the State.
 - The Louisiana National Guard normally operates warehousing functions under the direction of the DHH Office of Public Health (DHH/OPH), but assistance through EMAC may be needed.
 - Local and State Police normally operate security functions, but assistance through EMAC may be needed.
 - The Louisiana National Guard normally operates distribution functions under the direction of the DHH/OPH as well as providing backup distribution security, but assistance through EMAC may be needed.
 - ESF #7 has crossover responsibilities; the lead State agency is the Governor's Office of Homeland Security and Emergency Preparedness.

Federal

- HHS headquarters maintains contracting mechanisms for medical equipment and supplies, including pharmaceuticals.
- The SNS includes Push Packs and Managed Inventory, and provides on-site technical assistance. Additional procurement mechanisms exist through VA and DOD.

Command and Control

- The State DHH/OPH operates the RSS with assistance from assets obtained through EMAC (e.g. personnel and transportation) and Federal assets (e.g. TARU) as needed.
- The State DHH and Office of Emergency Preparedness maintain communications with Federal ESF #8 at the Joint Field Office (JFO) through the ESF #8 liaison at the State EOC.
- Federal ESF #8 functions in the field are conducted by the ESF #8 Incident Response Coordination Team (IRCT).

Operations

- The Federal IRCT, and State Offices of Public Health Emergency Preparedness (OPHEP)/OPO/OPEO works with the Federal Advanced and National Emergency Response Teams (ERT-A and ERT-N) and Federal Regional and National Response Coordination Centers (RRCC/NRCC) to pre-identify and prioritize assembly areas of pre-deployment of medical supplies to strategic locations.
- Requests for health and medical equipment and supplies will be submitted through EMAC or the ARF/MA process. The DHH Emergency Operations Center (EOC) forwards requests for Federal assistance to the State EOC.

Logistics and Communications Support

- The State logistics cell provides support through the State EOC.
- ESF #8 logistics support is coordinated through FEMA logistics at the JFO.

Reporting and Planning

- The Federal ESF #8 Technical Assistant to the DHH Emergency Operations Center (EOC) will track requests for and deliveries of medical equipment and supplies and report this information to State and Federal ESF #8 leadership.
- The following essential elements will be reported to maintain a Common Operating Picture (COP):
 - Requests for medical equipment and supplies, including quantity and types of items requested, purpose, source, and location of request.Quantities of medical equipment and supplies ordered, enroute, and delivered.

ANNEX XIII

State of Louisiana Department of Health and Hospitals All Hazards Behavioral Health Plan

INTRODUCTION

A disaster can be large or small and can occur with or without warning. The type of disaster influences the duration and severity of psychological distress experienced by individuals and communities and the type of response needed. This distress is often a normal reaction to an abnormal or unusual situation. For various reasons, some people in Louisiana may be more vulnerable or at risk for experiencing distress as a result of disaster. A diverse pool of behavioral health professionals and community responders must be prepared and poised to act in a coordinated manner to adequately address the psychological and/or social needs of people impacted by disaster.

The Louisiana Behavioral Health All-Hazards Disaster Response and Recovery Plan is organized to create an easy-to-use guide for State level personnel responsible for the behavioral health care of those affected by the disaster. The plan narrative includes:

- General assumptions upon which the plan is built
- Concept of operations in a disaster
- Identification and deployment of disaster behavioral health personnel

PURPOSE

The purpose of this plan is to provide a framework for organizing the behavioral health response to disasters in Louisiana. Behavioral health in Louisiana includes mental health, substance abuse, and addictive behaviors assistance for citizens with developmental disabilities. Behavioral Disaster behavioral health services can help mitigate the severity of adverse psychological effects of the disaster and help restore social and psychological functioning for individuals, families, and communities. This plan is meant to be a dynamic document that can be modified to incorporate changing technologies and emerging best practices in behavioral health. The plan provides guidelines for use by the Louisiana Department of Health and Hospitals in its role as state coordinator of behavioral health care related to disaster.

GUIDING PRINCIPLES

These guiding principles provide the basis for organizing and developing the behavioral health response to disaster in Louisiana.

1. All-hazards response is a local responsibility first.

The first response to a disaster always occurs locally. The capacity to respond to the psychological effects of disaster must also be organized and implemented at the local level first.

Local planners understand the cultural, social, and psychological needs of people in their area. The Louisiana Behavioral Health Plan builds on the strengths of our communities.

2. Disaster behavioral health is part of a larger, multi-layer, multidisciplinary disaster response.

Disaster behavioral health responders work in concert with health care providers, public health, emergency management, first responders, and Louisiana Voluntary Organizations Active in Disasters (VOAD). The agencies responsible for the ESF-8 Behavioral Health care are Office for Addictive Disorders, Office for Citizens with Developmental Disabilities and Office of Mental Health.

3. The public behavioral health disaster response in Louisiana is organized and coordinated via the ten behavioral health regional areas in Louisiana.

The State recognizes that local behavioral health disaster resources are limited or may be overwhelmed if the effects of the disaster are severe or widespread. Regional coordination of human resources facilitates mutual aid and pooling of resources, and provides a single point of contact if additional resources are needed.

4. State level involvement in the behavioral health response to disaster builds upon the structure and organization of the local response.

Human resources mobilized by the State will build upon the structured response identified by the local entity responding first to the disaster. The State will augment, not replace, community structures already in place to deliver disaster behavioral health services.

5. Louisiana Voluntary Organizations Active in Disasters are valuable partners in meeting the psychological and social needs of people in disaster.

Disaster behavioral health interventions may be systemic and long-term, with the goal of restoring or rebuilding the social fabric of a community.

The limited number of licensed behavioral health professionals in Louisiana, and the tendency of people to seek assistance from natural support systems, creates a need for Disaster Behavioral Health Professionals to serve as consultants and a resource to natural support systems.

Individual disaster behavioral health services must be appropriately delivered, and adjusted accordingly to be gender and culture sensitive, linguistically, and developmentally appropriate, and suitable for the type, scope, and phase of the disaster.

Interventions during disaster response and recovery should be based on accepted professional standards and practices, to the extent possible.

DISASTER SITUATIONS COMMON TO LOUISIANA

The geography, location, and resources in Louisiana create vulnerabilities to disaster in the state

such as:

Natural Hazards

- **Weather related disaster** such as tornados, floods, drought, wind, hurricanes and infrequently ice storms.

Technological Hazards

- **Biological or Chemical** disaster risk for Louisiana is largely unknown, though the agricultural and industrial nature of the State creates unique vulnerabilities in this area. Risks to crops, food production, or the animal industry through intentional or unintentional contamination or disease could result in a number of economic and psychological consequences. Risk of chemical disaster is highest for chemicals such as anhydrous ammonia and other agricultural chemicals.
- **Nuclear** disaster risk is related to the transportation and storage of nuclear waste, and the presence of two nuclear power plants in Louisiana
- **Transportation** system accidents (railroad, busing, trucking, air travel).

Security Hazards

- This includes terrorist events or disasters linked to illegal activity resulting in community trauma or disruption. The psychological consequences related to these events tend to be more pronounced than for disasters stemming from natural or technological hazards.

CONCEPT OF OPERATIONS

Local Response Structures

Local Emergency Management structures are organized by parish in Louisiana. Local jurisdictions are responsible for initial response to a disaster. Each parish has a Local Emergency Operations Plan (LEOP). The local plan may contain information about how that county intends to meet the psychological and social needs of people in that area after a disaster.

Coordination of the Behavioral Health Disaster Response

The Local Emergency Operations Plan and the Local Public Health Emergency Response Plan may designate someone from the area as a disaster behavioral health coordinator. Local areas are in the best position to understand what may work best with the human resources available. However, emergencies can occur that require more assistance from behavioral health disaster resources than are available in the local area. For this reason, the Behavioral Health Regions serve as the primary local link to regional resources.

Regional Behavioral Health Authorities will designate staff or volunteers to serve as Regional Disaster Behavioral Health Coordinators. These coordinators will serve as a link with emergency management, public health, and other agencies and organizations within communities, and with

State agencies. The State will look to the Regions to provide local behavioral health information needed to prepare a FEMA Crisis Counseling grant application if a disaster occurs that makes the area eligible.¹⁷

State level coordination of resources during a disaster occurs only when local and regional resources are inadequate or overwhelmed. Behavioral Health Partners are responsible for maintaining capacity and readiness on the state level to assist communities in meeting their behavioral health needs following a disaster. The Assistant Secretaries of the Behavioral Health agencies will designate staff, volunteers, or personnel from other State entities with requisite experience and knowledge to serve as State Disaster Behavioral Health Coordinators. These coordinators will serve as liaisons from the State Behavioral Health to Regional Behavioral Health Authorities, to other Louisiana State agencies, and to other states with disaster behavioral health needs. Links to the Louisiana Governors Office of Homeland Security Emergency Preparedness Agency (GOHSEP) are particularly important, as GOHSEP is a link to all other emergency management activities in the state.

Coordination with Other Disaster Response Functions/Agencies

The Louisiana Governors Office of Homeland Security and Emergency Preparedness Agency (GOHSEP) maintains the State Emergency Operations Plan (SEOP). The SEOP places DHH/OPH in charge of organizing and activating the behavioral health disaster response for the state, not including the normal deployment of volunteer agencies.

Local emergency management and local public health departments coordinate with Regional Behavioral Health Authorities to identify local behavioral health providers and response agencies, and to identify someone who can serve as the primary local Behavioral Health disaster response contact.

Overview of Actions Before, During, and After a Disaster

Before a Disaster Occurs - Preparedness

Local Activities

Review Local Emergency Operations Plans with local emergency managers to become familiar with existing plans to meet the behavioral health needs of those affected by a disaster in the area.

Familiarize behavioral health providers and volunteers with the Incident Command System,¹⁸ an approach that details a strategy to define how behavioral health, public health, emergency management, hospitals, and other responders prepare, coordinate, and respond to an event.

Hold joint exercises to test emergency plans. Encourage inclusion of behavioral health responders along with hospitals, public health, and first-responder agencies.

Make psychological first aid training available to all involved in disaster response, specifically targeting community responders who may augment the behavioral health response to disaster.

Record key response contacts for behavioral health

Regional Activities

Identify staff or volunteers who may serve as a part of the Behavioral Health Team

Foster relationships between Emergency Managers, Public Health Departments, and those responsible for responding to behavioral health disaster needs in each parish included in the Behavioral Health Region.

Work with local Emergency Management and Public Health Departments to ensure that Local Emergency Operations Plan(s) and the Public Health Emergency Response Plan(s) contain sections addressing behavioral health.

Develop and keep up-to-date Regional plans to activate Disaster Behavioral Health Coordinators.

Forward contact information for Disaster Behavioral Health Coordinators to local Emergency Managers, the local public health department(s), and the State Division of Behavioral Health.

Foster training opportunities related to disaster behavioral health response in the Region, and make available information about trainings.

Distribute forms and materials that may be needed as part of disaster response.

State Activities

DHH designated offices identifies State Disaster Behavioral Health Team.

The DHH creates, fosters, and/or makes available information about training opportunities related to the psychological and social aspects of disaster response and recovery.

State Behavioral Health stakeholders meet regularly to:

- Review the Louisiana Behavioral Health All-Hazards Disaster Response and Recovery Plan
- Participate in State-level disaster exercises and/or training
- Make key contacts with State-level response agents
- Make key contacts with Regional Disaster Behavioral Health Coordinators

After a Disaster Occurs - Response

No flowchart or list of duties can accurately depict the exact sequence of events for every disaster response. A suggested flow of communication and authority following a disaster is provided.

1. Once a disaster occurs, local entities are tasked with conducting an initial assessment of the

behavioral health needs of individuals and the community affected by the disaster.

2. The Regional Behavioral Health Team should work with local resources to track the scope of the response from its onset including:

The number and type of behavioral health resources deployed

- Organizations & Individuals
- Volunteers & Paid Responders

The number and type of individual contacts made by behavioral health responders

Costs incurred as a result of the deployment

1. The Regional Disaster Behavioral Health Team, in consultation with local resources, will notify local emergency management and local public health departments if the disaster type, size, or scope overwhelms the ability of local and Regional resources to adequately respond to the psychological and social needs of those affected by the disaster. (Regional Disaster Coordinators should also notify the DHH Behavioral Health Section of this decision so that locating additional resources can begin. The Division of Behavioral Health will receive the official request for additional resources through the Emergency Management system.)
2. Local Emergency Management notifies the Louisiana Emergency Management Agency that area resources in disaster behavioral health are overwhelmed and that additional assistance from the State is required.
3. The Louisiana Emergency Management Agency follows the protocol laid out in the State Emergency Operations Plan and notifies the Director of the Department of Health and Hospitals that State involvement is needed to support the behavioral health response in the affected area.
4. The Department of Health and Hospitals, Behavioral Health Partners, assigns the State Disaster Behavioral Health teams to work with Regional Disaster Coordinators, the American Red Cross, identify and deploy appropriate resources to the affected area.
5. Once the disaster progresses through the response phase toward recovery, the Behavioral Health Partners work with the Behavioral Health Regions to identify recovery needs related to behavioral health in the affected area.

After a Disaster Occurs – Recovery

Recovery is a process that occurs over time for individuals and communities. Behavioral Health needs in recovery are dependent upon a number of factors, including the pre-existing state of individuals and communities, the nature, scope, and severity of the disaster, and the type of assistance that is made available through formal response mechanisms.

1. First Responders may be aided in the recovery process through the state Behavioral Health programs.

Generally, recovery is a local responsibility but there may be opportunities for assistance from Federal and State resources to meet this responsibility.

2. Declarations of disaster by the Governor may increase the likelihood of resources becoming available to the affected area to aid in recovery.
3. Declarations of disaster by the President may create opportunities for public reimbursement for response activities and may create the opportunity to apply for the FEMA Crisis Counseling Program
4. Local and Regional behavioral health personnel should be encouraged to join any long-term needs groups that may form in the affected area following disaster.
5. Regional Disaster Coordinators should report recovery needs and progress to the State Behavioral Health Partners through State Regional Representatives assigned to that Region.
6. The Behavioral Health Partners monitor activities and needs of affected areas so it is in a position to advocate for resources and funding if they become available.

SITES OF INTERVENTION

There are a variety of sites where behavioral health disaster responders may be needed. On an important note, behavioral health providers are often not needed at the site of the incident. Although it is a normal response to want to rush to these sites to be of assistance, the assistance that behavioral health responders provide will most likely be needed later, rather than at the time of immediate crisis. More importantly, these providers may impede the progress of rescue operations, and possibly place themselves at risk of injury.

Local and Regional Behavioral Health Disaster Teams should be prepared to deploy behavioral health disaster response workers to the following sites as personnel are available:

- Sites where survivors and families of victims gather
- Shelters, meal sites, disaster application centers, Red Cross service centers, hospitals, schools, police stations, survivors' homes, morgues, farms or ranches, etc.
- Mass care centers
- Mass clinics for immunizations and/or prophylactic medications
- Sites where first responders and other response workers gather
- Sites conducive to community education and outreach
- Community centers, shopping malls, schools, religious centers, business associations
- Newspapers, Radio, TV, Internet

- Organizations who request behavioral health response services
- Businesses, affected neighborhoods, farms or ranches

Meeting the needs of those already in the behavioral health system, such as those with severe mental illness or substance abuse issues, and developmental disabilities needs must also be considered.

A plan for continuity of services is primarily the responsibility of the service provider or facility.

In some situations, however, current service provision will need to be augmented with disaster behavioral health services. Those with current behavioral health issues are particularly vulnerable to experiencing strong reactions to a disaster. Service providers should recognize when their clients are affected by a disaster and request additional resources when needed from the Regional Behavioral Health Authority covering their area.

State Behavioral Health Coordinators should be prepared to work with Regions to identify behavioral health personnel to:

- Staff state sponsored hotlines
- Respond to the behavioral health needs related to disaster of State operated facilities in affected areas.

SPECIAL SITUATIONS

The following special situations have either additional task requirements, or special organizational details to be considered when deploying disaster behavioral health resources. The Behavioral Health Partners are responsible for coordinating these details.

State Declaration of Disaster

Work closely with the GOHSEP to determine if State resources are available to fund deployment of personnel. A State declared disaster may also place some state employees in a position to respond either as part of the disaster behavioral health response (if qualified) or as part of an American Red Cross response.

Presidential Declaration of Disaster

If a presidential disaster declaration makes individuals eligible for assistance, a Federal Emergency Management Agency (FEMA) Crisis Counseling Training and Assistance Program (CCP) grant must be applied for within 14 days of the declaration. The Immediate Services Program (ISP) Application covers the first 60 days of services. A Regular Services Program (RSP) Application is due within 60 days of the presidential declaration, and provides funds for an

additional 9 months of services.

Activation of State Emergency Operations Center (EOC)

If the State Emergency Operations Center (EOC) is activated, the State Disaster Behavioral Health Team takes the following actions:

- Work with the Public Information Officer (PIO) to activate a Risk Communication Consultant if needed and release messages that foster calm rather than panic.
- Work with Regional Behavioral Health Authorities to identify behavioral health personnel to consult in any call centers that are activated by the State.
- Communicate regularly with local and/or Regional behavioral health contacts at the disaster site to obtain status reports and provide updates on state activities related to disaster response.
- Ensure that State response teams have access to qualified behavioral health service during and following their assignments.
- State Behavioral Health Teams or staff from the Behavioral Health Partners may be asked to travel to the disaster site to assist local and Regional resources in assessing behavioral health needs or coordinating the behavioral health response. This may be done as part of the staff person's regular job, or as a volunteer activated by the Louisiana Emergency Management Agency. Remuneration of expenses incurred by the volunteer or the State Agency may not always be possible.
- A daily log of activities should be kept by Coordinators and passed from shift to shift.

Requesting Assistance from Other States

If the type, scope, or scale of a disaster is such that behavioral health resources from other states are needed, the Interstate Emergency Management Assistance Compact (EMAC) should be activated. To request behavioral health resources from other states, the State Disaster Behavioral Health Team sends a request to the ESF #8 Coordinator. The ESF #8 Coordinator contacts the director who will follow the standard operating procedures for requesting assistance from other states.

State Operated Facility is Involved in the Disaster

Louisiana Department of Health and Hospitals oversees facilities that provide behavioral health services and support

- Refer to the disaster plan of the facility for operational details.
- Work with the facility management to determine if additional resources are needed by consumers, staff, and their families to meet the behavioral health needs that result from the disaster.
- Involve local and Regional resources in a behavioral health response to a disaster that involves a state operated facility when possible.
- Contact other state operated facilities to determine if qualified personnel are available to serve as part of the behavioral health response to the affected facility.

Air Transportation Incidents

- According to their agreement with the National Transportation and Safety Board (NTSB), the American Red Cross is responsible for responding to all of the behavioral health needs of survivors of the incident, and families of survivors and victims’.
- The Regional Behavioral Health Partners responsible for the area in which the air transportation incident occurred should be ready to assist with any requests for behavioral health services and supports
- The Regional Behavioral Health Authority is responsible for serving the behavioral health needs of the community in which the incident occurred.

Terrorism/Bioterrorism

Incidents of terrorism, particularly biological or chemical terrorism, create fear and potentially panic. The role of behavioral health becomes acutely important in these instances. The State Disaster Coordinator will advocate for inclusion of a risk communication consultant in planning and discussions with public health, the public information officer, government officials, and law enforcement. The level of security will be higher than for a natural disaster as a criminal investigation will take place.

Instances of quarantine or recommendations to shelter in place should trigger the opening of a hotline that will require continuous staffing by behavioral health professionals.

Agricultural Terrorism / Disease Outbreak

- Agricultural terrorism or disease outbreak that results in depopulation of animals or quarantine of farms/ranches should trigger strategic deployment of professionals familiar with rural issues and community responders able to relate to rural populations. Work with the Regional Disaster Coordinators to insure that these responders in the field communicate their observations and activities to the State Disaster Coordinator.
- Communicate with the State Veterinarian to determine need for local or on site consultation between members of the LEDRS group and behavioral health.

PUBLIC INFORMATION

1. A statewide pool of behavioral health professionals with competency in risk communication, risk assessment, and public information will be identified jointly by the Behavioral Health Team and State Health and Hospitals Public Information Officers. These professionals will assume the role of consultant to State Public Information Officials (PIO’s).

2. The person(s) in this role will generally perform the following functions:

- Review and comment on prepared messages with behavioral health content.
- Consult at the request of the PIO on message development or delivery before, during, or following a disaster.
- Provide consultation to public officials as requested.

- Assist emergency planners and responding agencies in assessing and responding to threats.
- Work closely with the State Disaster Behavioral Health Team and DHH Communications Public Information Officer to monitor information from behavioral health responders in the field, with a goal of quickly identifying trends and concerns that can be brought to the attention of Public Information Officers.

PLAN DEVELOPMENT AND MAINTENANCE

The Behavioral Health Team is responsible for ongoing evaluation and updating of the Louisiana Behavioral Health All-Hazards Disaster Response and Recovery Plan.

The Plan will go through an annual review and updating each year (and at such a time during the year that it can be used to inform the complete review of the State Emergency Operations Plan). Routine corrections and updates of the Plan will occur yearly. Notification and contact lists will be updated annually.

Changes to the plan should be communicated to stakeholders and other response agencies. Changes should be thoughtfully considered and made in a manner that maintains or enhances compatibility with other state plans.

LOUISIANA DISASTER BEHAVIORAL HEALTH ADMINISTRATIVE PERSONNEL

An overview of roles created by the structure used in this plan follows.

DHH Behavioral Health Team

Louisiana will maintain a pool of qualified employees ready to assume the role of DHH Behavioral Health Team. The role will be assumed on a day-to-day basis by a person designated by the Behavioral Health.

Qualifications

- Considerable knowledge of the State Behavioral Health delivery system
- Knowledge of disaster behavioral health concepts and applications
- Experience in behavioral health disaster response preferred, but not required

Regional Behavioral Health Team

Each Regional Behavioral Health Authority in Louisiana will maintain a pool of qualified personnel ready to assume the role of Disaster Behavioral Health Coordinator for its coverage area. The role will be assumed on a day-to-day basis by a person designated by each Regional Program Administrator.

Qualifications

Knowledge of Disaster Behavioral Health concepts and applications

Experience in behavioral health disaster response preferred

- Considerable knowledge of local behavioral health resources
- Considerable knowledge of the State Behavioral Health delivery system
- Serve as state behavioral health liaison to Regional disaster behavioral health contacts, state emergency service/disaster agents, state bioterrorism efforts, and federal disaster agency staff

Represent the agency in the State Emergency Coordination Center if needed Coordinate the administrative tasks listed in Appendices B-1 and B-2 on behalf of the Louisiana Division of Behavioral Health

Roles/Responsibilities

- Serve as regional behavioral health liaison to local behavioral health contacts, parish emergency service/disaster agents, local public health departments, and the State Disaster Behavioral Health Team
- Represent the Regional Behavioral Health Authority with area Emergency Management

LOUISIANA BEHAVIORAL HEALTH DISASTER RESPONSE WORK FORCE

This limited availability of disaster behavioral health resources often leads to reliance on other supports for disaster behavioral health service such as primary health care providers, faith leaders, school personnel, and law enforcement. These professionals may also assume multiple roles in rural communities— volunteer rescue squad member, volunteer fire fighter, mayor, or community leader. The blurring of roles in small communities and rural areas creates challenges for work force identification and deployment in disaster and unique opportunities for cross-training, understanding, and risk communication.

The majority of Louisiana's behavioral health professionals are concentrated in the metropolitan areas of New Orleans and Baton Rouge. Organization of the behavioral health work force for disaster response occurs at the local and regional level. This work force is mostly volunteers and consists of behavioral health professionals, alcohol and drug addiction specialists, faith leaders, health professionals, educators, other human service professionals, and community responders or community members trained to respond to disaster.

Organization of a Behavioral Health Response to Disaster

Regional Behavioral Health Authorities

Actions required to coordinate and organize the work force:

- Work with Regional OAD, OCDD and OMH partners to determine the possible scope and size of local deployment of their disaster behavioral health volunteers
 - Recruit additional unaffiliated volunteers for training and inclusion in the behavioral health response to disaster
 - Collect information from volunteers that will facilitate quick deployment including:
 - Type of responder (i.e., professional behavioral health, faith leader, community responder)
 - Current licensing and training
 - Information on special skills (i.e., bilingual, work with children, etc.)
 - Response affiliations
- The Regions will provide leadership as Louisiana moves toward the development of a listing or database of pre-credentialed disaster behavioral health responders that can potentially respond to a local, regional, or statewide disaster. Precredentialing is important for several reasons:
 - It provides a more accurate picture of Louisiana's behavioral health disaster response capabilities
 - It facilitates quick and strategic deployment of human resources
 - Regional Behavioral Health Teams represent multi-county geographic areas with an existing organizational structure for public behavioral health resources. The Regions already have responsibility related to organization and coordination of emergency behavioral health services in the State. The addition of coordinating capacity development for the disaster behavioral health work force is a natural extension of this responsibility.
 - Pre-credentialing can assist in getting appropriate help to affected areas that may be restricted.
 - For those who are pre-credentialed, information is readily available to confirm their identity and their qualifications so that an access ID can be issued to them quickly. Not being listed in the database does not prevent a qualified disaster behavioral health responder from assisting with the response, but it does take longer to verify their qualifications.

ESF-8 Stress Management Team

This team serves as a resource for addressing the potential psychological effects of disaster for responders in all behavioral health categories. Teams consist of both licensed behavioral health professionals and trained peers. The peers are professionals from the fields served— first responders, including law enforcement, emergency medical personnel, fire fighters, hospital personnel, corrections, and dispatchers. Professionals who are active Stress Management team members are recognized as possessing training and skill sets that make them uniquely qualified to provide services to first responders following disaster.

Health Professionals: Primary Care, Nursing, Hospital Personnel

In many communities primary care physicians and nursing personnel fill the role of provider for behavioral health services. It is recognized that during and after a disaster these professionals may continue to be viewed as the principal conduit for care by affected communities. The Louisiana

plan recognizes the need to include primary care, nursing, and hospital-based personnel in training and readiness activities for meeting the psychological and social needs of people following disaster. These professions possess unique skills and public trust. The behavioral health response to disaster must include close collaboration with community health professionals.

Public Behavioral Health System Disaster Response Personnel

The following sections provide an overview of qualifications and responsibilities for different types of response personnel who may be part of the publicly activated behavioral health response to disaster.

Licensed / Certified Behavioral Health Professionals

The role in a disaster response of individual behavioral health professionals will conform to the scope of practice for that licensed profession.

Qualifications

- Verified current license/certification.
- Basic training in behavioral health disaster response is required for precredentialing
- Advanced training in behavioral health disaster response is encouraged

Responsibilities

- Provide basic support and comfort to the population affected
- Provide specialized care consistent with their profession (i.e., prescribing needed medications, diagnosis and/or treatment of those with previously existing/newly presenting mental illness, treatment of Acute Stress Disorder and/or Post-Traumatic Stress Disorder)
- Supervision of other behavioral health responders (i.e., those with provisional licenses, students training in behavioral health professions,
- During the recovery phase of disaster response, treatment of severe mental disorder, such as post-traumatic stress disorder, depression, anxiety, and other emotional disorders should be undertaken by professional mental health practitioners who have the appropriate training and skills to address the disorder.

Disaster Behavioral Health Community Responders/Natural Helpers

Community Responders may augment the behavioral health response to disaster. Many of these responders already occupy natural helping roles within a community. They may be educators, human service professionals, or community volunteers. Many will self-identify as wanting to be ready to respond or help if a disaster occurs. It is important to note that **even with the appropriate training, not everyone is suited for disaster response work**. Training in psychological first aid can be a first step toward building readiness.

Qualifications

The key personal characteristics and abilities of those who are particularly suited for disaster work are noted below:

- Mature
- Sociable
- Calm
- Knowledgeable about how systems work
- Flexible

- Tolerates ambiguity well
- Empathetic
- Genuine
- Shows positive regard for others
- Good listener

Roles/Responsibilities

- Serve as an empathetic listener
- Provide education and outreach to survivors regarding normal reactions to disaster
- Refer to a professional for assessment if indicated
- American Red Cross mental health disaster response
- Professional peers and behavioral health personnel

Community Responders will not be trained or expected to perform any tasks in disaster response which are best reserved for behavioral health professionals. Initial training should include psychological first aid principles, an overview of disaster behavioral health, and when to refer to a professional.

Faith Leaders

Louisiana recognizes that faith leaders have a special role in disaster response. Faith leaders are uniquely positioned to provide spiritual care for many individuals in an affected population. As part of the provision of spiritual care, faith leaders will also often provide care and support similar to that provided by the trained community responder.

Special Skills

Some faith leaders will have the following special skills and/or training:

- Faith leaders who are Certified Pastoral Counselors (CPCs) are qualified to operate as mental health professionals under the scope of their certification
- Faith leaders who have training in disaster behavioral health response and are pre-credentialed will be called upon to provide spiritual care and support to survivors, families of victims and survivors, emergency responders, and other affected populations

Responsibilities

- Provide spiritual care and support for members of their congregations
- Qualified faith leaders may voluntarily assist in providing emotional and spiritual care for survivors, families of victims and survivors, emergency responders, and other affected populations as part of a Behavioral Health disaster response
- Faith leaders with special skills and who are pre-credentialed may be actively recruited to enhance the care and support functions of a behavioral health disaster response
- Elderly

Training / Education

Different forms of early intervention require different sets of skills, training, and background knowledge. Professionals are encouraged to take part in continuing education activities that enhance their skills and abilities to respond to disaster.

Those with training/experience in the following areas may have special skills that would be useful during a behavioral health disaster response:

Specializations

- Experience with special populations:
 - o Children
 - o Physically disabled
 - o Developmentally disabled
 - o Homeless
 - o Prisoners
 - o People with a history of mental illness
 - o People with a history of substance use/abuse
 - o Farmers/Ranchers/Agricultural workers
- Cultural competency with the following:
 - o Non-English speakers
 - o New Louisianans/Refugees
 - o Cultural sub-groups/Minority populations
- Ability to prescribe medication

Credentialing

Licensed/certified behavioral health professionals should always bring their Professional license with them when they respond to a disaster.

Regional Behavioral Health Authorities and local emergency management agencies are urged to pre-credential volunteer community responders when possible. The Regions and local emergency management should coordinate this pre-credentialing and issue ID's suitable for local response needs to those who participate in trainings and are listed in the Regional responder databases.

Supervision of Responders During Disaster Response

Louisiana recognizes that the initial phases of disaster response are intense and often chaotic, requiring supervisors to be skilled and experienced in disaster behavioral health work. For this reason, supervision of field work should fall to licensed behavioral health professionals, preferably with disaster response training and experience.

1. Adequate clinical supervision of behavioral health disaster responders protects both service recipients and responders.
2. Licensed behavioral health professionals with experience in assuming clinical supervision roles should use the following guidelines to provide "adequate supervision" to behavioral health disaster responders:
 - Be accessible to responders in the field
 - Accessibility includes availability by phone or radio for immediate consultation, and availability on site for intervention or referral
 - Insist that behavioral health responders receive orientation prior to service and opportunities for defusing/debriefing following service
 - Insist that behavioral health responders be deployed in teams – never solo
 - Take time to know the strengths and limitations of the responders assigned to you for supervision

- Consider pairing community responders with licensed behavioral health, use a “buddy system”
 - Insist that behavioral health responders identify themselves to survivors and those they are serving to allow the potential recipient of service to decline if desired
 - Licensed behavioral health responders should identify themselves according to their licensed profession
 - Behavioral health responders should spend adequate time at a site to ensure behavioral health needs are met
 - Insist that behavioral health responders who are licensed behavioral health professionals conform to provision of informed consent when engaging in formal interventions such as debriefing – reviewing the potential risks and benefits prior to beginning the intervention
 - Work with administrative personnel to create reasonable working hours and conditions for those you supervise
3. Geographic areas without immediate access to licensed behavioral health experienced in disaster response should request the addition of such a responder as soon as possible. Community responders assuming a lead role in behavioral health responses in the interim should be cognizant of the guidelines listed above when actively deploying or supervising behavioral health responders immediately following a disaster.
4. The behavioral health response is part of an overall coordinated health response. Clinical supervisors should keep administrative personnel apprised of activities in the field through incident command structures. The clinical supervisors may also be in the field and can forward information to administrators about conditions, responses, and concerns that may contribute to the coordination of an overall response that more effectively meets the needs of those affected