



ALTERNATE CARE SITE GUIDANCE

Alternate Care Site Local Plan Development Guide



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*Cover Photo: Iowa State University gym used as an Alternate Care Site during the flu epidemic of 1918.
Image courtesy of University Archives, ISU Library.*



1. Introduction

One of the steps local communities must take to prepare for the medical response to a disaster or catastrophic mass casualty event is the development of an Alternate Care Site (formerly Alternative Medical Treatment Site) plan. Hospitals across Florida are extremely busy on a daily basis, and in a disaster situation will, therefore, become overwhelmed. It is important that their resources remain available for treating critical patients. One method to achieve this is to open Alternate Care Sites (ACS) to handle the “green-tagged” or “minor” patients. Since medical surge is firstly a “hospital facility” issue and then a “local community” issue, it is important that a local plan be developed ahead of time to facilitate the rapid initiation and operation of an ACS, should one be needed.

The Florida Department of Health has a role in supporting such local operations, when additional assistance becomes necessary. As such, it has developed a State ACS Standard Operating Procedure (SOP) to support these operations. Additionally, it has developed guidelines for communities to use in the establishment, operation, and demobilization of ACSs. Copies of the State ACS support SOP and *ACS Operations Guide* are available on the FDOH website, a link for which can be found in the Section 20 of this guideline.

2. Purpose

The purpose of this document is to provide a guideline (including “steps to be taken”) that can be used for the development of a local Alternate Care Site plan.

3. Resources

A number of good resources are available for communities to use in the development of their local plan. Included are:

- This *Florida Department of Health ACS Local Plan Development Guide*
- *Florida Department of Health ACS Operations Guide*
- *Providing Mass Medical Care with Scarce Resources: A Community Planning Guide*
- *Altered Standards of Care for Mass Casualty Incidents*
- ACS “Quick Start” Guide (for field use in establishing an ACS)
- *Alternate Care Site Plan PowerPoint Slide Presentation*
- *Rocky Mountain Bioterrorism Facility Assessment Tool*

Links for these and other resources are listed in Section 20 of this Guide.

4. Organization

Initiation and operation of an ACS during a disaster situation will require the participation of many agencies. Therefore, it is essential that the political leadership and community government managers be committed to such an endeavor.

In organizing a team for local ACS plan development, the lead agency should identify the key players needed to

assemble the plan. The team should consist of people from a wide variety of agencies (see Section 5) who have the authority to make decisions on action items. Further, this cadre of individuals could ultimately develop into the team that activates an ACS, and responds to make the site operational. Additionally, the local ACS plan needs to mesh with other localized or regional plans that address response to mass casualty incidents. In other words, in a disaster, an ACS will likely be very important, but it will only be one of many issues the community will have to manage.

5. List of Community Participants

Quick implementation and successful operation of an ACS requires cooperation on the part of a wide variety of community agencies and partners. For organizational purposes, the coordination of resources should be vested in the local emergency management agency. In developing the community ACS plan, participants should include:

- Healthcare Coalitions
- Local Emergency Management
- Fire Departments
- Law Enforcement Agencies
- County Health Departments
- Hospitals
- Private and third service ambulance agencies
- Political representatives
- Regional Domestic Security Task Force representatives, including the Health and Medical Co-chairs
- Communication Center personnel
- Transportation agencies
- School / School Board representatives
- Local Medical Director(s)
- Medical Examiner office representatives
- Florida Department of Health representatives including Regional Emergency Response Advisors (RERA)
- Volunteer agencies including the Salvation Army, Red Cross, Medical Reserve Corps, and Community Emergency Response Teams
- Hazardous materials response team representatives
- Public Information Officer Response Team representatives
- Appropriate local government agency participants including City/County Managers, Public Works, Finance, Traffic Engineering, Facilities, Maintenance, etc.
- Other community partners

6. Timetable for Development

The timetable for developing a local ACS plan will be dependent upon a number of factors, but should be expedited as much as possible. The reason for this is that we never know when a major incident may strike causing an immediate need for an ACS. A **three to six month time period** should be sufficient for developing an ACS plan, with an additional three to six month time period required for training and exercising of the plan. Again, use of the FDOH resources and guidelines can help expedite the drafting of a local plan.

7. Facilities Identification

One of the key aspects of establishing an ACS is the facility chosen to house the operation. While specific incidents and their proximity to hospital facilities will somewhat dictate the site of an ACS, jurisdictions should make every effort to **pre-identify potential sites** in their community to aid in the planning and logistical components. In addressing facility options, the following portions of the FDOH *ACS Operations Guide* should be referenced:

- Typing
- Facility Selection
- Facility Options
- Additional Options for Ancillary Sites
- Timing
- Throughput
- Security
- Facilities Layout
- Facilities Management

It should also be noted that there needs to be flexibility on the selection of an ACS based on the situation presented. Some incidents may dictate an **ACS near the scene of the disaster**, while others may require that the ACS be established at **some point midway between the scene and the hospital**. Still other situations may require the ACS to actually be located in **close proximity to the hospital or on the hospital campus**. (This would help in handling an overload of “self transports” that have arrived at the hospital but do not need critical care.) Some hospital systems across the country utilize “outpatient” community treatment site campuses as ACS locations to keep the hospital emergency department available for the more critical patients.

ACS FACILITY ASSESSMENT TOOL

The Rocky Mountain Regional Care Model for Bioterrorism Events has been developed to help communities respond to the medical needs of a bioterrorism situation. This tool helps in identifying appropriate facilities for use as an Alternate Care Site facility.

<https://archive.ahrq.gov/research/altsites/alltoolmatx.htm>

8. Activation and Notification Process

It is likely that, in the event of a terrorism incident or other disaster situation which requires a community response, personnel will already be informed about the status of the disaster. Still, it is very important to have an activation and notification process in place to ensure that ACS implementation personnel are alerted as soon as possible when the potential exists for a site activation. This becomes a bit problematic since multiple agencies will be involved, many of which will not have been dispatched from or notified by the communications center of the jurisdictional agency. Therefore, an activation / notification methodology needs to be developed so that multiple points of communication are utilized to get everyone notified quickly. To accomplish this, multiple agencies should maintain notification lists and the appropriate emergency 911 communication centers in the area should be set up to make the appropriate contacts, should an event occur. Most modern communication centers have automatic calling equipment with a feature that allows specific call groups to be pre-programmed. This feature should be utilized to establish an ACS call-out list.

9. Field Guide Reference

A “*Quick Start*” Guide has been developed as part of the FDOH *ACS Operations Guide*. The “*Quick Start*” Guide provides field personnel with a template for getting an ACS operational quickly. It can be used in local ACS plan development to identify what needs to be done to make an ACS operational on short notice. The guide includes tasking sheets for ACS personnel, and checklists to identify needed actions. The *Operations Guide* includes a “sequence of events”, as well as a “typical patient sequence” that can be useful in planning operations.

10. Memorandums of Understanding and Pre-plan Agreements

Pre-planning is the key to a successful activation and operation of an ACS. As part of the planning process, memorandums of understanding and other agreements should be in place before the need for an ACS arises. Such agreements should be forged with owners or operators of the facilities to be used, medical supply and equipment vendors, transportation agencies, and any other entity with whom it would be beneficial to have such an agreement in place.

11. Equipment and Caches

In an effort to be response-ready, grant-funded equipment has been purchased by the FDOH and has been strategically located throughout the state. Included are mass casualty trailers, ACS start-up equipment, pharmaceutical caches, and other specialized equipment, including communications gear. The request process and contact information for acquiring these resources should be included in the local plan so that they can be activated quickly when needed. It should also be noted that several pre-hospital plans call for ACSs to be utilized as triage points, minimal care sites, quarantine locations, and as distribution sites for pharmaceuticals or other prophylaxis measures.

12. Use of Specialized Teams

In preparing for disasters, Florida has developed response resources designed to be deployed wherever they are needed throughout the state. Again, a list of some of these is located in the FDOH *ACS Operations Guide*. The contact numbers and procedures for activation of these resources should be included in the local ACS plan.

13. Specialized Assistance

In order to effectively operate an ACS it will be necessary to call for certain agencies or resources to provide specialized assistance. This includes (but is not limited to):

- Law Enforcement for security
- Fire Departments for decontamination
- Transportation agencies for patient transport
- Animal Control to assist with pet issues
- Mortuary services to handle deceased patients
- Pharmaceutical suppliers to assist with medications
- Other agencies or specialized teams as appropriate

14. Pre-identification of Staff

As stated in the FDOH *Operations Guide*, the biggest challenge in getting an ACS operational will be staffing. When an incident occurs, the EMS system, including the hospitals, will realize a surge in their activities and staffing needs. This surge will make it difficult for agencies to field personnel to set up and operate an ACS. The initial actions to establish an ACS may need to be taken by the EMS first responders. Staffing can then be augmented by volunteers, hospital off-duty staff, Community Emergency Response Team members, Medical Reserve Corps personnel, State Medical Response System personnel, Health Department personnel, Disaster Medical Assistance Teams, or any combination of these.

15. Regional Domestic Security Task Forces (RDSTF)

Given the role of the RDSTF's in supporting the regional response to terrorism incidents, it is important to include them in planning for ACS implementation. Representatives from this body, especially the Health and Medical Co-chairs, can be instrumental in arranging for ACS operational and logistical support.

16. Healthcare Coalitions (HCC)

A Healthcare Coalition (HCC) is a collaborative network of healthcare organizations and their respective public and private sector response partners. Together, they serve as a multi-agency coordination group to assist Emergency Management, through ESF8, with preparedness, response, and recovery activities related to health and medical disaster operations.

17. Questions to Address

There are a number of questions that the development planning team will need to address as a plan is created. This includes (but is not limited to):

- What agency will assume responsibility for coordinating the establishment and operation of an ACS?
- What triggers will be used to know when it is time to activate an ACS, and what person or persons will have the decision-making authority to establish an ACS?
- What facility or location will be used for the ACS?
- What Memorandum of Understanding needs to be in place for use of a facility as an ACS?
- Who will pay for the setup and operation of an ACS?
- Will communities be reimbursed under a disaster declaration for ACS operations?
- Can an ambulance unit transport a patient to an ACS, given that it is not a hospital?
- Who will staff the ACS, both initially and long-term?
- What statutes authorize the establishment of an ACS?
- What State and Federal resources are available for ACS support?
- What criteria will be used to make the decision to demobilize an ACS?
- Who will be responsible for worker issues such as workers compensation, injury at the site, etc.?
- Other questions that need to be answered prior to the implementation of the ACS plan.

18. Fifty Steps for Creating a Local ACS Plan

To aid in identifying what needs to be done to get a local plan in place, here is a list of steps that should be taken:

FIFTY STEPS FOR CREATING A LOCAL ACS PLAN

1. Contact the Florida Department of Health (FDOH) consultant on Alternate Care Site planning in the Medical Surge Unit for **local plan implementation information**.
2. Read through this *ACS Local Plan Development Guide* (along with referenced documents), and request a **presentation on the ACS concept / plan** by a FDOH representative.
3. Consider developing the local ACS plan through the **appropriate Healthcare Coalition (HCC)**, as the agencies who will need to be participants in the plan are likely part of the HCC.
4. **Identify a team** of people from various disciplines that will oversee the development of the local ACS plan.
5. **Involve City and County Managers / Administrators and political officials** in the process to solicit support for the ACS concept.
6. **Hold an ACS local plan concept meeting** to include Hospital, Health Department, Fire Department, Law Enforcement, and Emergency Management administrators to obtain support for plan development.
7. Use the **FDOH ACS Operations Guide document as a framework** for writing the local ACS plan.
8. **Identify a “lead” agency** for making the appropriate notifications during the activation phase of an ACS operation.
9. **Organize the ACS plan under Emergency Management** as part of the local Comprehensive Emergency Management Plan (CEMP). This will help to ensure agency coordination, EOC involvement, and continuity with the State CEMP.
10. **Publish an information sheet** on ACS local plan development to let people know what is being worked on, and why.
11. **Hold planning meetings** to discuss various ACS issues, **and involve the appropriate agencies** in the process. For example, if ACS security is being planned, representatives from the hospitals, law enforcement, and traffic engineering should be involved in the process.
12. **Establish a core group of people** that will serve as the coordinating group for ACS plan and implementation decision making. Include representatives who will have the authority to authorize the activation of an ACS.
13. **Identify who will serve in the “incident command” positions** for an ACS operation. **Establish a list of incident commanders** (as well as command and general staff positions) at least “three deep” so qualified people can be assembled quickly to put an ACS into operation. Also, give consideration to an **“ACS establishment response team”**.
14. **Reference the FDOH ACS Operations Guide** (specifically the section of the concise guide titled, *“Quick Start” Guide*) to identify the key areas that need to be addressed.
15. **Pre-identify sites** in the local community that could be pressed into service as an ACS.
16. **Establish memorandums of understanding** with potential ACS facilities and with medical supply sources to facilitate quick action when a site needs to be activated.
17. **Identify the staffing needed for the ACS, and from where it will be coming.** This may involve obtaining commitments from various agencies who will agree to supply a predetermined level of staffing when an ACS is implemented. (During prolonged ACS operations in previous disasters, local jurisdictions made use of Medical Reserve Corps personnel, university health professionals, and Disaster Medical Assistance Teams.)
18. **Pre-identify the any assets available from the State Medical Response System (SMRS)**, (as they may have cached equipment for setting up and operating an ACS), and log the contact number and procedures for their activation so that they can be summoned early in the activation process.

FIFTY STEPS FOR CREATING A LOCAL ACS PLAN

19. Identify how the **transportation of patients will be accomplished**. In addition to the EMS transport units that respond to the scene, other transportation units including ambulances, vans, and buses will most likely be needed. If large-scale assistance in transporting patients is needed, support is available as detailed in the FDOH SOG titled: *Patient Movement SOG*, a link for which can be found in Section 20 of this Guide. Keep in mind that patients will need to be transported:
 - a. From the scene to the hospitals
 - b. From the scene to the ACS
 - c. From the ACS to the hospitals
 - d. From the hospitals to the ACS
20. In addition to emergency services and health / medical personnel, volunteers, such as the Medical Reserve Corps and Community Emergency Response Teams, will be needed to operate an ACS. **Pre-establish the use of these resources, and identify the notification / activation procedures.**
21. **Decontamination** of patients may be necessary in a terrorism situation. **Pre-identify the resources** that will be used to carry out this mission. Keep in mind that the decontamination process will be needed at the scene, at the ACS, and at the hospitals.
22. Security will be necessary at an ACS, and law enforcement resources will, most likely, be stretched thin during a situation that results in ACS activation. **Pre-establish how security will be carried out**, and from where the necessary resources will come.
23. If an incident mandates a large ACS, multiple ACSs or a long duration ACS, State and Federal resources may be required for assistance. **Establish the procedures and the activation process for State Medical Response System assets, Disaster Medical Assistance Teams and other state/federal assets.**
24. In an ACS activation, the **Regional Domestic Security Task Force (RDSTF)** can be of assistance in expediting additional requested resources. The RDSTF regional Health / Medical Co-chair should be contacted for input into the local plan.
25. An **ACS activation notification list** (with contact numbers) needs to be developed as part of the local ACS plan to include at *least* the following:
 - a. Emergency Manager
 - b. Health Department Director
 - c. Hospital Operations Representatives
 - d. Fire Chief
 - e. Law Enforcement Chief
 - f. EMS System Administrators
 - g. Medical Director
 - h. Communication Center Director
 - i. Local Government Administrators
 - j. RDSTF Health and Medical Co-chairs
26. Communications always presents challenges during a disaster situation. A **communications plan**, with plans to utilize local communications equipment as well as radios that are part of local and State caches, needs to be developed. The ACS, for records, credentialing process, etc., will also require Internet access. Keep in mind that communications will have to be facilitated between the:
 - a. Scene and EOC
 - b. Scene and ACS
 - c. Scene and Hospitals

FIFTY STEPS FOR CREATING A LOCAL ACS PLAN

- d. ACS and EOC
 - e. ACS and Hospitals
 - f. EOC and Hospitals
 - g. Local EOC and State EOC
 - h. Local, State and Federal agencies in large scale ACS operations
27. **Public information** will be a critical aspect of an ACS operation and must be planned for in advance. The reasons for this are manifold, but include:
- a. the fact that loved ones will be seeking information, and access to the ACS, if family members are being treated there,
 - b. that “self-reports” in the “green” category will need to report to the ACS rather than the hospital,
 - c. that, since the hospital may send people to the ACS, the ACS must be accepted as a viable treatment center,
 - d. that people who have been exposed to the incident may need treatment / assessment / follow-up guidance.
28. At some point in the process it would be good to **identify a key public figure** that can serve as a spokesperson for the ACS plan. This will serve to give the plan more credibility, will foster media coverage of the concept, and will help ensure public acceptance of such facilities.
29. In keeping with good emergency management practices, and to interface with other agencies, the **National Incident Management System (NIMS)** should be applied to local ACS plan development.
30. In addition to planning for terrorism events, the local ACS plan should be designed so that it can be used for **“all hazards” application**.
31. The local ACS plan should mesh with **other local and regional EMS plans**, including (among others) mass casualty plans and Metropolitan Medical Response System plans.
32. The local plan should take into consideration that there will be a large number of psychological patients during a disaster situation. **Behavioral health assistance response should be included in the plan.**
33. As with any disaster response operation, logistics will play a significant role in the activation and operation of an ACS. As such, a good **logistical plan** must be included in the overall local ACS plan. Equipment, supplies, medications, food, water, signage, transport vehicles, staff support items, sanitation services, stretchers/beds, etc. are just some of the items that will have to be quickly acquired. Having a list of needed items, where they can be acquired, how they will be transported to the ACS, how they will be funded, etc. will go a long way towards a successful operation.
34. The local plan should include the necessary **forms to facilitate ACS start-up and operation**.
35. The local ACS plan should include **sample ACS layouts** of varying size to provide guidance to those who will be responsible for getting the ACS operational. Guidance for layouts can be obtained by referencing the HRSA “Federal Medical Stations” information, which addresses layouts for 50, 100, and 250 bed stations. Sample layouts can be found in the FDOH *Alternate Care Site Standard Operating Procedure*, a link for which can be found in Section 20 of this Guide.
36. Once an organizational structure is developed for the local ACS plan, **tasking cards** should be drawn up for all positions. If these are laminated and stored with ACS caches or administration “go packs”, they can be distributed to responders to ensure that the mission of each position is properly carried out.
37. Since activation of an ACS will, most likely, be a rare event, **“go packs”**, with all of the proper forms, procedures, tasking cards, checklists, notification lists, etc. should be developed so that an ACS can be brought online in short order.

FIFTY STEPS FOR CREATING A LOCAL ACS PLAN

38. Funding will be a key issue in ACS operation. While this will likely be a shared responsibility among those who operate the site, a **funding plan** should be part of the local plan, and include the process for reimbursement for declared disasters.
39. A decision will have to be made by those formulating the local plan as to the **scope of the ACS plan**. While most situations will fall into the “short fused – short duration” event category, there is the potential for more long term ACS operations such as a pan flu response or the closure of a hospital due to some technological or natural hazard.
40. Once a plan is developed, **training** will need to be developed and scheduled to ensure that participants fully understand how to activate and operate an ACS.
41. Once training has been delivered, there will need to **exercise or test the plan**. After this is completed, “lessons learned” can be applied and the plan adjusted to ensure that it will function as desired during a real event.
42. ACS planning should include how the plan will be maintained and kept up to date. Hopefully, activations will be few and far between but this makes it important to **keep the plan as current as possible**. Given the turnover rate of personnel, training will have to be repeated periodically so responders are kept knowledgeable about ACS operations. Online education modules on ACS planning and operations are available in the State “TRAIN” System. (See link in Section 18 of this Guide)
43. One key step in formulating the ACS plan is to **identify who can authorize ACS initiation**. This decision should involve the local Emergency Manager, Hospital Director, Health Department Director, Medical Director and the Fire Chief or administrative officer who oversees local EMS response. A sign-off by the jurisdiction’s lead administrative officer or political figure may be needed, given that the authorization of funds expenditure may be involved.
44. As people are selected to fill the various roles associated with ACS operation, a key point to remember is the need to **select “can do - proactive” people** to fill the key roles. This will ensure that a *proactive* rather than a *reactive* approach is used in getting an ACS operational.
45. Since the operation of an ACS is a multi-agency undertaking it is important that the proper **mutual assistance agreements** are in place to allow agencies to work together and to respond across jurisdictional lines.
46. Once the draft ACS plan is completed it should be circulated among all of the key agencies / participants to be **reviewed for errors, omissions, additions, deletions, etc.**
47. If **agencies outside of the local jurisdiction** will be called upon to assist in the operation of an ACS, they should be made aware of the plan and the part they will be asked to play. Again, involvement of Healthcare Coalitions can help ensure smooth ACS operational planning.
48. One of the key elements of an ACS is the **medical staffing** that will be needed. It will be necessary to acquire an adequate number of medical personnel including doctors, nurses, lab personnel, technicians, etc. to operate in the assessment-triage / treatment / transport areas. Since some operations may last longer than one day, it will be necessary to line up backup staffing for the operation. The FDOH *ACS Operational Guidance* contains staffing guidelines, including recommended staffing levels.
49. There are a wide variety of **resources and specialized response teams** that can be summoned to assist in the operation of an ACS. These resources should be cataloged with contact numbers and procedures so they can be quickly activated for assistance.
50. A **Concept of Operations Guide** for the ACS that details the policies and procedures to be followed in the initiation, operation and demobilization of the site, needs to be developed as part of the local plan.

19. Checklist

While there are many steps to creating a viable local Alternate Care Site plan, the previous fifty measures provide a base from which to work. These have been reduced condensed into the following “check list”:

PLAN DEVELOPMENT CHECKLIST

- Obtain a copy of the Florida Department of Health (FDOH) *ACS Operations Guide*.
- Read FDOH *ACS Operations Guide*, *ACS SOP*, and associated documents.
- Identify and compile a list of all agencies in the community who would have a role in the establishment and operation of an ACS.
- Assemble a team, from members of the community agencies, that can serve as the ACS plan development committee.
- Identify the “lead agency” for the local ACS plan, and schedule an organizational meeting of the plan development committee.
- Use this checklist and the FDOH *ACS Operations Guide* as a framework for writing the ACS local plan.
- Use local Emergency Management as the coordinating agency for the local ACS plan.
- Develop local ACS command structure for the plan remembering to make it NIMS compatible.
- Develop a list of people who can fill the positions in the ACS command structure, remembering to have several people identified for each position for coverage.
- Pre-identify sites in the community that could be used as an ACS facility. Keep in mind that the ACS may need to be set up near a scene, midway between a scene and a hospital, or just outside of a hospital facility.
- Establish memorandums of understanding with potential facilities, vendors, transportation agencies, etc.
- Establish agreements with vendors to ensure a quick response of medical supplies, equipment, and other needed items when an ACS is placed in service.
- Identify needed staff for the ACS, and from where they will come. Reference the FDOH *ACS Operations Guide* document for staffing guidelines.
- Establish agreements with various agencies to supply personnel on short notice to get an ACS operational quickly.
- Make a list of the closest State Medical Response Teams, as they maintain ACS start-up equipment caches. Note the procedures for requesting the resources, including contact numbers.
- Develop a patient transportation plan including from where transport resources will come. Keep in mind that a large number of patients may have to be transported so make arrangements for vans, buses, etc. to be utilized. The FDOH *Patient Movement SOG* can be referenced for further information.
- Develop agreements with volunteer agencies that you will need to carry out the ACS mission.
- Develop a security plan for the ACS to include how responding personnel will be credentialed, how security will be implemented, and who will provide security services.
- Develop a safety plan for the ACS to include the use of Safety Officers for enforcing the plan.
- Plan for the decontamination of patients to include what equipment will be needed and who will carry out decontamination duties. Keep in mind that this may need to be done at several different locations including the scene, the ACS, and the hospitals.

PLAN DEVELOPMENT CHECKLIST

- Identify the procedure (and document it on a task sheet) for activating State and Federal resources, should the ACS elevate to a level where this level of assistance will be required.
- Develop a list of individuals and agencies that need to be activated or notified when an ACS is placed into operation.
- Review the FDOH *ACS Operations Guide* document for information on getting an ACS operational. This section lists a typical sequence of events that can aid in identifying those areas that will need to be addressed.
- Develop a communications plan for the ACS.
- Develop an ACS Public Information plan, and remember to include public information issues as part of this local plan development.
- As the local plan is being developed, research other plans to ensure that the ACS plan meshes with them.
- Develop a logistical plan for the ACS to address all of the logistical needs of an operation. Such a plan should include a list of items that will be needed, from where they will come, and how they will be transported to the ACS.
- A sample layout of the ACS should be developed to provide guidance to those who will be setting up an ACS, usually on short notice. Guidance on layouts can be obtained by looking at the ones used for the various sizes of Federal Medical Stations which can be found in the FDOH *Alternate Care Site Standard Operational Procedures*.
- Develop tasking cards for all positions in the ACS. This will provide guidance to personnel who have to fill positions when an ACS is activated.
- Develop “go packs” with all of the organizing tools for the ACS such as task cards, contact numbers, check off lists, procedures, etc. so that the site can be quickly organized.
- Identify how an ACS will be funded, giving thought to both reimbursement (declared disaster) and non-reimbursement scenarios.
- Identify how personnel responding to an ACS will be credentialed. This would include making use of State databases to verify worker credentials, as well as how people will be credentialed for access into the site for security purposes.
- Decide on how patients will be tracked in and out of the ACS, including how their records will be transferred to receiving facilities.
- Develop a plan for dealing with special needs patients, including all of the special equipment used to address the needs of these patients.
- Develop an “out-processing” procedure for the ACS.
- Develop an “exit strategy” for the ACS which will facilitate shutting down the operation at the appropriate time.
- Ensure that the proper mutual aid agreements are in place to facilitate a response from other agencies for ACS operation.
- Reference continuing work that is going on across the State to further develop medical protocols and procedures being developed for ACS operations. Coordinate with Healthcare Coalitions to enhance plan development and implementation.
- Develop a concept of operations guide for the ACS that details the policies and procedures to be followed for the initiation, operation, and demobilization of the local ACS.

20. Websites with Information Relative to Alternate Care Sites

In addition to the below-listed resources, it should also be noted that a number of communities across Florida have already developed their own local ACS plans. These plans can be referenced for ideas on how to develop a local plan.

WEBSITES

FDOH Alternate Care Site Standard Operating Procedure

http://www.floridahealth.gov/preparedness-and-response/preparedness-planning/_documents/alternate-care-site-sop.pdf

FDOH Alternate Care Site Operations Guide

http://www.floridahealth.gov/programs-and-services/emergency-preparedness-and-response/_documents/alternate-care-site-ops.PDF

Providing Mass Medical Care with Scarce Resources: A Community Planning Guide

<https://archive.ahrq.gov/research/mce/mceguide.pdf>

Rocky Mountain Regional Care Model for Bio-terrorist Events: Locate Alternate Care Sites During an Emergency

<https://archive.ahrq.gov/research/altsites.htm>

Altered Standards of Care in Mass Casualty Events

<https://archive.ahrq.gov/research/altstand/>

Surge Capacity: Facilities and Equipment

<http://archive.ahrq.gov/news/ulp/btbriefs/btbrief8.pdf>

Hospital Incident Command System

<https://emsa.ca.gov/disaster-medical-services-division-hospital-incident-command-system-resources/>

Medical Reserve Corps

<https://mrc.hhs.gov/HomePage>

Surge Hospitals: Providing Safe Care in Emergencies

http://www.jointcommission.org/assets/1/18/surge_hospital.pdf

Acute Care Center: A Mass Casualty Care Strategy for Biological Terrorism Incidents

http://www.cidrap.umn.edu/sites/default/files/public/php/24/24_guide.pdf

Florida Incident Field Operations Guide (FOG)

<https://www.floridadisaster.org/globalassets/importedpdfs/flfog.pdf>

TRAIN Florida: FDOH Learning Management System (ACS Online Modules)

<https://fl.train.org/DesktopShell.aspx>

FDOH Patient Movement SOG

http://www.floridahealth.gov/programs-and-services/emergency-preparedness-and-response/preparedness-planning/_documents/patient-move-support-sog.pdf

21. Summary

With the continuing threats of natural disasters, pandemic influenza, and terrorism, it is essential for proactive communities to have a plan in place to implement Alternate Care Sites. Taking the initiative NOW to establish a plan and involve the key participants will pay huge dividends later if an incident occurs. In previous disasters, multiple ACSs have been implemented to assist with medical surge. In communities where no local ACS plan was in place, this endeavor took much longer, and was not as efficient as it could have been. Most agree that it is not a question of *if* ACSs will be needed in future events, but rather *when*.

Developing a local ACS plan, and then establishing and operating an ACS when needed, will go a long way in helping a community deal with medical surge in a large-scale emergency or disaster.

22. Contact Information

Planning Unit

Bureau of Preparedness and Response

Florida Department of Health

4032 Bald Cypress Way - Bin A-23

Tallahassee, FL 32399

850.617.1510

Terry.Schenk@flhealth.gov