

## ALTERNATE CARE FACILITIES

**Definition:**

An alternate care facility (ACF) is a site where “medical needs” sheltering, urgent care services and select traditional inpatient services are not usually provided but which is deliberately repurposed for provision of such services during select disasters. ACFs may be established at sites where no medical care is usually provided or at medical facilities where the usual scope of medical services does not include large-scale urgent care or traditional inpatient services. Most ACFs will be selected from existing sites of convenience, although temporary structures may be erected by responding partners such as the federal government. ACFs are only to be established during emergencies or anticipated high-risk events (e.g. political conventions).

**Anticipated Scenarios:**

Establishment of operational ACFS may be necessary as part of Seattle-King County’s medical response to disasters. ACFs may have utility when:

- 1) Surges in patients overwhelm regional ambulatory care and hospital capacity to adequately care for those in need and timely evacuation to other regions is not possible.  
Examples: epidemic, large scale toxic inhalation
- 2) Damaged medical infrastructure results in regional ambulatory care and hospital capacity which is insufficient to adequately care for those in need and timely evacuation to other regions is not possible.  
Examples: earthquake without large numbers of serious injuries, flooding
- 3) Combination of 1 and 2.  
Examples: earthquake with many serious injuries, nuclear device detonation

**ACF Objectives** (Select objectives may not be applicable for some disasters)

- 1) To deliver sufficient medical care for a surge of patients who have disaster-related acute illnesses or injuries (non-immediate life-threatening) and who cannot be adequately and timely cared for by the regional healthcare system.
- 2) To deliver urgent care for both disaster-related and –unrelated medical conditions to offload Emergency Departments (ED) and ambulatory care clinics, so that these sectors can maximize care for other patient needs.
- 3) To deliver sufficient non-complex care which is traditionally provided in inpatient settings to offload acute care hospitals to maximize care for more seriously ill patients with potentially survivable conditions.
- 4) To deliver sufficient non-complex care which is usually provided at home with home health services for patients that have insufficient home situations and for when home health care services and hospitals are operating above maximal capacity to offload acute care hospitals to maximize care for more seriously ill patients (“Special medical needs shelter”)
- 5) To facilitate sufficient follow-up services so patients can be safely discharged to a non-medical site (e.g. home, shelter) and where follow-up at EDs or ACFs is minimized.
- 6) To screen large numbers of potentially exposed people (e.g., radiation, pathogen, toxic substance), and facilitate treatment and follow-up for recommended groups.

### **Activation and Recovery**

#### *Authority*

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#### *Disclaimer*

The Seattle and King County healthcare system provides world-class medical care to residents and visitors. Provision of this expected level of quality medical care in ACFs has numerous logistical, process and social barriers, and thus, it must be anticipated that the medical care in ACFs will be lower quality than what is usually available in Seattle and King County. Nevertheless, our region is at risk of hazards, such as earthquakes and epidemics, where our population’s immediate medical needs may overwhelm available medical resources. If external agency support (e.g., state, regional EMAC support, or

federal) cannot immediately meet the gap in need, many Seattle and King County residents may have to forgo relief of suffering and life-sustaining medical care. For such situations, activation and operation of ACFs may help many of these people receive sufficient medical care.

Given that medical care in ACFs is likely to be different than that usually available, a guiding principle is **MEDICAL CARE USING ACCEPTABLE TREATMENT SPACES IN LICENSED MEDICAL FACILITIES IS ALWAYS BETTER THAN PROVIDING CARE IN AN ALTERNATE CARE FACILITY**. The activation and recovery process has been developed to balance the need during a disaster response to preserve usual medical care whenever possible and initiate extraordinary measures when the usual medical care is far from meeting acceptable care for people in immediate need. To maximize the benefit of ACFs and minimize the barriers to quality medical care in these austere settings, extensive resources have been invested by Seattle and King County for planning, equipment procurement, and staff training.

*Declaration*

ACFs are not intended to augment a small surge in everyday healthcare system need.

ACFs may only be used for readily apparent event of high consequences (e.g. large earthquake) or unconfirmed, but highly suspected chemical exposure or outbreak (e.g. high suspicion but awaiting laboratory confirmation). Before an ACF can be activated, a *Regional Declaration of Emergency* must be declared by the King County executive or their agent.

*Pre-Deployment Surge Capacity Efforts*

Prior to deployment of ACFs, regional attempts at healthcare system surge capacity must be exhausted. If people with acute medical needs can receive adequate care in an existing medical facility within a reasonable time period, then alternate care facilities should not be approved to receive patients. Efforts to support augmentation of the healthcare system's capacity should be prioritized in hopes of forestalling the need for ACFs. The following activities must be confirmed before approval for ACF opening can be granted.

**Hospitals**

- Staffing has been augmented by canceling vacations, maximizing staffing ratios, maximizing use of agency healthcare staff, and external assistance has been requested (intrastate hospital MOUs, request to state for additional assistance (NDMS, ESAR-VHP, EMAC).
- All hospitals have suspended ED saturation, and ED "treat and transfer".
- All inpatients who can be safely discharged are sent to home, nursing homes, assisted-living, and discharge centers.
- Elective surgeries are deferred.
- ? Scheduled labor inductions are deferred.

**Home Health**

- Staffing has been augmented by canceling vacations, maximizing staffing ratios, and maximizing use of agency healthcare staff.
- For all agencies, new patient evaluations can be performed at night and during weekends.

**Nursing Homes and Long-Term Care Facilities**

- Staffing has been augmented by canceling vacations, maximizing staffing ratios, and maximizing use of agency healthcare staff.
- For all facilities, new patient evaluations can be performed at night and during weekends. Patients can be discharged from hospitals to facilities at night or during weekends.

*Activation Criteria*

Diverse disasters require different medical responses, so some healthcare system sectors (e.g. ambulatory primary care clinics, specialty clinics, acute care hospitals) may be more directly impacted than others. Hence, activation criteria for ACFs may at first seem daunting to define. However, patient flow and medical need in the Emergency Department is interdependent on and reflects the ability of ambulatory care (primary care and subspecialty), long-term care (nursing homes) and acute inpatient care to continue to manage additional patients. By example, if critical care services are full, then additional critically ill and injured patients admitted through the ED requiring ICU admission would remain in the ED for prolonged periods of time. If primary care clinics are operating at capacity, then additional patients requiring care are likely to search out care in EDs, and the ED volume will increase. Hence, ED status is an appropriate gauge of functionality throughout the King County healthcare system. Opening of ACFs may be warranted if the **PLANNING SECTION OF ESF#8** predicts any of the following criteria may be met by **>75% of hospitals within the same zone during the next 48 hours operational period:**

- 50% of Emergency Department (ED) beds are occupied with patients awaiting acute, non-elective hospital admission and the average boarding time in the ED is anticipated to be > 24 hours.

**-OR-**

- > 50% of patients with potentially life-threatening illness/injury (Triage level ?) will not receive stabilizing care within 30 minutes.

**-OR-**

- > 75% of patients (Triage level ?) in Emergency Department waiting rooms will not be seen by a clinician within 12 hours.

These criteria are intended to provide semi-quantitative guidance for defining events where ACFs may be useful. When any of these criteria are met, final determination of the need to open ACFs rests with the unified command of ESF#8. Also, the unified command of ESF#8 can declare the need for ACFs even prior to the criteria being fulfilled, if it is readily apparent that a catastrophic event will outstrip healthcare system resources and timely evacuation is not possible.

**Scope of Care:**

As part of the determination to open an ACF by the aforementioned criteria, the healthcare sectors which are overwhelmed and impacting ED flow must be identified. The disaster's impact on the King County healthcare system will determine which if any of the ACF potential objectives (see Objectives section) are applicable to the situation. The ACF overall objectives determine the possibilities of required care. Not all disasters are likely to require all of the objectives and thus not all proposed possibilities of care will be necessary for all events.

*To offload Ambulatory Care Clinic, Urgent Care sites and Emergency Department  
Unscheduled Patient Visits (Objectives 1 and 2)*

- 1) Patients requiring simple wound management
- 2) Patients with nausea and vomiting requiring oral or IV fluid resuscitations
- 3) Non-narcotic prescription refill
- 4) Other patients without potentially life-threatening symptoms or vital signs

**Care Processes:**

- 1) Wound management including suturing
- 2) Short-term IV fluid resuscitation
- 3) Short-term Oxygen delivery
- 4) Oral medications (select)
- 5) Short-term fracture/ musculoskeletal injury management
- 6) Bronchodilator Therapy/ Peak Flow assessment
- 7) Non-narcotic prescription authorization
- 8) ? Laboratory
- 9) ? Radiology

*To offload inpatient volume (Objectives 3 and 4)*

- 1) Patients with IV antimicrobial needs without many additional medication/laboratory needs.
- 2) Post-surgical patients anticipated for hospital discharge within 48 hours

- 3) Patients who are homeless/ or who have inadequate home situations and whose medical conditions would have allowed for discharge if their home situation were more functional.
- 4) Patients ready for discharge and awaiting a vacant bed at a long-term care facility or skilled nursing facility.
- 5) Patients who would normally be admitted primarily for IV antimicrobials and monitoring to insure their condition does not worsen and who are expected to be discharged within 48-72 hours (e.g. patient with diabetes and moderately severe cellulites without sepsis).
- 6) Patients who are dying and for whom no advanced interventions are available or deemed appropriate.

Care Processes:

- 1) IV fluid resuscitation
- 2) IV antimicrobial administration
- 3) IV symptom relief (e.g. antiemetics)
- 4) Oral medications (select)
- 5) Traditional inpatient Physical Therapy
- 6) ? Oxygen delivery (if possible can expand above patient qualifications)
- 7) ? Laboratory
- 8) ? Radiology

**Special Populations Considerations:**

- 1) Pediatrics (if not at ACF, what is the age cutoff?)
- 2) Prisoners (if yes, what security protocols are established)
- 3) Select ethnic groups (should they try to get care where they usually do?  
Translator and culturally sensitive services.

**Sites:**

Currently one primary site and at least one alternative site (in case first site is rendered unusable by disaster circumstances) will be identified for each of the three King County zones. All sites must have sufficient enclosed space to, at a minimum, be able to care for at least 250 “inpatient” treatment spaces concurrently. A number of other crucial facility characteristics have been identified (TBD). While no ACF site may have all of the ideal facility characteristics, sites that have the best combination of characteristics will be prioritized.

Pre-event memoranda of understanding (MOU) will be established between King County and the site operators for at least 2 sites within each zone. MOUs with additional identified and evaluated sites are encouraged but not currently mandated.

**Administrative Structure/ Site Incident Management:**

See Site Incident Management roles and responsibilities section (TBD).

**Site Layout and Function:**

See individual site layout appendix (TBD).

See individual function sections for additional details (TBD).

- Ingress/Egress ? screen for weapons  
 Enforce any entry restrictions (e.g. limited patient visitors)  
 Initiate infection control interventions as applicable  
 Control general public entrance, ambulance transport area  
 Visitor sign in station with contact information
- Triage: Evaluates all self-referring and transported patients (from non acute hospital sites).  
 Determines whether or not patient can be cared for at ACF or requires an advanced level of care.
- Registration: Collect required information on all urgent care patients  
 Collect information on all inpatients  
 Collect information on all palliative care patients  
 Provide periodic aggregate data to ACF administration
- Urgent Care: Evaluation and treatment of non-life threatening medical conditions  
 Identification of serious or life-threatening medical conditions and communication with medical control about potential transfer  
 Admit to ACF if meets criteria  
 Suggest post-ACF follow-up requirements to discharge planner (if applicable)
- Pharmacy: Appropriate storage, tracking, and accounting for medications  
 Identifying and correcting possible dosing order errors  
 Substituting similar drugs if ordered drug is in limited quantity or unavailable  
 Medication expertise consultation  
 Mixing IV medications  
 Dispensing oral medications
- Inpatient Care: Accepting and evaluating newly transferred patients from hospitals  
 Providing sufficient care as determined by resources  
 Identifying if patient condition deteriorates to warrant readmission to hospital and communication with medical control about potential transfer.
- Palliative Care: Assessment of pain and suffering and administration of symptom relief based on available resources  
 Spiritual support

Patient family, partner, or friend support

- Discharge      Track all patients transferred to hospitals
- Coordination:    Track all patients who die  
                      Track patients cared for as “inpatients” who are discharged  
                      Coordinate follow-up services for urgent care (if needed) and inpatient  
                      patients (if needed)
- Death Services: Collect and maintain bodies per Mass Fatalities guidelines  
                      Provide periodic aggregate summary to ACF administration

**APPENDIX:****Alternate Care Facility Activation Decision Work Sheet****A. Disaster Situation (all criteria must be met)**

- Apparent disaster or high suspicion for event
- Regional Emergency Declaration signed by County Executive or agent

**B. Current Healthcare System Status (At least one of three must be met for ACF opening)**

Planning section of ESF#8 predicts any of the following criteria may be met by >75% of hospitals within the same zone during the next 24 hours operational period:

- 50% of Emergency Department (ED) beds are occupied with patients awaiting acute, non-elective hospital admission and the average boarding time in the ED is anticipated to be > 24 hours.

**-OR-**

- > 50% of patients with potentially life-threatening illness/injury (Triage level ?) will not receive stabilizing care within 30 minutes.

**-OR-**

- > 75% of patients (Triage level ?) in Emergency Department waiting rooms will not be seen by a clinician within 12 hours.

**C. Current Surge Activities (all criteria must be met for ACF opening)****Hospitals**

- Staffing has been augmented by canceling vacations, maximizing staffing ratios, maximizing use of agency healthcare staff, and external assistance has been requested (intrastate hospital MOUs, request to state for additional assistance (NDMS, ESAR-VHP, EMAC).
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**D. Alternative Surge Efforts (any met criteria negate current need for ACF)**

- Evacuation of patients within 12 hours to outside jurisdictions is likely to negate initiation criteria from section B
- Other surge processes exist to negate initiation criteria from section B

**E. Authority for Alternate Care Facilities Approval**

\_\_\_\_\_

**Public Health Seattle-King County** **Date**

**Health Officer**

approves the opening of an alternate care facility at \_\_\_\_\_

(location)

which shall remain functional until recovery criteria are met, and the facility is deemed no longer necessary.