Health/Medical
Multi-Agency Coordination (MAC)
Group Handbook

Prepared by:
Region 1 NW Oregon Health Preparedness Organization
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Preface

This is the second update to a Handbook initially developed by the NW Oregon Health Preparedness Organization as part of a CDC Pandemic Influenza Planning grant. The Handbook describes the role and operations of a regional Health/Medical Multi-Agency Coordination Group.

This Handbook is written to be inclusive of all counties in Oregon Healthcare Preparedness Region 1 and Washington Region IV. During emergencies, this region utilizes a host County Emergency Coordination Center (ECC) to provide specific regional health/medication coordination functions (e.g. regional situational awareness, health/medical resource ordering). City and County ECCs/Emergency Operation Centers still provide significant support for health responders for all other response activities.

We would like to acknowledge the Pacific Northwest Wildfire Coordinating Group (PNWCG) for offering its Northwest Multi-Agency Coordination (MAC) Handbook as an example to use when developing this resource. We extend our utmost thanks and gratitude to the staff of Organizational Quality Associates for the invaluable expertise, direction and guidance they provided for the development of this tool.

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OVERVIEW

Health/medical policy decisions are made by local public health officials at the jurisdictional level. In the event of a large-scale regional health emergency, the Health/Medical Multi-Agency Coordination (MAC) Group is convened when responding to public health emergencies involving more than one county. The 2009 H1N1 Influenza events provided an opportunity for broad regional coordination of health/medical efforts between public health officials, area hospitals, community health clinics, emergency management and State officials, in order to ensure efficient and effective response to this pandemic. This multi-agency coordination was a key component in developing policy-level decisions and directives that were then disseminated to affected communities and target populations. Participants agreed on the need for regional coordination during an emergency with significant health impacts and endorsed the concept of establishing a Health/Medical MAC Group.

This MAC Group Handbook provides the framework for MAC Group activities during a public health emergency with significant regional impacts in Healthcare Preparedness Region 1 and Washington Region IV. *(See Appendix 1 for a map of the region).*

Mission
When activated, the MAC Group will provide a structure for public health and healthcare leaders to come together to discuss policy decision-making and prioritization. Specifically, the MAC Group will provide:
- Regional representation and participation in incident prioritization decisions related to a strained healthcare delivery system;
- Ethically-based regional strategies related to the allocation/re-allocation of critical resources;
- Proposed altered standards of care and alternative care systems;
- Community mitigation approaches to limit transmission of disease in the community; approaches will be based in ethical guidance and considerations;
- Assure consistent and accurate information concerning the health emergency within the region.

MAC Group Authorities
The MAC Group is established under the state statutes and laws of the State of Oregon and State of Washington and codes of participating counties *(see Appendix 2)*.

MAC Group Overview
A MAC Group is part of the Multi-Agency Coordination System (MACS) under the National Incident Management System (NIMS) and is comprised of agency representatives who have jurisdictional, functional or significant supportive responsibilities in an incident or incidents. Health/Medical MAC Group membership may vary during emergencies and will be tailored to the jurisdictions and agencies impacted by the event.

Agency Administrators will appoint and authorize MAC Group Agency Representatives, through a written letter of delegation of authority, to commit their agency funds and resources; have authority to speak on behalf of their organization; make decisions for the prioritization of critical resources; resolve issues, and propose new interagency policy during an emergency. Assisting and cooperating agencies may attend MAC Group meetings for technical input or to gain information, but will not participate in the decision-making process. Agency Administrators will also designate at least one alternate agency representative who will stand in for the primary member when they are not available. The alternate(s) will have the same scope and authority as the primary representative. Appendix 3 offers additional information for training that is strongly encouraged for all MAC Group Representatives and Coordinators MAC Group Agency Representatives may include:
- Health Department Administrator/Health Officer or designee (Tri-County Health Officer, Clark County Health Officer, and County Administrator during an actual health emergency)
- Hospital Administrator or designee
- Community Clinical Representative (physician, clinic manager)

M AC GROUP ORGANIZATION

The regional Health/Medical MAC Group consists of designated Agency Representatives and a MAC Group Coordinator, and is hosted at a County Emergency Coordination Center (ECC). The host County ECC facilitates regional coordination of health/medical functions including health/medical situation status, critical health/medical resource ordering and allocation, and hosting the Health/Medical MAC Group. Ideally, a County ECC provides the MAC Group with the needed Incident Support Organization (ISO) including technical specialists, as the situation warrants.

The hosting County ECC may need additional staffing in the following positions to support the MAC Group:
- Planning Section Chief (PSC)
    - Resource Unit Leader (RESL)
    - Situation Unit Leader (SITL)
    - Documentation Unit Leader (DOCL)
    - Technical Specialists (THSP)
- Logistics Section Chief (LSC)
    - Communications Unit Leader (COML)
    - Facilities Unit Leader (FACL)
    - Expanded Resource Ordering Group Leader (EROL)
    - Fully staffed Expanded Resource Ordering Group
- Public Information Officer (PIO)

Each General or Command Staff Unit will fill additional positions within the unit as needed.

The diagrams in *Appendix 4* and *5* display the flow of information between the MAC Group and the host County ECC, other county ECCs and State ECCs.

R OLES & RESPONSIBILITIES

Agency Administrators
- Approve the activation of the MAC Group.
- Appoint Agency Representatives through a written delegation of authority *(see Appendix 6)*.
- Recommend issues needing MAC Group action.
- Implement MAC Group decisions and recommendations.
- Provide approval of MAC Group policy proposals.

MAC Group Agency Representatives
- Develop strategies to alleviate critical resource shortages and meet anticipated health/medical resource demands.
- Establish priorities for the allocation or re-allocation of critical health/medical resources within the region.
- Communicate MAC Group decisions to agency administrators.
- Maintain a dialogue with host County ECC, local Public Health (LPH), Hospital Incident Command Posts (ICP), Hospital Coordination Centers, ECCs and others, when necessary.
- Ensure that agency IMTs provide requested situation status reports *(see Appendix 7)* and other MAC Group information, as requested.
- Orient agency alternate(s) and keep them current on decisions, issues, and new business

MAC Group Coordinator
The MAC Group Coordinator manages MAC Group needs and requests and disseminates decisions made by the MAC Group through the Incident Support Organization provided by the host County ECC. The MAC Group

Coordinator also facilitates MAC Group decision-making and implementation. The MAC Group Coordinator should have credibility with the Agency Administrators and be knowledgeable of ICS and MACS within NIMS. Finally, the MAC Group Coordinator should be qualified for the position and pre-selected by Public Health Administrators to do the following:

- Coordinate all MAC Group requests and needs with the host County ECC Manager.
- Establish a daily schedule for meetings and conference calls and provide schedule and agenda information *(see Appendix 8, 9, 10)* to all MAC Group participants.
- Facilitate all conference calls and MAC Group meetings.
- Screen issues to evaluate if they are appropriate for MAC Group consideration. (*see Appendix 14*)
- Obtain health/medical intelligence information to support MAC Group activities.
- Provide regular and timely updates for the host County ECC Manager.
- Ensure subject matter expertise is available to MAC Group (e.g., epidemiology & surveillance, clinician).
- Coordinate official approval of MAC Group decisions.
- Document and disseminate MAC Group decisions to the host County ECC Manager and other agencies.
- Provide records of MAC Group activities and decisions to the Documentation Unit Leader.
- Maintain dialogue with Hospital Command Centers, Hospital and Public Health Incident Command Posts and other healthcare response organizations.

MAC Group Incident Support Organization (ISO)
MAC Group support will be provided by and integrated with the host County ECC ISO or the MAC Group will supply its own ISO positions.

 Logistics Section
- Arranges work area for MAC Group and MAC Group ISO for meetings and operations *(see Appendix 12).*
- Ensures adequate equipment and supplies are available for MAC Group and MAC Group ISO meetings and operations *(see Appendix12).*
- Reserves conference call times and provides schedule and access information to all participants.
- Supervises and manages the Expanded Resource Ordering Group (EROG).

 Planning Section
- Provides recommendations for the allocation, reallocation and release of critical resources.
- Collects the Situation Status Reports and any additional information needed by the MAC Group for prioritization and allocation of critical resources and decision-making.
- Maintains and inputs incident information into the database and display matrix for incident prioritization.
- Tracks incident critical resource needs (orders) through the EROG and visually displays the allocation of critical resources during each operational period.
- Assesses and recommends additional staffing, changes to procedures and data needs to the MAC Group to provide for efficient, accurate and timely information for decision-making.
- As needed, contacts Incident Management Teams (IMTs) for clarification and updates on incident status and needs.
- Provides short term, strategic and contingency planning to meet MAC Group needs.
- Develops and displays all needed schedules, tables, data sheets or other information.
- Organizes, files and maintains all MAC Group records and notes.
- Keeps accurate email distribution lists and other contact information for distribution of documents and decisions.
- Records meeting minutes.
- Ensures accurate MAC Group membership contact information.
- Supervises any technical specialists requested by the MAC Group.

Technical specialists* may be used to gather analyze and display data, develop reports, prepare briefings for H/M MAC group members; and provide projections on the consequences of alternatives being considered.

- o The technical specialist is not a H/M MAC Group member.
- o The technical specialist role is to provide technical information/expertise related to a specific issue brought before the H/M MAC Group.
- o The purpose of the information provided by the technical specialist is to assist the H/M MAC Group in making an informed decision.
- o Technical specialists should only participate in H/M MAC Group meeting as requested; the burden is on the H/M MAC Group to define what they want from the specialist.

These parameters guide the use of technical specialists at H/M MAC Group meetings:
- o Specify the amount of time allotted for their comments.
- o Clarify that their role is as a consultant and not as a group member.
- o Ask them to keep comments specific to the issue at hand.
- o Ask them to give pros and cons for a specific issue or alternative, but not to generate new alternatives.
  *These guidelines apply to outside technical specialists who are not H/M MAC group members

Public Information Officer
Communicates MAC Group decisions to Joint Information Center (JIC) and maintains appropriate dissemination of information to public.

OPERATIONAL GUIDELINES

Activation
- MAC Group functions are executed by Public Health Department Administrators/Health Officers during low activity.
- The MAC Group and MAC Group Coordinator will meet via conference calls and in person, as necessary, during moderate to high levels of activity impacting Public Health and Healthcare Delivery System response operations.
- During very high to extraordinary levels of activity impacting Public Health and Healthcare Delivery System response operations, the MAC Group functions are executed by Public Health Department Administrators/Health Officers and Healthcare Delivery System Agency Representatives (e.g. Hospital Administrator on Duty, Clinicians, etc.). The MAC Group will meet via conference calls and in person, as necessary. The MAC Group will be supported by a host County ECC ISO and a MAC Group Coordinator.

Activation Procedures
Agency Administrators will approve activation of the MAC Group. The MAC Group Coordinator will contact pre-designated Agency Representatives. If pre-designated Representatives have not been chosen or are not available, the respective Agency Administrator will be asked to identify an appropriate substitute for MAC Group representation.

Meeting Procedures
- MAC Group Coordinator will facilitate all conference calls and meetings. Conference calls will be scheduled as necessary *(see Appendix 9 and 10 for standard conference call agendas)*.
- All routine meetings will begin at predetermined times.
- MAC Group meetings should last no longer than 2 hours.

- Coordination/information sharing between the ISO, MAC Group Coordinator and the MAC Group Representatives should happen prior to the MAC Group meetings to ensure issues are clearly and concisely described and managed.
- Recommended issues for discussion during MAC Group meetings will be summarized by MAC Group Representatives in writing in advance of all meetings by the person who has identified the issue. The Representative raising the issue will facilitate the discussion at the MAC Group meeting. A template for issue prioritization for use in H/M MAC Group Meetings is found in *Appendix 14*.
- New issues will be conveyed from the H/M MAC Coordinator to the group in one of the following ways: conference calls before a meeting, in writing before a meeting or at the beginning of a meeting for last-minute issues.
- All briefing materials will be included in the permanent MAC Group record.

MAC Group Meeting Objectives
- Provide an informational update on the regional situation status.
- Prioritize incidents *(see Appendix 13)*.
- Identify, clarify and resolve regional issues (pro-active).
- Recommend new or adjusted policy to Agency Administrators.
- Allocate critical health/medical resources.
- Make and document all health/medical related decisions.
- Determine need for contingency plans as appropriate.
- Provide/recommend overall MAC Group objectives to Agency Administrators.

A typical day in the life of a MAC Group is outlined in Appendix 15.

Attendance
The MAC Group Agency Representatives (or the agency alternate), MAC Group Coordinator and other personnel requested by the MAC Group should attend all MAC Group meetings in person or by teleconferencing.

MAC GROUP DECISION-MAKING

MAC Group decisions should always consider and strive to maintain essential health services and be aligned with an ethical framework. Key elements of the ethical framework include common good, justice, prudence, and respect *(see Appendix 16).*

Meeting Format
To facilitate the MAC Group decision-making process, each meeting will be organized in the following manner:

1) Introduction
   - Review working guidelines (*see Appendix 17*) and ethical framework (*see Appendix 16*)
   - If a new member is present, select a method from *Appendix 19* to welcome the new member
   - Optional well-being check-in with members

2) Briefing:
   - Current situation update, probable future situation (e.g. assessment of the current healthcare system for event and non-event related illness, projected demand surge from event, related illness and related resource needs, projected reduction of available space, staff and other response capability [e.g. equipment/supplies]);
   - Current issues described;
   - New issues introduced; and
   - Questions/clarification.

3) Discussion/Decision:
- Review identified and new issues;
- Review criteria for establishing incident priorities and prioritize incidents (*see Appendix 13*). This includes the maintaining of essential services and unique capabilities of the total health care system (*see Appendix 14* f*or Issue Prioritization Criteria worksheet*);
- Discussions and decisions on issues; ensure alignment with ethical framework *(see Appendix 16);*
- Review situation status reports provided by the IMTs for background information to allocate critical resources *(see Appendix 7)*;
- Allocate critical resources;
- Discuss how to resolve media and VIP interface issues; and
- Consider needs for contingency and strategic planning.

4) Output :
- Decisions/priorities/allocations determined and communicated to affected parties;
- Decision action *(see below)* is identified and documented;
- Draft new policy or revised policy; communicate with Agency Administrators for approval, as necessary; and
- Plan in place for media interfacing that assures the timely release of information.

Decision-Making by Consensus
The H/M MAC group strives to make decisions via group consensus. These are the possible outcomes of the decision-making process:
- Option 1: Make a collaborative decision and assign responsibility for implementation;
- Option 2: Defer decision for consideration at a later date (e.g., until more information has been collected). Set a specific date and time when the issue will again be looked at for a decision,
- Option 3: Determine if the issue is outside of the MAC Group's responsibilities and mission. If so, defer the issue to the appropriate organization or individual.

For the purpose of this document and group function, consensus is defined as a substantial majority of the group agreeing on a decision or position to be presented as representative of the entire group. Consensus does not necessarily indicate unanimity, that the decision is considered the best or most desirable by those involved, or that there are no significant concerns; it simply connotes acceptability.

It is not uncommon for issues to come before a MAC Group where consensus cannot be reached. Even when consensus has been reached on an issue, over time the circumstances creating the issue can change and one or more MAC Group members can no longer support the consensus decision.

Chances for consensus on complex issues can be strengthened by:
- Recognition of complex issues that may present difficulty in achieving consensus prior to placing them on the MAC Group agenda.
- Accurate and thorough analysis of issues and related information by support staff prior to the MAC Group meeting.
- Effective display and presentation of the issue analysis to the MAC Group to facilitate a clear understanding of the issue.
- Advance notice to group members of the issue/related information.

Options when there is not 100% consensus during initial decision-making:
1. Assign a H/M MAC Group member to monitor the situation and when the situation affecting the issue changes, bring the issue back to the H/M MAC Group.

2. H/M MAC Group members who agree with the decision agree to implement it. H/M MAC Group members who disagree can decide not to implement.
   a. Not a desirable situation but may be most practical to resolve the issue with a majority of represented agencies/organizations.
   b. Requires documentation clearly explaining the lack of consensus and rationale.

3. Defer the decision for consideration at a later date.
   a. Facilitate collaboration between Agency Administrators to resolve the issue and bring back to the H/M MAC Group at a later date.
   b. Assign responsibility to a H/M MAC Group member for developing more information about the issue and bring back to the H/M MAC Group at a specific time and date.
   c. Wait for further development of the situation that created the issue and bring back to the H/M MAC Group at that time.
   d. Delegate the decision to H/M MAC Group member, the H/M MAC Group Coordinator, or staff, stating clear expectations of the intended outcome or results

When the overall situation changes
1. When a H/M MAC Group decision is made, anticipate and identify circumstances that will lead to adjusting the decision and bring the issue back to the H/M MAC Group when those circumstances occur. This should be part of the decision documentation.

2. The H/M MAC Group Coordinator may delegate responsibility to a H/M MAC Group member to monitor the situation and bring the issue back to the H/M MAC Group when the overall situation changes. The expected outcome should be part of this delegated responsibility.

When one or more members dissent after the decision has been made
1. H/M MAC operational guidelines provide Agency Administrators an opportunity to request reconsideration. Agency Administrator provides written request and rationale to H/M MAC Group Coordinator. Some decisions will require vetting with Agency Administrators.

2. Avoid dissention after the decision is made through effective facilitation and group process during issue discussion.
   a. H/M MAC Group Coordinator facilitates the meeting to ensure that all H/M MAC Group members are participating in discussion of every issue and that perspectives of all agencies are represented.
   b. Silence will not be interpreted as consent.
   c. H/M MAC Group Coordinator will interrupt silence by encouraging all members to express their opinions on the issue.

Record Keeping & Documentation
The following should be documented and retained by appointed staff:
- Attendance at all MAC Group meetings.
- All information presented at MAC Group meetings.
- MAC Group decisions and supporting documentation.
- All daily critical resource allocation documents, signed by the MAC Group Coordinator.
- All decision criteria used by the MAC Group to prioritize incidents and allocate critical resources.
- All notes taken during MAC Group meetings and conference calls (*these materials are subject to external requests*).

The documentation package will be developed by the ECC Documentation Unit Leader, unless otherwise indicated, and will be retained by the host County ECC Manager.

Communicating MAC Group Decisions
- All official decisions will be printed on MAC Group letterhead (template to be developed and agreed upon by appointed MAC Group Representatives) and signed by the MAC Group Coordinator.
- All MAC Group decision documents will be promptly disseminated to the host County ECC Manager, other public ECC Managers and other agency and organizations' leadership (via email, print, conference call, Web sites, etc.), as identified.
- MAC Group decisions and other information will be disseminated to Agency Administrators by Agency Representatives.
- MAC Group decisions will be made available to the public through the host County PIO who will coordinate with the JIC.

Appendix 18 illustrates a matrix of various potential communication and information exchange pathways between individuals, agencies and organizations related to the Health/Medical MAC group.

Reviewing MAC Group Decisions
Agency Administrators should route issues or concerns about MAC Group decisions through their Agency Representative, who will bring it to the MAC Group Coordinator, for further discussion and review.
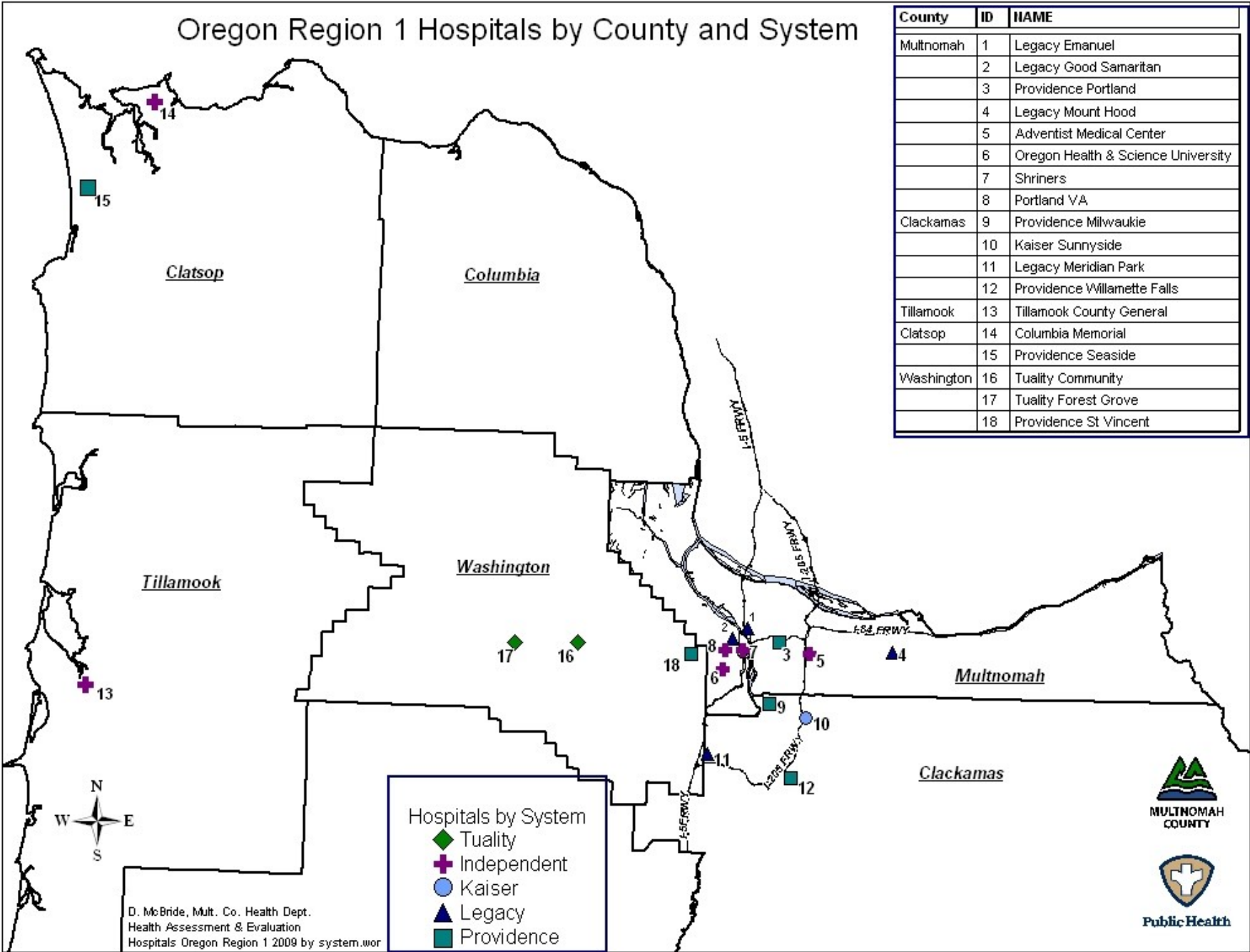
Appendices

APPENDIX 1
Maps of Oregon Region 1 and Washington Region IV: 1 of 3

Oregon Region 1 Hospitals by County and System

County	ID	NAME
Multnomah	1	Legacy Emanuel
	2	Legacy Good Samaritan
	3	Providence Portland
	4	Legacy Mount Hood
	5	Adventist Medical Center
	6	Oregon Health & Science University
	7	Shriners
	8	Portland VA
Clackamas	9	Providence Milwaukie
	10	Kaiser Sunnyside
	11	Legacy Meridian Park
	12	Providence Willamette Falls
Tillamook	13	Tillamook County General
Clatsop	14	Columbia Memorial
	15	Providence Seaside
Washington	16	Tuality Community
	17	Tuality Forest Grove
	18	Providence St Vincent

Hospitals by System
- ◆ Tuality
- ✚ Independent
- ● Kaiser
- ▲ Legacy
- ■ Providence

D. McBride, Mult. Co. Health Dept.
Health Assessment & Evaluation
Hospitals Oregon Region 1 2009 by system.wor

MULTNOMAH COUNTY

Public Health

Washington Region IV Hospitals by County and System

County	ID	
Clark	1	
	2	
Cowlitz	3	

Wahkiakum

OCEAN BEACH HWY

Cowlitz

3

I-5 FRWY

Clark

2

Oregon Region 1 and Washington Region IV

APPENDIX 2
Health/medical Authority for Emergency Response in the States of Oregon and Washington

State of Oregon

401.309 Declaration of state of emergency by local government; procedures; mandatory evacuations.
(1) Each county, city or other municipal corporation in this state may, by ordinance or resolution, establish procedures to prepare for and carry out any activity to prevent, minimize, respond to or recover from an emergency. The ordinance or resolution shall describe the conditions required for the declaration of a state of emergency within the jurisdiction and the agency or individual authorized to declare that a state of emergency exists.

401.315 City or county authorized to incur obligations for emergency services; county determination of emergency.
In carrying out the provisions of ORS 401.015 to 401.107, 401.257 to 401.325 and 401.355 to 401.584, counties or cities may enter into contracts and incur obligations necessary to mitigate, prepare for, respond to or recover from emergencies or major disaster. A county shall assess whether an emergency exists. [1983 c.586 §13; 1991 c.418 2]

431.415 Powers and duties of local health boards; rules; fee schedules.
(1) The district or county board of health is the policymaking body of the county or district in implementing the duties of local departments of health under ORS 431.416.

431.416 Local public health authority or health district; duties.
The local public health authority or health district shall:

(1) Administer and enforce the rules of the local public health authority or the health district and public health laws and rules of the Department of Human Services.

(2) Assure activities necessary for the preservation of health or prevention of disease in the area under its jurisdiction as provided in the annual plan of the authority or district are performed. These activities shall include but not be limited to:

(a) Epidemiology and control of preventable diseases and disorders;

(b) Parent and child health services, including family planning clinics as described in ORS 435.205;

(c) Collection and reporting of health statistics;

(d) Health information and referral services; and

(e) Environmental health services. [1961 c.610 §8; 1973 c.829 §23; 1977 c.582 §28; 1983 c.398 §4; 2001 c.900 §150]

431.530 Authority of local health administrator in emergency.
(1) The local public health administrator may take any action which the Department of Human Services or its director could have taken, if an emergency endangering the public health occurs within the jurisdiction of any local public health administrator and:

(a) The circumstances of the emergency are such that the department or its director cannot take action in time to meet the emergency; and

(b) Delay in taking action to meet the emergency will increase the hazard to public health.

(2) Any local public health administrator who acts under subsection (1) of this section shall report the facts constituting the emergency and any action taken under the authority granted by subsection (1) of this section to the Director of Human Services by the fastest possible means. [1973 c.829 §9; 1977 c.582 §31]

433.443 Authority of Public Health Director during public health emergency; penalties; access to and use of individually identifiable health information; rules. (1)(a) During a public health emergency proclaimed under ORS 433.441, the Public Health Director may, as necessary to appropriately respond to the public health emergency:

(A) Adopt reporting requirements for and provide notice of those requirements to health care providers, institutions and facilities for the purpose of obtaining information directly related to the public health emergency;

(B) After consultation with appropriate medical experts, create and require the use of diagnostic and treatment protocols to respond to the public health emergency and provide notice of those protocols to health care providers, institutions and facilities;

(C) Order, or authorize local public health administrators to order, public health measures appropriate to the public health threat presented;

(D) Upon approval of the Governor, take other actions necessary to address the public health emergency and provide notice of those actions to health care providers, institutions and facilities, including public health actions authorized by ORS 431.264;

(E) Take any enforcement action authorized by ORS 431.262, including the imposition of civil penalties of up to $500 per day against individuals, institutions or facilities that knowingly fail to comply with requirements resulting from actions taken in accordance with the powers granted to the Public Health Director under subparagraphs (A), (B) and (D) of this paragraph; and

(F) The authority granted to the Public Health Director under this section:

(i) Supersedes any authority granted to a local public health authority if the local public health authority acts in a manner inconsistent with guidelines established or rules adopted by the director under this section; and

(ii) Does not supersede the general authority granted to a local public health authority or a local public health administrator except as authorized by law or necessary to respond to a public health emergency.

(b) The authority of the Public Health Director to take administrative action, and the effectiveness of any action taken, under paragraph (a)(A), (B), (D), (E) and (F) of this subsection terminates upon

the expiration of the proclaimed state of public health emergency, unless the actions are continued under other applicable law.

State of Washington

RCW 43.06.010: General powers and duties

(12) The governor may, after finding that a public disorder, disaster, energy emergency, or riot exists within this state or any part thereof which affects life, health, property, or the public peace, proclaim a state of emergency in the area affected, and the powers granted the governor during a state of emergency shall be effective only within the area described in the proclamation;

RCW 70.05.060: Powers and duties of local board of health

Each local board of health shall have supervision over all matters pertaining to the preservation of the life and health of the people within its jurisdiction and shall:

(1) Enforce through the local health officer or the administrative officer appointed under RCW 70.05.040, if any, the public health statutes of the state and rules promulgated by the state board of health and the secretary of health;

(2) Supervise the maintenance of all health and sanitary measures for the protection of the public health within its jurisdiction;

(3) Enact such local rules and regulations as are necessary in order to preserve, promote and improve the public health and provide for the enforcement thereof;

(4) Provide for the control and prevention of any dangerous, contagious or infectious disease within the jurisdiction of the local health department;

RCW 70.05.070: Local health officer—Powers and duties

The local health officer, acting under the direction of the local board of health or under direction of the administrative officer appointed under RCW 70.05.040 or 70.05.035, if any, shall:

(2) Take such action as is necessary to maintain health and sanitation supervision over the territory within his or her jurisdiction;

(3) Control and prevent the spread of any dangerous, contagious or infectious diseases that may occur within his or her jurisdiction;

(4) Inform the public as to the causes, nature, and prevention of disease and disability and the preservation, promotion and improvement of health within his or her jurisdiction;

(5) Prevent, control or abate nuisances which are detrimental to the public health;

(9) Take such measures as he or she deems necessary in order to promote the public health, to participate in the establishment of health educational or training activities, and to authorize the attendance of employees of the local health department or individuals engaged in community health programs related to or part of the programs of the local health department.

RCW 43.20.050: **Powers and duties of state board of health — State public health report — Delegation of authority — Enforcement of rules.**

(d) Adopt rules for the imposition and use of isolation and quarantine;

(e) Adopt rules for the prevention and control of infectious and noninfectious diseases, including food and vector borne illness, and rules governing the receipt and conveyance of remains of deceased persons, and such other sanitary matters as admit of and may best be controlled by universal rule; and

WAC 246-100-036: Responsibilities and duties – Local health officers.

(1) The local health officer shall establish, in consultation with local health care providers, health facilities, emergency management personnel, law enforcement agencies, and any other entity he or she deems necessary, plans, policies, and procedures for instituting emergency measures necessary to prevent the spread of communicable disease or contamination.

Official Collaboration

Overlapping state and local authorities in the two-state area covered by Region 1 and Region 4 will necessitate close coordination among key officials to ensure decisions and response actions are clear and consistent.

Hospital Standards

The Joint Commission (TJC) Standard EM.02, requires hospitals to develop emergency operations plans that coordinate communications, resources and patient clinical support activities during emergencies.

APPENDIX 3
MAC Group Training and Training Assignments

Trainees, using the shadowing process are encouraged for the MAC Group Coordinator and Agency Representative positions. Trainees should be limited to no more than three at any one time and coordinated through the MAC Group Coordinator.

NOTE: I-100 through 400 _should_ be taken before filling the MAC Group Agency Representative and Coordinator positions.

The following additional courses are available and will help in the background training for MAC Group positions:

- M-480 – Multi-Agency Groups – Eight hour course with classroom instruction and exercises for MAC Group Representatives and MAC Group Coordinators.

- I-401 – Multi-Agency Coordination and MAC Groups – Seven hour course with classroom instruction and exercises for MAC Group Representatives and MAC Group Coordinators.

- IS-701 – Multi-Agency Coordination Systems – Online and classroom course and exercises for broad understanding of the NIMS coordination system.

APPENDIX 4
Health/medical Resource Ordering and Information Flow between IMTs, the Host County ECC, County ECCs and the State ECC

County ECCs will continue to support all non-medical incidents while the host County ECC supports all health/medical incidents.


```
            OR/WA
          State ECCs

                              County
                                ECC

Host County                   County
   ECC                          ECC

                              County
                                ECC

                              County
                                ECC

IMT          IMT         IMT         IMT
(Hospital)   (LPH)    (Hospital)    (LPH)
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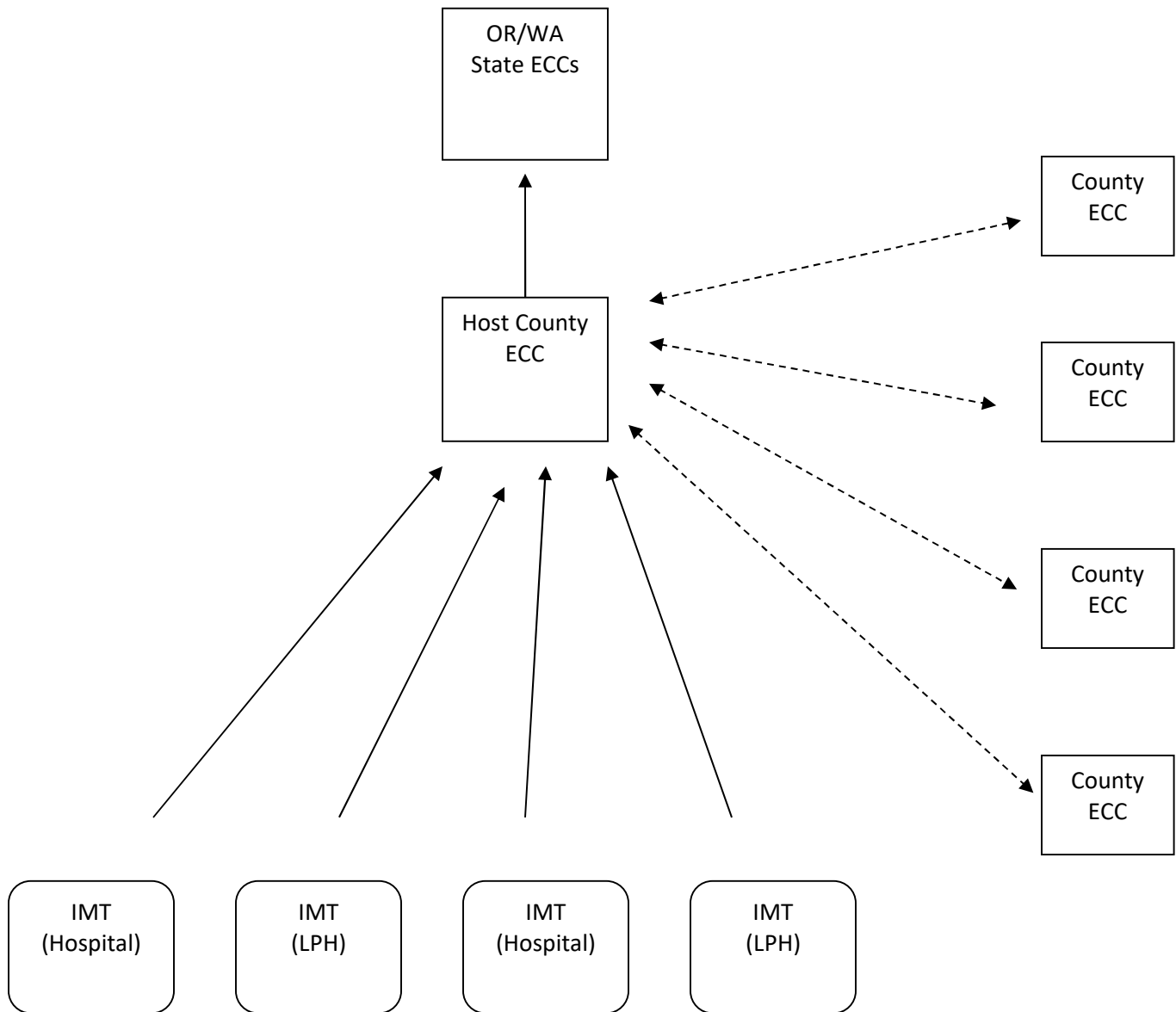
◄—————— Resource Ordering

◄- - - - -► Information flow

APPENDIX 5

Resource Information and Ordering Flow for Host County ISO, MACG and IMTs

1 – Orders from IMT to EROG

2 – EROG to RESL of critical resources

3 – RESL informs MACG of critical resources

4 – MACG informs EROG of assignment of resources

5 – EROG fills priority orders w/ available resources
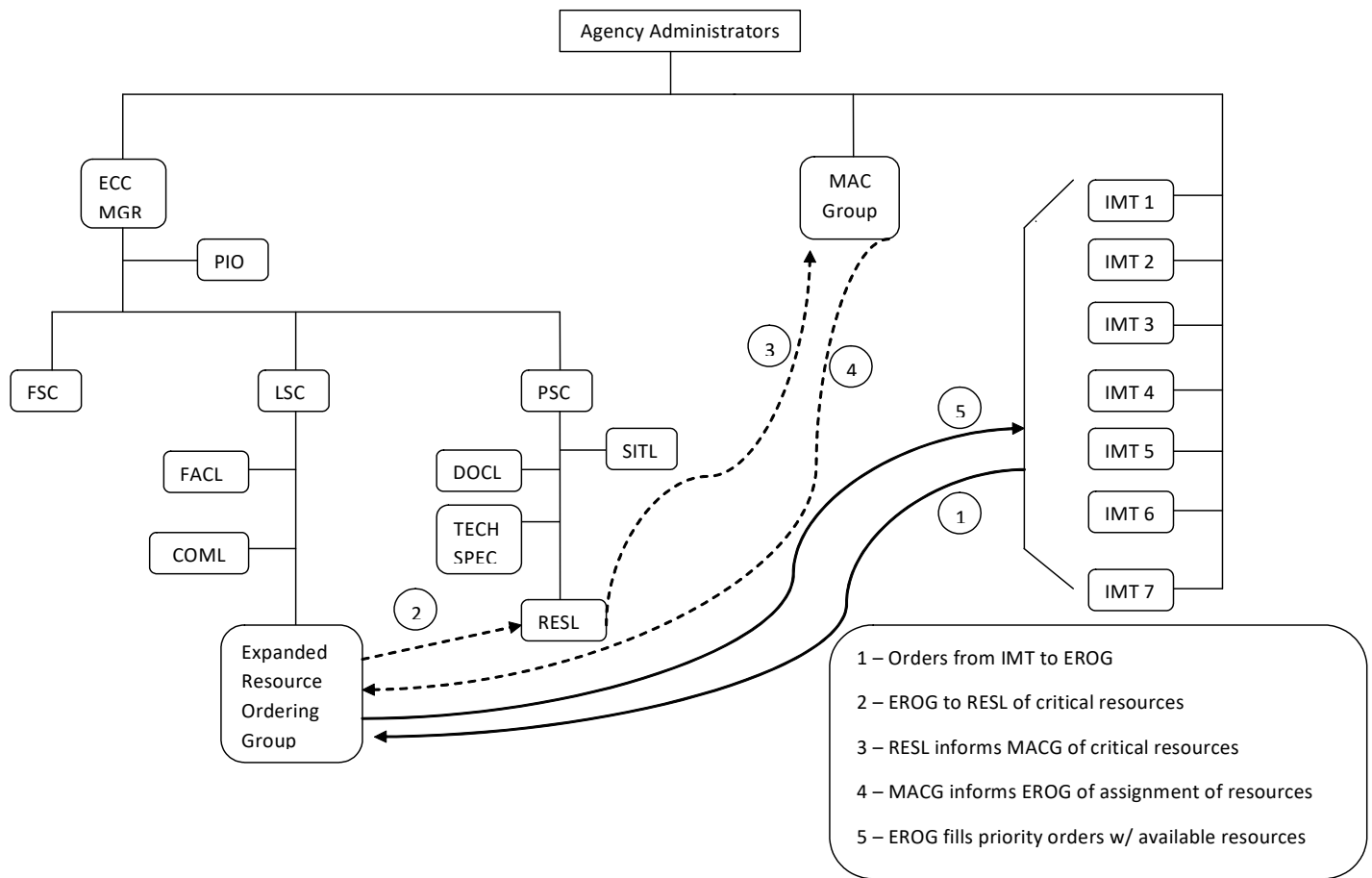
Incident Support Organization Positions:
- PSC – Planning Section Chief
- RESL – Resource Unit Leader
- SITL – Situation Unit Leader
- DOCL – Documentation Unit Leader
- THSP – Technical Specialists
- LSC – Logistics Section Chief
- COML – Communications Unit Leader
- FACL – Facilities Unit Leader
- EROG – Expanded Resource Ordering Group
- PIO – Public Information Officer

APPENDIX 6
Sample Letter of Delegation of Authority
For Health/Medical MAC Group Representatives
(On Agency or Organization Letterhead)

Date: Current Date

Subject: Agency Health/Medical Multi-Agency Coordination (MAC) Group Representative Appointment

To: Name of MAC Group Representative

You are hereby delegated to act on my behalf as a representative on the regional Health/Medical MAC Group. In that capacity, you are authorized to represent [name of your agency/organization's] interests in MAC Group deliberations to do, as necessary, any/all of the following:

1.   Establish interagency strategies to alleviate critical resource shortages and meet anticipated health/medical resource demands.

2.   Establish priorities for the allocation or re-allocation of critical health/medical resources within the region.

3.   Contribute to the development of region-wide policy recommendations/guidance.

4.   Identify regional health/medical issues and help develop interagency solutions.

5.   Commit agency health/medical resources (e.g., staff, money, supplies, etc.).

This delegation is effective the date of this document and will remain effective until the Health/Medical MAC Group completes its work, or until relieved of your assignment, whichever comes first.

I ask that you brief myself or my designee daily on the current situation, any policy decisions that have been agreed upon or any major changes of events.

Print name:

_____
Agency Administrator

Signature:

_____
Agency Administrator

APPENDIX 7
Sample Situation Status Report

HOSPITAL/CLINIC NAME: _____

SITUATION REPORT FOR _____ (date) & _____ (time)

TO: Hospitals in Oregon Region 1/Washington Region IV
FROM: Oregon Region 1/Washington Region IV Health/Medical MAC Group

1) Please estimate the number of people seeking care for influenza evaluation in your Emergency Department and the subsequent impact (i.e. 50 patients with flu-like symptoms seeking evaluation; result is the loss of timely evaluation causing 16 hour wait):

2) Complete the following table describing the effects of not having your critical resource orders filled within the requested reporting time:

	What will happen if your resource request is not filled in the next 24 hours?		
	ED MDs REQUESTED:	**ED RNs REQUESTED:**	**ICU RNs REQESTED:**
PERSONNEL	Impact on hospital operations:	Impact on hospital operations:	Impact on hospital operations:
	Impact on patient survival:	Impact on patient survival:	Impact on patient survival:
	AMBULANCES REQUESTED:		
EQUIPMENT	# of bed not staffed:		
	Impact on patient survival:		
	N95s (20 ct) REQUESTED:	**SURG. MASKS (50 ct) REQUESETD:**	**GLOVES(1000 ct) REQUESTED:**
PERSONAL PROTECTIVE EQUIPMENT	Implications for staff:	Implications for staff:	Implications for staff:
	Implications for patients:	Implications for patients:	Implications for patients:

3) What are your organization's 3 most critical issues/concerns?

4) Has your organization activated its Incident Command Post and/or Incident Management Team?
   ☐ Yes   ☐ No

APPENDIX 8
MAC Group Meeting Agenda Checklist

1) MAC Group members notified.

2) Time and location determined and communicated.

3) Meeting agenda and MAC Group issues prepared by MAC Group Coordinator.

Introduction
- ☐ Review working guidelines (see Appendix 17) and ethical framework
- ☐ If a new member is present, select a method from Appendix 19 to welcome the new member
- ☐ Optional well-being check-in with members

Briefing Portion
- ☐ Current situation update, probable future situation (e.g. assessment of the current healthcare system for event and non-event related illness, projected demand surge from event, related illness and related resource needs, projected reduction of available space, staff and other response capability [e.g. equipment/supplies]);
- ☐ Current issues described;
- ☐ New issues introduced;
- ☐ Questions/clarification.

Discussion/Decision Portion
- ☐ Review identified and new issues;
- ☐ Review criteria for establishing incident priorities and prioritize incidents *(see Appendix 13)*. This includes the maintaining of essential services and unique capabilities of the total healthcare system;
- ☐ Discussions and decisions on issues; ensure alignment with ethical framework *(see Appendix 16)*;
- ☐ Review situation status reports provided by the IMTs for background information to allocate critical resources *(see Appendix 7)*;
- ☐ Allocate critical resources;
- ☐ Discuss how to resolve media and VIP interface issues;
- ☐ Consider needs for contingency and strategic specific plans.

MAC Group Meeting Outputs
- ☐ Decisions/priorities/allocations determined and communicated to affected parties;
- ☐ Decision action *(see p.8)* is identified and documented;
- ☐ Draft new policy or revised policy; communicate with Agency Administrators for approval, as necessary;
- ☐ Plan in place for media interfacing.

APPENDIX 9
MAC Group Coordinator / MAC Group Representatives Conference Call Template

[Date & Time]

Roll call [MAC Group members at the host ECC MAC]   **MAC Group Coordinator**

Roll call [MAC Group members present via phone]

National Update   **MAC Group Coordinator**

MAC Group Update   **MAC Group Coordinator**
- [Short bullet statements with key points or information items (e.g. incident updates, VIP visits, new or ongoing key initiatives, etc.)].

Report on Critical Resources   **MAC Group Coordinator/ECC Manager**
- [Short bullet statement(s) related to the flow/availability of resources].

Outlook   **Incident Support Organization Technical Specialists**
- Projections for the next X hours or X days.

Report on Incidents   **Incident Support Organization Situation Leader**
- Current incident information presented in priority order.
- New activity(s).

Recommendations of Critical Resource Allocation   **MAC Group Coordinator**
- Discussion of proposed allocations by MAC Group Representatives and MAC Group Coordinator with Representatives on the phone.

Issue Identification/Resolution   **All**
- **Issue:** Name of individual presenting the issue followed by a short issue statement.
- **Decision:** Document the decision.

Necessary Actions/Follow up   **MAC Group Coordinator**

Schedule Next Conference Call

Date: _____, _____ - _____, 2009

Time: _____

APPENDIX 10
MAC Group / Incident Commander Conference Call Template

[Date & Time]

Roll Call [Names of individuals – Incident or Agency Office they represent]   **MAC Group Coordinator**

Summary of Oregon and Washington situation

MAC Group Coordinator

MAC GROUP Update   **MAC Group**
Coordinator

IC Update [Presented in order of MAC Group priority]   **Incident Commanders**

In 3 minutes or less, address the following:

- Incident objectives for the day and the probability of success

- Critical resources needs not listed in the last situation report/IPW:
    o Identify threats to be mitigated
    o Critical objectives to be accomplished with resources
    o Consequences of not receiving critical resources

- Additional items of interest for the MAC Group and/or the other ICs

Resource Status Report   **MAC Group Coordinator/ECC Manager**

Final IC Issues or Concerns Not Covered Yet   **Incident Commanders**

Wrap-up with ACs or ICs   **MAC Group Coordinator**

The call with the ICs is now complete. If an Agency Administrator or State ECC conference call is to follow, ICs are invited to remain on the line at their discretion.

Schedule Next Conference   **MAC Group Coordinator**

Date: _____, _____ - _____, 2009

Time: _____

APPENDIX 11
At-A-Glance Comparison of Coordination and Command

Off–Site Coordination	On–Site Command
Coordination occurs off the incident site	On site direct control and management
Does not require the use of ICS, although similar functions (planning, logistics, PIO) may be utilized	Requires use of the Incident Command System (ICS)
Does not command but does have ECC Managers and/or MAC Group Coordinator	There is one Incident Commander or Unified Command
Has no Operations Section as there is no on-site tactical operations to oversee	Has an Operations Section and Operations Section Chief to oversee tactical operations
The Command and General Staff duties are done by an Incident Support Organization (ECC staff)	The Command and General Staff duties are done by an Incident Management Team
Terms associated with off-site Coordination	**Terms associated with on-site Command**
Emergency Coordination Center (ECC)	Incident Command Post (ICP)
Multi-Agency Coordination (MAC) and MAC Group	ICS and Incident Management Team (IMT)
ECC Daily Action Plan	Incident Action Plan (IAP)
Joint Information Center (JIC)	Incident Management Team's PIO
Expanded Resource Ordering Group (EROG)	Support branch of a Logistics section of an IMT

APPENDIX 12
MAC Group Logistical Needs Within the Host ECC

The following should be available or assembled to support a MAC Group operation:

Telephones:
- 1 phone line for voice for each MAC Group Representative
- 1 phone line for voice for the MAC Group Coordinator
- 2 conference phones

Computers:
- DSL or similar system networked for each MAC Group Representative's lap top
- Ability to network MAC Group Representatives lap tops to ECC printers

Work Areas:
- Tables and/or desks for each MAC Group Representatives and MAC Group Coordinator
- Closed meeting room with table and chairs for size of MAC Group
(Includes white boards, room for easel boards, space to post information on walls)

Electronic Display Board:
- 1 four panel white board with copy capability & dry board markers

Copy Machine:
- Access to a copy machine

FAX Machine:
- Access to a FAX machine that doesn't interfere with ECC activities

TV Monitor and VCR/DVD:
- Access to VCR/DVD with monitor

Office Supplies:
- Paper, pencils, pens, paper clips, masking tape, file folders, markers, file boxes, local telephone directory, easel boards, dry markers easel pads

Miscellaneous:
- MAC Group Incident Status Summary and Prioritization Forms (wall display size)
- Health/Medical MAC Group Handbook

APPENDIX 13
Incident Prioritization Criteria

A health/medical mass casualty emergency or disease epidemic that affects the counties in Oregon Region 1 or Washington Region IV are considered "incidents". The role of the regional MAC Group is to prioritize hospital, public health and other care facilities within the region for response/recovery activities, and if necessary, prioritize the allocation of critical resources.

The following criteria are to be used in establishing priorities unless otherwise agreed to by the MAC Group:

1. Potential for loss of life of responders.

2. Potential for loss of life of the public.

3. Potential to cause injury to human life or cause suffering

4. Potential to harm:

   i.   Communities and their long-term social structure.

   ii. Community infrastructure (including long-term effects to economic sustainability and viability).

   iii. Commercial and economic structure within the regions.

   iv. Public Health efforts to contain the spread of the disease.

5. Maintain critical healthcare capabilities (e.g. trauma, burn, stroke, heart attack).

APPENDIX 14
Issue Prioritization Criteria

How are issues identified?
Issues can come before the H/M MAC Group from the following sources:
1. H/M MAC Group Coordinator identifies the issues.
2. H/M MAC Group Coordinator works with Agency Administrators to identify issues.
3. Agency Representatives (H/M MAC Group members) recommend issues.
    i. Agency Representatives identify issues for future meeting at end of each H/M MAC Group meeting.
    ii. Agency Representatives presenting issues for H/M MAC Group resolution will prepare a written summary with supporting information for presentation to H/M MAC Group.
4. Agency Administrators recommend issues.

In all cases issues should be analyzed and the presenter should prepare a written summary describing the issue. H/M MAC Group Coordinator or members should ideally use a pre-determined series/checklist of questions that will help evaluate whether an issue should be brought to the H/M MAC Group.

These guidelines on prioritizing and choosing issues should be interpreted based on the event; prioritization is event-driven.

Who prioritizes issues?
The H/M MAC Group Coordinator:
- Prioritizes the issues when obvious; allows whole group to view issues accepted and rejected
- Is transparent about the issues brought up but not considered
- Coaches agencies why issues were not selected as priority
- Uses conference calls as needed to prioritize issues
- Facilitates H/M MAC Group in prioritizing the issues when the situation is more complex

How are issues prioritized?
- First cut (triage) should be done by the H/M MAC Coordinator
- Allow the whole group to look at those issues accepted & rejected as appropriate for H/M MAC group
- Focus on broad Health/Medical issues; redirect others to appropriate MAC groups or agencies
- Issues, with few exceptions, should be multi-jurisdictional/multi-agency
- H/M MAC Group Coordinator develops yes/no questions for issue prioritization:
    * What is the urgency of the issue?
    * Does this issue involve a threat to life?
    * Does this issue involve a threat to property?
    * Is this a long-term issue or a short-term issue?
    * To what degree will the community be affected?
    * What is the perception of agencies about the importance this issue?
    * What is the perception of the public about the importance of this issue?

Purpose of this template: To be used by the Health/Medical MAC Coordinator to help determine issues to be presented to the H/M MAC. May also be used by individual MAC members to help them decide whether or not to present an issue for consideration by the Coordinator or the MAC group.

Issue 1:_____

Issue 2:_____

Issue 3:_____

Issue 4:_____

Issue 5:_____

Issue ➝ **Prioritzation Criteria** ↓	Issue 1	Issue 2	Issue 3	Issue 4	Issue 5
Does this involve a threat to life?					
Does this involve a threat to property?					
How many agencies or jurisdictions are affected?					
Is this a long-term or short-term issue?					
To what degree is the community affected?					
What is the perception of agencies about this issue?					
What is the perception of the public about this issue?					
How urgent is this issue?					
Conclusions/ Priority (1st, 2nd, 3rd, 4th, 5th)					

Notes:

APPENDIX 15
A Typical Day in the Life of a MAC Group

TIME	ACTIONS	WHO
0800-0830	• Updates from organizations and agencies with MAC Group Reps. • Review new SITREPS and information.	**MACG, MACC**
0830-0900	MACG Briefing to MACG Reps. on the situational update, VIP and Media, unresolved issues and policies that have not been resolved left over from the day before.	**SITL, RESL, PIO and MACC**
0900-1300	• Select issues and policy recommendations that will be addressed before the MACG afternoon meeting. • Develop recommended policy for AA approval. Develop issue resolutions. • Update the need for Technical Specialists or outside information needed and give to the MACC and PSC. • Develop Critical Resource Allocation criteria or update from day before. • Continue to do networking with host agencies and organizations.	**MACG or sub groups of MACG, MACC**
1300-1400	• Gather as a MACG to present drafts of policy recommendations, common issue resolution • Assign how and with who these items will be shared with.	**MACG, MACC, PIO, PSC**
1400-1430	• Prepare for MACG afternoon meeting. • Read any updates from the RESL on resources and items from the SITL and PIO.	**MACG, MACC**
1430-1630	• See standard items and agenda for the MACG Meeting: NOTE – This is when the Critical Resource Allocation is completed by the MACG Reps. with the help of the RESL, PSC and MACC.	**MACG, MACC, PSC, RESL, SITL, PIO**
1630-???	• Complete any needed unfinished action items before ending for the night. • Do a final trap line. • Set draft agenda for the next operational period. • Hold any needed small group work or informational meetings. • Go get dinner!	**MACG, MACC**

AA – Agency Administrator
AREP – MACG Agency Representatives
MACC – MAC Group Coordinator
MACG – MAC Group
PIO – Public Information Officer (in the MACG Support Organization)
PSC – Planning Section Chief (in the MACG Support Organization)
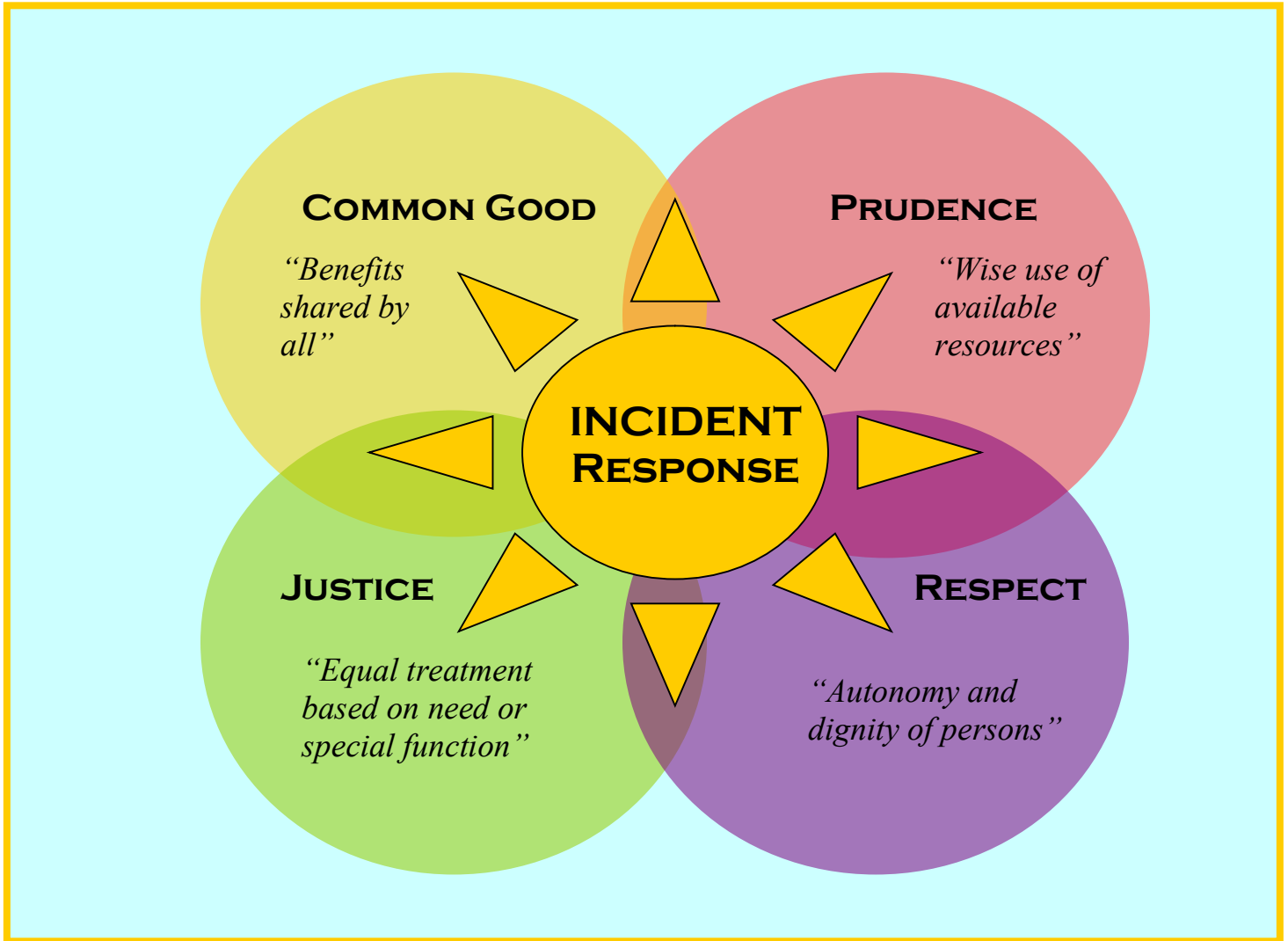RESL – Resource Unit Leader (in the MACG Support Organization)
SITL – Situation Unit Leader (in the MACG Support Organization)

APPENDIX 16
Ethical Framework and Criteria

Illustrated below is an ethical framework based on a series of community discussions in NW Oregon and SW Washington during the Summer of 2009. The discussions were designed to identify community values and priorities related to the provision of medical services during a large scale health incident. Additionally, this framework was compared against existing literature in the field of health ethics for consistency and alignment purposes. It is the synthesis of these two components that yields the following framework.

COMMON GOOD
"Benefits shared by all"

PRUDENCE
"Wise use of available resources"

INCIDENT RESPONSE

JUSTICE
"Equal treatment based on need or special function"

RESPECT
"Autonomy and dignity of persons"

Ethics Framework for Incident Response Strategy

These principles provide a foundation for specific decisions about allocation of clinical resources and facilities during the phases of the incident response.

1. **Common good**: design the response to protect the health related wellbeing of the whole population and the continuing functioning of society.
   - Minimize the total illness and death that is likely to result from the incident.
   - Design the response to protect essential societal functions.
   - Minimize the negative effects of the incident on the general functioning of society.

2. **Justice**: design the response to provide a fair distribution of health related benefits and burdens that result from public health activities.
   - Seek an equitable distribution of opportunity for health benefits relative to the capacity for benefit.
     - Life saving
     - Illness minimization
   - Seek an equitable distribution of burdens relative to the capacity to bear burden.
     - Risk of death
     - Risk of injury
     - Inconvenience
   - Seek equity across socioeconomic spectrum: adjust for effects of poverty, language and ethnicity on health and access to services.
   - Conflict of interest:
     - Personal conflicts: decision makers declare any potential conflicts and remove themselves from decision control when appropriate.
     - Institutional conflicts: institutional leaders share responsibility for decisions.

3. **Prudence**: use relevant expert inputs while designing and implementing the public health response.
   - Epidemiologic and medical science
   - Effectiveness of interventions to achieve goals
   - Efficiency in the use of resources
   - Agility in response to evolving epidemic

4. **Respect:** maintain communication and procedures to respect autonomy and dignity.
   - Transparency: explain the rationale for the response and state reasons for unequal distribution of benefits and burdens likely to occur.
   - Autonomy: offer the opportunity for members of the community to be in accord with the actions of the public health authority.
   - Coercion: act with respect when it is necessary to override the wishes of some members of the community for personal health services.

Questions to Guide Decision Process

Decision makers can use the following questions to apply the above ethical principles to policy development and implementation. Consensus based answers to these questions will form the ethical dimension of ongoing decisions and communication with the community about the public health response to the incident.

1. **Common good**: In what way will all members of the community share equally in the societal well being hoped for in this strategy? What social functions does this strategy seek to protect?

2. **Justice**: In what way are the several norms of justice being met?
   - Equality: What categories did we consider in applying the equality norm? In what ways is the plan based on equality among persons with similar characteristics of age, health potential, gender, social status?
   - Inequality: What rationales did we use to justify unequal treatment among selected members of the community?
     - What compensatory aid did we set up for persons with special needs? What categories of special need have we considered, included, and excluded (with statement of rationale for inclusion, exclusion decisions)?
     - Merit: what groups were given priority based on their essential social role?
   - Exclusions: What is the rationale for excluding specific persons from the outreach effort?
   - Conflict of interest: What potential conflicts of interest have been considered and how are they being dealt with?

3. **Prudence**: What categories of expertise did this strategy incorporate into planning? What expertise are we consulting during implementation?

4. **Respect**: Are we producing appropriately brief, clear, and simple statements of how the incident response strategy protects the general well being of society? How does this strategy respect the rights of individuals to knowledge, autonomy, and dignity?

Health/Medical MAC Group Decision-Making Tool and the Ethical Framework

Definition of the situation/problem: _____

_____

What is the goal of the decision we are making? _____

The decision being considered: _____

Questions from Mac Handbook Appendix 14:
- What is the potential for loss of life of responders?

- What is the potential for loss of life of the public?

- What is the potential to cause injury to human life or cause suffering?

- Would this decision cause potential harm to—

  - Communities & their long-term social structure?

  - Community infrastructure (including long-term effects to economic sustainability & viability)?

  - Commercial & economic structure within the regions?

  - Public Health efforts to contain the spread of the disease?

Questions that reflect the Ethical Framework:
- Who benefits from this decision? (community as a whole, specific segments of the community, individuals)

- What do the benefits look like?

- Who is put at risk if we make this decision?

- What do those risks look like?

- What is the equity distribution among providers/institutions if we make this decision?

Rationale for Decision based on the Ethical Framework

Decision ➞	
Ethical Framework Criteria ↓	**Rationale**
Prudence Wise use of available resources	
Common Good Benefits shared by all	
Justice Equal treatment based on need or special function	
Respect Autonomy & dignity of persons	

Conclusions/Final Decision Comments/ Implementation Notes:

Ethical Framework Tool for Health/Medical MAC Group

Definition of the situation/problem:

What is the goal of the decision we are making?

Option 1 Decision:

Who benefits from this decision? (community as a whole, specific segments of the community, individuals)

What do the benefits look like?

Who is put at risk if we make this decision?

What do those risks look like?

What is the equity distribution among providers/institutions if we make this decision?

Option 2 Decision:

Who benefits from this decision? (community as a whole, specific segments of the community, individuals)

What do the benefits look like?

Who is put at risk if we make this decision?

What do those risks look like?

What is the equity distribution among providers/institutions if we make this decision?

Options → Ethical Framework Criteria	Option 1	Option 2
Prudence *Wise use of available resources*		
Common Good *Benefits shared by all*		
Justice *Equal treatment based on need or special function*		
Respect *Autonomy & dignity of persons*		
Conclusions/final decision preference		

APPENDIX 17
Working Guidelines

The H/M MAC Group established these guidelines for their meetings:

Behavior Expectations
- Treat others with Respect
- Each person's perspective adds value to the group
- Listen to understand, not just to respond
- No side conversations
- Friendly disagreement is OK
- Start & end on time
- Keep your sense of humor
- Assume good intentions
- Lay your cards out, be transparent about your concerns
- Cell phones on vibrate / No texting
- Step out of the room for taking phone calls and texting
- Schedule call/Text breaks
- Inform the group at the beginning of the meeting if you have to leave early

Business/Decision Making
- Come prepared to meetings
- Follow through on commitments for work assigned
- Try for consensus
- Obligation to bring up differing opinion
- Use ethical framework
- Make informed decisions
- Have a standing parking lot (Bike Rack)

Created and adopted on May 10, 2010

APPENDIX 18
Information Exchange of Organizations
Associated with the Health/Medical MAC Group

		A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q
MAC Group																		
• Representatives	A	X	X					X	X			X			X			X
• Coordinator	B	X	X	X	X	X	X	X	X	X	X	X			X	X	X	X
Host ECC																		
• Manager	C		X	X	X	X	X	X	X	X	X	X			X	X	X	X
• Logistics Section Chief	D		X	X	X	X												
• Expanded Resource Ordering Group	E		X	X	X	X			X	X			X				X	
• Planning Section Chief	F		X	X			X	X	X	X	X		X				X	
• Situation Unit Leader	G	X	X	X			X	X	X	X	X		X					
• Resource Unit Leader	H	X	X	X		X	X	X	X	X	X		X					
• Documentation Unit Leader	I		X	X		X	X	X	X	X	X							
• Public Information Officer	J		X	X			X	X	X	X	X	X	X	X				
Incident Management Teams																		
• Incident Commander	K	X	X									X	X	X				X
• Command & General Staff	L					X	X	X	X		X	X	X	X				
Joint Information Center																		
• Public Information Officer	M			X							X		X	X				
County ECCs																		
• ECC Manager	N	X	X	X											X	X		X
State ECC																		
• ECC Manager	O		X	X											X	X		
• Expanded Resource Ordering Group	P		X	X		X												
Responding Agencies																		
Agency Administrators	Q	X	X	X								X			X		X	X

APPENDIX 19
Bringing New Members into the H/M MAC Group

Multi Agency Coordination Groups will often have alternates or new Agency Representatives attending meetings. The MAC Group should have agreed upon standards and methods to bring these new members into the group to help assure they feel part of the team and are up to date on issues, information and group standards and guidelines.

Examples of Methods to Bring in New MAC Group Members

♦ The primary Agency Representative will <u>continually </u>share all decisions, upcoming business, current and upcoming issues, and meeting notes with all their Alternate Agency Representatives.

♦ The primary Agency Representative will discuss with their Alternates the MAC Group Handbook, Working Guidelines, and Ethical Framework.

♦ The MAC Group will agree on methods to introduce new members and Alternates to the group during meetings. Examples could be:
  o At the start of the meeting, physically move to another part of the room and ask that everyone stand in a circle and share information about themselves. Below are examples of information that other groups include:
    ▪ Name
    ▪ Organization or agency they are representing and their non MAC Group position in that organization
    ▪ One strength they bring to the MAC Group process
    ▪ One weakness they want everyone to help them with to be more effective in the MAC Group process
    ▪ Why they are involved in public emergency response
    ▪ Two personal background items about themselves
  o In the limited time a MAC Group has during meetings, all the examples of information to share probably can't be used so the MAC Group Coordinator or MAC Group should decide ahead of time which items would be used.

APPENDIX 20
Glossary of Terms

Agency Administrator (AA) – Person(s) in charge of the agency/agencies or jurisdiction(s) that has responsibility to respond to an incident.

Critical Resources – Resources ordered by an incident which cannot be filled within the requested reporting time. Often also called scarce resources.

Delegation of Authority – A statement provided to the Agency Representative on a Multi-Agency Coordination (MAC) Group by the Agency Administrator delegating authority and assigning responsibility. This can include objectives, priorities, expectations, constraints and other considerations or guidelines as needed.

ECC – [Emergency Coordination Center] – Facility which houses the coordination organizations such as a jurisdiction's emergency manager and their Incident Support Organization (ISO) and a MAC Group.

ECC Manager – Supervises the ISO and other organizations in the ECC, except for the MAC Group.

EROG – [Expanded Resource Ordering Group] – A centralized group of ordering specialists who receive and fill all orders from a number of incidents.

IAP – [Incident Action Plan] – Contains objectives reflecting the overall incident strategy and specific tactical actions and supporting information for the next operational period. It may include incident objectives, organizational assignment list, division assignments, communication plan medical plan, traffic plan, safety plan and incident map.

ICP – [Incident Command Post] – Location at which primary command functions are executed; may be co-located at the incident base or other incident facilities.

ICS – [Incident Command System] – A standard on-scene emergency management concept designed to allow users to adopt an integrated organizational structure equal to the complexity and demands of single or multiple incidents, without being hindered by jurisdictional boundaries.

IMT – [Incident Management Team] – The Incident Commander and appropriate Command and General Staff personnel assigned to an incident.

ISO – [Incident Support Organization] – May includes Planning, Logistics, Administration/Finance sections and Public Information Officer positions to support the operation of an ECC and MAC Group.

JIC – [Joint Information Center] – An off-site facility housing an interagency group of PIOs who provide public and media information from an interagency perspective.

JIS – [Joint Information System] – Integrates incident information and public affairs into a cohesive organization to provide consistent, coordinated, accurate, accessible, timely and complete information during incident operations. Provides a structure and system for developing and delivery of coordinated interagency messages.

MAC Group – [Multi-Agency Coordination Group] (MACG) – A generalized term which describes the functions and activities of representatives of involved agencies and/or jurisdictions who come together to make decisions regarding the prioritization of incidents and the assignment of critical resources.

MAC Group Objectives – Broad interagency objectives that apply to all the incidents involved within the MAC Group's geographic area of responsibility.

MAC Group Agency Representative (AREP) – An individual assigned to a MAC Group with delegated authority to represent their agency in carrying out the roles and responsibilities of the group.

Multi-Agency Coordination Systems – (MACS) Provides the structure to support coordination for incident prioritization, critical resource allocation, communications systems integration and information coordination. The elements of Multi-Agency coordination systems include facilities, equipment, personnel, procedures and communications. The two most commonly used elements are ECCs and MAC Groups.

NIMS – [National Incident Management System] – System that provides for a consistent nationwide approach for Federal, State, local and tribal governments; the private sector, and nongovernmental organizations to work together effectively and efficiently to prepare for, respond to and recover from domestic incidents, regardless of cause, size or complexity. NIMS includes a core set of concepts, principles and terminology. These are ICS, MAC Systems, training; identification, typing and management of resources; qualification and certification; and the collection and tracking and reporting of incident information and incident resources.

Resources – Personnel, equipment, services and supplies available for assignment to an incident.

MEMORANDUM OF UNDERSTANDING

Hospital/Health System Facility Emergency Mutual Aid

Created by:

NW Oregon Health Preparedness Organization

Healthcare Preparedness Region 1

September 2007

Public Health

Memorandum of Understanding
Hospital/Health System Facility Emergency Mutual Aid
NW Oregon Health Preparedness Organization
Healthcare Preparedness Region 1

I. INTRODUCTION

Northwest Oregon is susceptible to disasters, both natural and human-made, that could severely tax or exceed the capabilities of the region's hospitals and health systems. A disaster could result from a large-scale incident generating an overwhelming number of patients (e.g., major transportation accident or act of terrorism), or from an incident generating a smaller number of patients whose specialized medical requirements exceed the resources of the Impacted Facility (e.g., hazmat, pulmonary, or traumatic injuries), or from incidents such as hospital building or physical plant problems resulting in the need for partial or complete evacuation of a hospital/health system facility.

II. PURPOSE

This Memorandum of Understanding (MOU) is a voluntary agreement among the hospital/health system facilities in Northwest Oregon Healthcare Preparedness Region 1 (and Southwest Washington) listed on Exhibit A for the purpose of 1) coordinating emergency planning; 2) preparing for a coordinated health sector response to large-scale emergencies; 3) facilitating communications; and 4) providing mutual aid at the time of a medical disaster.

For purposes of this MOU, a **medical disaster** is defined as an overwhelming incident that **exceeds the effective response capability** of the impacted hospital/health system facility or facilities. The disaster may be an "external" or "internal" event for hospital/health system facilities and assumes that each affected hospital/health system facility's emergency management plans have been fully implemented.

This MOU is not a legally binding contract; rather, it signifies the belief and commitment of the participating hospital/health system facilities that in the event of a disaster, the medical needs of the community will be best met if the hospital/health system facilities cooperate with each other and coordinate their response efforts. By signing this MOU, each hospital/health system facility is evidencing its intent to abide by the terms of the MOU in the event of a medical disaster as described above. The terms of this MOU are to be incorporated into the hospital/health system facilities' emergency management plans.

This MOU is not intended to replace individual hospital/health system facilities' disaster plans. Each hospital/health system facility has the responsibility for maintaining its own emergency management plan that includes, at a minimum, provisions for the care of patients in an emergency or disaster situation, maintenance of disaster equipment, appropriate training of staff and the implementation of an internal incident command system based on the principles of the Hospital Incident Command System (HICS) and compliant with the National Incident Management System (NIMS).

III. DEFINITION OF TERMS

Health Alert
Network (HAN)   A State of Oregon sponsored web-based system designed to broadcast
                          warnings of impending or current disasters affecting the ability of health
                          officials and healthcare providers to provide disaster response services to
                          the public. The HAN is also used to push routine and emergency health

information to partners and contains an access controlled online information library and public health directory.

NW Oregon Health Preparedness Organization (HPO)	A public/private planning partnership to prepare the health sector to respond to large-scale emergencies. The HPO serves as the regional health preparedness board for northwest Oregon and covers six counties including Clackamas, Clatsop, Columbia, Multnomah, Tillamook and Washington.
Impacted Facility	A hospital/health system facility where the disaster occurred or where disaster victims are being treated. Referred to as the "Recipient Facility" when pharmaceuticals, supplies, equipment, and/or personnel are requested or as the "Patient-Transferring Facility" when the evacuation of patients is required.
Medical Disaster	An incident that exceeds the response capability of one or more participating hospital/health system facilities that cannot appropriately resolve the incident solely by using its own resources. Such disasters will create the need for additional medical and support personnel, pharmaceuticals, supplies, and/or equipment from another facility, and may require the emergent evacuation of patients.
Participating Hospital/Health System Facility	A hospital/health system facility that has fully committed to and signed the MOU. A list of Participating Hospital/Health System Facilities will be maintained and disseminated by the HPO.
Patient-Transferring Facility	An Impacted Facility where patients must be evacuated from due to a disaster.
Patient-Receiving Facility	A responding Participating Hospital/Health System Facility that receives patient transfers from an Impacted Facility.
Recipient Facility	The Impacted Facility. The hospital facility where disaster patients are being treated and have requested pharmaceuticals, supplies, equipment and/or personnel from another facility.
Regional Hospital	A communication hub for all hospitals in the Portland metropolitan area that is responsible for coordinating patient destination during mass casualty incidents (MCI) and other emergency or disaster situations.
Resource-Transferring Facility	A responding Participating Hospital/Health System Facility that sends pharmaceuticals, supplies, equipment and/or personnel to the Recipient Facility or receives patient transfers/evacuations.

IV. AGREEMENT

A. Participation in Regional Health Sector Emergency Preparedness Planning

1. Each Participating Hospital/Health System Facility will designate a representative to the NW Oregon Health Preparedness Organization (HPO) Steering Committee. The designee will have authority to speak on behalf of the organization s/he is representing and contribute to the development of regional operational procedures and coordination of mutual aid initiatives. Participation on the HPO

Steering Committee will foster coordination with other disaster relief and emergency medical providers and public agencies involved in disaster response efforts.

2. Each Participating Hospital/Health System Facility will designate appropriate representatives to participate in regional hospital-related emergency management groups including but not limited to the NW Hospital Emergency Management Committee and the ED Nurse Managers Committee.

B. Communication

1. Each Participating Hospital/Health System Facility will report equipment, bed capacity, and other regional health resource information during drills or disasters to the State's web-based hospital capacity reporting system. In the event of a medical disaster, this system is used by all hospitals in the region to report open/closed/divert status in real-time. Data requests and reporting via the system can be collected and disseminated to all hospitals simultaneously.

2. Each Participating Hospital/Health System Facility agrees to use, maintain, and upgrade when necessary the equipment necessary to participate in the following communication systems, where applicable:

   a. Routine Communications – Each Participating Hospital/Health System Facility will:
      i. Communicate utilizing the routine communication guidelines identified in the Healthcare Preparedness Region 1 Communications Plan.

   b. Emergency Communications – Each Participating Hospital/Health System Facility will:
      i. Communicate and coordinate efforts to respond to a medical disaster primarily via their liaison officers, public information officers, and incident commanders.
      ii. Utilize Regional Hospital and/or the Health Alert Network to receive alert information regarding any medical disaster or other special incidents.
      iii. Communicate with each other's Emergency Operations Centers (EOC) by phone, fax, email, and maintain radio capability to communicate with Regional Hospital as a minimum back-up.
      iv. Communicate utilizing the emergency communication guidelines identified in the Healthcare Preparedness Region 1 Communications Plan.

C. Mutual Aid Received by or Provided to Participating Hospital/Health System Facilities

1. Authority and Communication

   The scenario and impact of a medical disaster or emergency will determine how requests for assistance are made between Participating Hospital/Health System Facilities.

   a. One hospital impacted by an event
      i. If one Participating Hospital/Health System Facility experiences a medical disaster, only a Hospital Administrator or designee of that facility which has a need for staff or equipment ("Recipient Facility") has the authority to initiate the request for transfer of patients or receipt of personnel and/or material resources pursuant to this MOU. The request for pharmaceuticals, supplies, equipment and/or personnel must be made to Hospital Administration at the Resource-Transferring Facility.
      ii. Requests may initially be made verbally to Hospital Administration but must be followed by written documentation specifying more detail (See section 4.C.3 Transfer of Pharmaceuticals, Supplies and/or Equipment). Hospital Administrator or designee of the

Recipient Facility will deliver this request to the other Participating Hospital/Health System Facility and coordinate the response with staff from the Resource-Transferring Facility.

b. Multiple hospitals impacted by an event
   i. If multiple Participating Hospital/Health System Facilities experience a medical disaster, it is assumed that each facility will be organized to respond under the Hospital Incident Command System (HICS). In this circumstance, only Command Staff (likely the Liaison Officer) or designees of the Recipient Facility have the authority to initiate the request for transfer of patients or receipt of personnel and/or material resources pursuant to this MOU. The request for pharmaceuticals, supplies, equipment and/or personnel must be made to Command Staff at the Resource-Transferring Facility.
   ii. Requests may initially be made verbally to Command Staff but must be followed by written documentation specifying more detail (See section 4.C.3 Transfer of Pharmaceuticals, Supplies and/or Equipment). Command Staff or designees of the Recipient Facility will deliver this request to the other Participating Hospital/Health System Facility and coordinate the response with staff from the Resource-Transferring Facility.
   iii. If multiple Participating Hospital/Health System Facilities are experiencing a medical disaster or emergency which result in requesting assistance from other hospitals in the region, Command Staff will notify County Emergency Management and County Public Health of the event and any anticipated future needs for support.

2. Personnel (and Volunteers)

Personnel employed by, contracted with or on the staff of the Resource-Transferring Facility who are dispatched to the Recipient Facility shall be limited to staff that are certified, licensed, privileged and/or credentialed in the Resource-Transferring Facility, as appropriate, given such staffs' professional scope of practice. Resource-Transferring Facility employees who are dispatched to a Recipient Facility shall provide proof of their professional licensure (e.g. RN, MD) to the Recipient Facility.

The Recipient Facility's Labor Pool Unit Leader or designee will identify where and to whom emergency Resource-Transferring Facility Personnel are to report and who will direct and/or supervise them. This supervisor will brief the personnel of the situation and their assignments. The Recipient Facility will provide and coordinate any necessary demobilization and post-event stress debriefing. If needed or requested, the Recipient Hospital is responsible for providing the Resource-Transferring Facility Personnel with transportation for their return to the Resource-Transferring Facility.

In compliance with Joint Commission standards, when the Recipient Facility's emergency management plan has been activated, the Labor Pool Unit Leader or designee may grant emergency privileges to licensed independent practitioners with evidence of appropriate identification. Acceptable sources of identification include a current professional license in the State in which the Recipient Facility is located, a current facility ID plus license number or verification of the subject practitioner's identity by a current medical staff member. (See JOINT COMMISSION EC.4.10.14 and HR.4.35).

3. Transfer of Pharmaceuticals, Supplies and/or Equipment

The request for the transfer of pharmaceuticals, supplies, and/or equipment initially can be made verbally but must be followed by written documentation specifying the following:

a. Quantity and exact type of requested items;

b. An estimate of how quickly the pharmaceuticals, supplies and/or equipment is needed;

c. Time period for which the pharmaceuticals, supplies and/or equipment will be needed;

d. Location and person or staff position to which the pharmaceuticals, supplies and/or equipment should be delivered.

The Resource-Transferring Facility is responsible for tracking the transferred inventory, including the items involved, the condition of the equipment (if applicable), and the responsible parties for the borrowed materials, including return of inventory if applicable.

The Recipient Facility is responsible for appropriate safeguards, use, protection and maintenance of all transferred pharmaceuticals, supplies, and/or equipment. Upon conclusion of the event, the Recipient Facility will promptly return equipment and unexpended supplies and/or pharmaceuticals to the Resource-Transferring Facility.

4. Transfer / Evacuation of Patients

In the event a partial or full evacuation of a Participating Hospital/Health System Facility is necessary, it is recognized that multiple hospitals/health systems in the community may need to assist in the orderly evacuation of patients by providing care to as many evacuated patients as possible. This care may be provided temporarily as patients are staged for transportation to other hospitals or long term care facilities, or until evacuated patients can be returned to the care of their primary facility.

The Patient-Transferring Facility (impacted hospital) must specify the following:

a. The number of patients needed to be transferred;

b. The general nature of their illness or condition;

c. Any type of specialized services required, e.g., ICU bed, burn bed, trauma care, etc.

The Patient-Transferring Facility (impacted hospital) requesting transfer of one or more of its patients is responsible for providing the Patient-Receiving Facility (assisting hospital) with copies of the patient's pertinent medical records, registration information, insurance and other information necessary for care.

The Patient-Transferring Facility is responsible for notifying both the patient's family or guardian and the patient's attending or personal physician of the transfer. The Patient-Receiving Facility may assist in notifying the patient's family and personal physician.

Once the patient arrives to the Patient-Receiving Facility, such facility becomes responsible for the care of the patient. If requested, the facility that assumes the care of the transferred patients may grant temporary medical staff privileges or emergency privileges, in accordance with its medical staff bylaws, to the patient's original attending physician.

Once the transferred patient is discharged, the Patient-Receiving Facility will return all original medical records, including X-ray films and labs, back to the Patient-Transferring Facility.

V. MISCELLANEOUS PROVISIONS

    A. Term and Termination

This MOU shall commence upon execution by an authorized officer of the Participating Hospital/Health System Facility and shall continue until terminated. Any Participating Hospital/Health System Facility may terminate its participation in this MOU at any time by providing 30 days written notice to all other Participating Hospital/Health System Facilities on this signed agreement (see Exhibit A).

    B. Confidentiality

Each Participating Hospital/Health System Facility shall maintain the confidentiality of all patient health information and medical records in accordance with applicable State and Federal laws, including, but not limited to, the Health Insurance Portability and Accountability Act (HIPAA) privacy regulations.

    C. Insurance

Each Participating Hospital/Health System Facility shall maintain, at its own expense, professional, workers' compensation and general liability insurance coverage or programs of self-insurance for itself and its respective employees and, where the Participating Hospital/Health System Facility is a Recipient Facility, it also agrees to extend its professional and general liability coverage to loaned personnel consistent with its existing coverage for other employed Volunteers for claims arising out of services provided by such Volunteers on behalf of the Recipient Facility.

    D. Defense and Indemnification

The Recipient Facility shall assume the defense and indemnification for liability claims arising from or asserting the negligent acts and omissions of Personnel who are employed by and otherwise covered by the Resource-Transferring Facility. Volunteers who are licensed independent practitioners and who are not employees of a Participating or Resource-Transferring Facility will procure their own professional and general liability coverage and the Recipient Facility shall not assume the liability, defense or indemnification obligation for such independent Volunteers arising out of participation in this MOU.

    E. Hold Harmless Condition

The Recipient Facility should hold harmless the Resource-Transferring Facility for any general or professional liability claims, expenses, and damages including reasonable attorneys' fees or other costs resulting solely from the acts or omissions of personnel covered by the Recipient Facility while such personnel are providing services for the Recipient Facility pursuant to this MOU. The Resource-Transferring Facility, however, is responsible for appropriate credentialing of personnel and for the safety and integrity of the equipment and supplies provided for use at the Recipient Facility.

    F. Certification

A signed copy of this MOU signature page shall be sent via facsimile or mail to the HPO.

Executed below by an authorized officer of Participating Hospital/Health System Facility:

_____   _____
Name   Date

Signature

Title

Hospital/Health System Facility

County/State

EXHIBIT A

Hospital/Health System Facilities in Oregon Healthcare Preparedness Region 1

**Adventist Medical Center

**Cedar Hills Hospital

**Columbia Memorial Hospital

**Kaiser Permanente

- Kaiser Sunnyside Medical Center
- Kaiser Westside Medical Center

**Legacy Health
- Legacy Emanuel Medical Center
- Legacy Good Samaritan Medical Center
- Legacy Meridian Park Medical Center
- Legacy Mt. Hood Medical Center
- Legacy Randall Children's Hospital

**OHSU
- Oregon Health & Science University Hospital
- Doernbecher Children's Hospital

**Providence Health & Services
- Providence Milwaukie Hospital
- Providence Portland Medical Center
- Providence Seaside Hospital
- Providence St. Vincent Medical Center
- Providence Willamette Falls Medical Center

**Shriners Hospital for Children

**Tillamook Regional Medical Center

**Tuality Healthcare
- Tuality Community Hospital
- Tuality Forest Grove Hospital

**Vibra Specialty Hospital of Portland

Hospital/Health System Facilities in Southwest Washington
**Legacy Health
- Legacy Salmon Creek Medical Center

**Indicates hospital/health system facility has signed the MOU and is a Participating Hospital/Health System Facility. MOU agreement applies to all hospital/health system facilities that have signed the document.