California Department of Public Health Standards and Guidelines for Healthcare Surge During Emergencies

Volume I: Hospitals

California Department of PublicHealth

California Department of Public Health Standards and Guidelines for Healthcare Surge During Emergencies

Foundational Knowledge
Volume I: Hospitals
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1. California's Healthcare System Response to a Healthcare Surge

An attack using biological, chemical, or radiologic agents, the emergence of diseases such as severe acute respiratory syndrome or pandemic influenza or the occurrence of a natural disaster are threats capable of imposing significant demands on California's healthcare resources and state-wide healthcare delivery system. While California has built a strong network of healthcare services and agencies through local health departments, local emergency medical services agencies, hospitals, clinics, long term care facilities and healthcare professionals, developing a coordinated response to a dramatic increase in the number of individuals requiring medical assistance following a catastrophic event will be challenging. The overwhelming increase in demands for medical care arising out of such an event is called healthcare surge. While many hospitals, clinics and other healthcare providers have developed individualized healthcare surge plans, the sheer magnitude of a disaster or wide-spread disease may require a different planning approach.

In *Emergency Management Principles and Practices for Healthcare Systems*[1], the Institute for Crisis, Disaster, and Risk Management has found that healthcare system response during emergencies demonstrates the following recurrent findings:

- Local response is primary: The initial response to any medical event will be almost entirely based upon locally available health and medical organizations.

- Medical response is complex: The response to a large scale emergency impacts an entire community and involves numerous diverse medical and public health entities, including healthcare systems and facilities, public health departments, emergency medical services, medical laboratories, individual healthcare practitioners, and medical support services.

- Coordinated response is essential: An effective healthcare system response to major events usually requires support from public safety agencies and other community response entities that are not normally partnered with the community healthcare systems during everyday operations.

- Bridging the "public-private divide": Healthcare organizations have traditionally planned and responded to emergencies as individual entities. This has occurred in part because of the "public-private divide," the legal, financial, and logistical issues in planning and coordination between public agencies and primarily private healthcare entities. Healthcare organizations must view themselves as an integrated component of a larger response system.

- Public health as an essential partner: Public health departments are not traditionally integrated with other community emergency response operations, including the acute care medical and mental health communities. Public health departments are an

essential partner in any successful response to a healthcare surge.

- The need for robust information processing: Medical issues that arise from large scale incidents are rarely immediately apparent, and complex information must be collected from disparate sources, processed and analyzed rapidly in order to determine the most appropriate course of action. This requires a robust information management process that can differ markedly from any routinely used healthcare system.

- The need for effective overall management: Medical response to a healthcare surge situation can be exceedingly complex, with many seemingly diverse tasks. Responsibility for each of these activities can vary significantly among organizations in different communities. Even within a single healthcare system, many actions require coordination between disparate operating units that don't work together on a regular basis. Despite these challenges, all necessary functions must be adequately addressed for a successful mass casualty or mass effect response.

- Medical system resiliency: A major hazard impact that creates the need for healthcare surge capacity also is likely to impact the normal functions of the everyday healthcare systems (i.e., some degree of mass effect). Medical system resiliency is necessary for the system to maintain its usual effectiveness and, at the same time, to provide a reliably functioning platform upon which medical surge may occur. Medical system resiliency is achieved by a combination of mitigation measures and adequate emergency preparedness, assuring continuity of healthcare system operations despite emergency.

Healthcare providers face several challenges achieving optimal emergency preparedness. The traditional approaches to delivering healthcare do not typically support an integrated community-wide response that is usually necessary during a healthcare surge. Therefore, it is critical that healthcare systems and providers not only be prepared to provide services on individual basis but also be prepared to participate in an overall emergency community response. An effective response will assure healthcare system resiliency as well as the most efficient care for victims given the severity of the event.

1.1 California Department of Public Health Initiates Planning for Healthcare Surge

In order to assist communities and healthcare providers to successfully plan for a healthcare surge, in 2007 the California Department of Public Health (CDPH) launched a project to address the issues of surge capacity during an emergency. The *Development of Standards and Guidelines for Healthcare Surge during Emergencies* project was initiated to develop standards and guidelines manuals to assist healthcare providers develop plans for responding to a healthcare surge.
A key predecessor to the *Development of Standards and Guidelines for Healthcare Surge*

during Emergencies project was the California Hospital Surge Capacity Survey that CDPH conducted in February 2006. Survey findings determined that many California healthcare providers could improve their planning process to identify the resources that would be needed to treat patients during surge emergencies. Based upon these findings, the State Budget Act for fiscal year 2006-2007 authorized CDPH to initiate the *Development of Standards and Guidelines for Healthcare Surge during Emergencies* project to identify obstacles hindering healthcare delivery during a healthcare surge and to identify strategies and recommendations to mitigate the identified obstacles.

To identify key surge planning issues, CDPH undertook a multi-phase process that involved bringing together participants representing federal agencies, national organizations, state agencies, local health departments, healthcare providers, health plans and community organizations to identify issues and develop recommendations to address those issues. The project placed particular emphasis on a framework for standards of care and scope of practice during an emergency, liability of healthcare providers during a surge, reimbursement of care provided during an emergency, planning for and operating alternate care sites and surge capacity operating plans at individual hospitals.

The results of these earlier activities form the basis for the healthcare standards and guidelines manuals, operational tools, reference manual and training curriculum which are intended to help every community and healthcare provider in California plan and put into operation an effective surge response to major disasters.

1.2 Healthcare Surge Standards and Guidelines Manuals, Operational Tools and Training Curriculum

The surge planning materials have been assembled into healthcare surge standards and guidelines manuals which contain recommendations and options for consideration by communities and providers planning for a healthcare surge. Materials should be evaluated for implementation based upon specific needs of the emergency but should not be considered mandates or requirements issued by the State of California. Applicability of an individual guideline and recommendation will be dependent upon the specific emergency or the surrounding circumstances as well as community and provider structure.

The Standards and Guidelines Manuals issued from this project are:

- **Foundational Knowledge.** This manual defines healthcare surge, describes the existing emergency response system in California and how healthcare providers participate in this system. It also discusses transitioning patient care from individually-focused to population-based care in a severe surge.

This manual is prerequisite to volumes I -III, operational tools, reference manual and training curriculum described below.

- **Volume I: Hospitals.** Primarily developed for use by hospitals, but also beneficial for use by other providers and health plans, this manual contains information on general emergency response planning and related integration activities for hospitals. This manual also includes guidance for hospitals related to increasing capacity and expanding existing workforce during a surge, augmenting both clinical and non-clinical staff to address specific healthcare demands, addressing challenges related to patient privacy and other relevant operational and staffing issues during surge conditions. This manual addresses the assets under a hospital's control that can be used to expand capacity and respond to a healthcare surge.

- **Volume II: Government-Authorized Alternate Care Sites.** This manual contains planning information related to the establishment of government-authorized Alternate Care Sites that may be used for healthcare delivery during a healthcare surge. It includes specific guidance and general planning considerations for coordinating site locations, developing staffing models, defining standards of care and developing administrative protocols. Specific guidance on federal and State reimbursement at government-authorized alternate care sites is also provided.

- **Volume III: Payers.** This manual outlines specific sets of recommendations for commercial health plans to consider when working with providers, employers and others during the surge planning process. Recommended approaches to changes in contract provisions which focus on simplifying administrative and reimbursement requirements are included. This volume also contains specific information on the impact that a healthcare surge may have on a health plan's administrative and financial relationship with Medicare Advantage, Medi-Cal Managed Care and Workers' Compensation.

- **Other Reference Material:**

    - **Operational Tools Manuals.** Includes forms, checklists and templates that might be used by providers and health plans to assist in the implementation of recommendations and strategies outlined in the respective Standards and Guidelines Manual.

    - **Reference Manual.** The reference manual contains an overview of federal and State regulations and compliance issues, including statutes, laws, regulations and standards and their corresponding legal interpretations and potential implications for use during a healthcare surge. Also included in the reference manual is detailed information regarding Hospital Incident Command System roles and responsibilities to assist with planning for

command staff at a hospital. In addition, information regarding funding sources that may be available during a declared healthcare surge is included as well as those funding sources that were used during previous states of emergency.

- **Training Curriculum.** Outlines the intended audience, methods of delivery and frequency of training for the information presented in the manuals.

These volumes are meant to be actively used for community and provider planning for a healthcare surge. The information contained in the materials will be updated as new information is learned and community surge planning practices evolve.

Additional volumes, operational tools and training curriculum that address clinics, licensed healthcare professionals and long-term care facilities are in development and are scheduled to be issued in 2008.

1.3 Key Healthcare Surge Planning Concepts for California

The following key healthcare surge planning concepts provide the context and perspective to understand the information presented in the healthcare surge standards and guidelines manuals for California.

During a catastrophic emergency, the movement from individual-based care to population-based outcomes challenges the professional, regulatory, and ethical paradigms of the healthcare delivery system. The standard of care will focus on saving the maximum number of lives possible. The standard of care during a healthcare surge is defined as the utilization of skills, diligence and reasonable exercise of judgment in furtherance of optimizing population outcomes that a reasonably prudent person or entity with comparable training, experience or capacity would have used under the circumstances.
Under current state statute and regulations, a move to a population-based healthcare response may be challenging. When a State statute or regulation does not provide flexibility during a healthcare surge, Executive Standby Orders issued by the Governor following his/her issuance of a declaration of emergency may result in suspensions that allow for flexibility. The manuals provide relatively straightforward examples of Executive Standby Orders and possible suspensions that may be put into effect during surge conditions.

In California, a healthcare surge is proclaimed in a local jurisdiction when an authorized local official, such as a local health officer or other appropriate designee,[2] using professional judgment determines, subsequent to a significant emergency or circumstances, that the healthcare delivery system has been impacted, resulting in an excess in demand over capacity in hospitals, long-term care facilities, community care clinics, public health departments, other primary and secondary care providers, resources and/or emergency medical services. The

local health official uses the situation assessment information provided from the healthcare delivery system partners to determine overall local jurisdiction/Operational Area medical and health status.

The coordination of activities during a healthcare surge entails significant responsibilities for local government as well as hospitals and other community healthcare professionals. Local government will be responsible for determining the state of the healthcare surge and the identification of and planning for the operations of Government-Authorized Alternate Care Sites. While the ultimate determination regarding surge related activities will be made by local government, healthcare providers and payers will be kept informed to provide a coordinated and integrated response.

A key barrier to effective healthcare surge response is the complexity of the healthcare delivery system. The intent of the *Development of Standards and Guidelines for Healthcare Surge during Emergencies* project is not to solve the challenges of the current healthcare delivery system but to operate within it. This is primarily addressed by considering the elements of response from an operating rather than a regulatory point of view.

While the current healthcare delivery system is complex, several areas can be simplified, such as professional scope of practice, recruitment of personnel, and patient tracking for clinical and administrative purposes. This simplification emphasizes the operational necessities of a coordinated response in a catastrophic event.

Preserving the overall financial liquidity of the healthcare delivery system during a catastrophe is an issue that is larger than any single stakeholder. There are practical ways that hospitals can take proactive steps to preserve a revenue stream during a surge event, while payers (government and commercial) can more effectively meet their obligations for their covered beneficiaries under the traditional third party payer system.

Ultimately, effective surge response requires all stakeholders to accept new responsibilities, behave differently than they may have been trained, and cooperate with each other in unprecedented ways. The purpose of these and future surge standards and guideline materials is to proactively engage California communities in advance planning for a healthcare surge and provide tools and training to support the surge planning process.

1.4 Overview of Hospitals Volume

A catastrophic emergency, whether a natural disaster, infectious disease or terrorist attack, will dramatically impact California's healthcare system. It is critical that hospitals, healthcare professionals and health plans doing business in California proactively work together to redefine the nature of their relationships to prepare for a healthcare surge and mitigate its potential impact on patient care, access and funding. Given the unpredictable nature of a

disaster and its potential to significantly impact the healthcare delivery system, sufficient planning and coordination between providers and payers will be essential to maintain business continuity and sustain operations at facilities providing medical care.

During a healthcare surge, the delivery of care will be different. The standard of care may change based on available resources. The scope of a provider's practice may change based on need, sites of care may look different due to access issues, and the traditional methods of claims identification and submission may be forced to undergo adjustments that require practical solutions. Additionally, during a catastrophic emergency, the primary focus of the healthcare community will be on responding to the emergency and caring for the ill and injured. These changes will require providers to work with health plan partners to meet the needs of the healthcare surge environment and ensure adequate provisions of care and cash flow.

"Healthcare surge" has varying meanings to participants in the healthcare system. For planning a response to a catastrophic emergency in California, "healthcare surge" is defined as follows: A healthcare surge is proclaimed in a local health jurisdiction when an authorized local official, such as a local health officer or other appropriate designee, using professional judgment, determines, subsequent to a significant emergency or circumstances, that the healthcare delivery system has been impacted, resulting in an excess in demand over capacity in hospitals, long term care facilities, community care clinics, public health departments, other primary and secondary care providers, resources and/or emergency medical services.

As a core participant in any healthcare delivery response, hospitals should use this volume and corresponding tools as a resource to build a comprehensive and coordinated approach to surge planning. Key guidance from the hospital volume includes the following:

- A general community response to a healthcare surge may include many different entities, including hospitals and public health entities, each playing several distinct roles and serving many different needs. These entities may take on roles other than those supported during normal conditions and any healthcare surge planning activities should take this potential for role expansion into consideration.

- The actions of the federal and State governments, legislative activities and the additional funding available during surge conditions play an integral role in any hospital planning efforts and enable hospitals to better understand the options available and how they may integrate into the overall disaster response.

- Understanding the opportunities available to hospitals when developing an approach to surge planning will enable hospitals to develop a surge facility plan which addresses many aspects of the operation including, increasing access to care, expanding the hospital workforce and augmenting clinical staff.

- A proactive approach when working with health plan partners is an important component of the planning process and may include developing revised agreements between providers and health plans which focuses on the simplification of administrative requirements and reimbursement obligations.

2. Provision of Care During a Healthcare Surge

Disaster response involves many different community resources—from police and fire to medical providers, engineers and transportation and housing experts. Hospitals play a crucial role in this larger picture. Hospitals are the epicenter of medical care delivered to those who are injured. Running hospitals is an enormously complex task under the best of circumstances; preparing hospitals for a disaster is infinitely more complicated. During a healthcare surge event, hospitals will have to convert quickly from their current care capacity to surge capacity to handle the maximum patient load possible.

2.1. Transitioning From Individual Care to Population-Based Care

During catastrophic emergencies, the demand for medical care may exceed available resources to deliver that care. Healthcare surge capacity planning for such resource-poor environments must therefore consider a departure from the individual patient-based outcomes that clinicians have been long conditioned to uphold in favor of an approach that saves the most lives. In other words, "clinicians will need to balance the obligation to save the greatest possible number of lives against that of the obligation to care for each single patient."[3] Those rendering care must be informed of surge status in their community so that they can adjust their practices accordingly and, to the fullest extent possible, this migration of a provider's obligation from individual responsibility to population outcome should adhere to the longstanding principles of ethical practice.

Healthcare facilities and providers managing excess of demand over supply of services during a healthcare surge will likely need to allocate resources in ways that are unique to the surge emergency. In 1993, the American Medical Association published *Ethical Considerations in the Allocation of Organs and Other Scarce Medical Resources among Patients*,[4] a report that gives guidance to physicians who must make critical allocation decisions due to a naturally limited supply of available resources. Guidelines from this report have been extracted and made applicable to a healthcare surge environment. The guidelines below give ethical guidance to healthcare facilities and providers for both the acceptable and the inappropriate criteria for making resource allocation decisions during a healthcare surge emergency.

Appropriate Criteria for Resource Allocation	Inappropriate Criteria for Resource Allocation
• Likelihood of survival • Change in quality of life • Duration of benefit • Urgency of need • Amount of resources required	• Ability to pay • Provider's perception of social worth • Patient contribution to disease • Past use of resources

It is anticipated that certain legal requirements concerning statutes, regulations and professional standards of practice may be waived or suspended by government authorities during a healthcare surge. Potential waivers or suspensions could relate to obtaining informed consent; honoring advance healthcare directives; communicating with healthcare agents, surrogates and next of kin; providing services to special needs populations; withdrawing care; and honoring cultural preferences and rituals in the process of disposing of human remains.

Under normal conditions, a healthcare professional is evaluated based on employing appropriate health and medical resources and responses to improve the health status and/or save the life of an individual patient. However, during a healthcare surge, the standard of care will shift from focusing on patient-based outcomes to population-based outcomes. According to a report by Health Systems Research Inc., *Altered Standards of Care in Mass Casualty Events*, (an Agency for Healthcare Research and Quality (AHRQ)[5] Publication, April 2005), providers should anticipate "a shift to providing care and allocating scarce equipment, supplies and personnel in a way that saves the largest number of lives in contrast to the traditional focus on saving individuals." Examples of these shifts in care may include:

- "Triage efforts that will need to focus on maximizing the number of lives saved. Instead of treating the sickest or the most critically injured first, triage would focus on identifying and reserving immediate treatment for individuals who have a critical need for treatment and are likely to survive. The goal would be to allocate resources in order to maximize the number of lives saved. Complicating conditions, such as underlying chronic disease, may have an impact on an individual's ability to survive.
- Triage decisions that will affect the allocation of all available resources across the spectrum of care: from the scene to hospitals to alternate care sites. For example, emergency department access may be reserved for immediate-need patients; ambulatory patients may be diverted to alternate care sites (including non-medical space, such as cafeterias within hospitals, or other non-medical facilities) where "lower level" hospital ward care or quarantine can be provided. Intensive or critical care units may become surgical suites and regular medical care wards may become isolation or other specialized response units.
- Needs of current patients, such as those recovering from surgery or in critical or intensive care units; the resources they use will become part of overall resource allocation. Elective procedures may have to be cancelled, and current inpatients may have to be discharged early or transferred to another setting. In addition, certain lifesaving efforts may have to be discontinued.
- Usual scope of practice standards that will not apply. Physicians may function outside their specialties. Credentialing of providers may be granted on an emergency or temporary basis.
- Equipment and supplies that will be rationed and used in ways consistent with achieving the ultimate goal of saving the most lives (e.g., disposable supplies may be reused).

- Not enough trained staff. Staff will be scared to leave home and/or may find it difficult to travel to work. Burnout from stress and long hours will occur, and replacement staff will be needed. Some scarce and valuable equipment, such as ventilators, may not be used without staff available that is trained to operate them.
- Delays in hospital care due to backlogs of patients. Patients will be waiting for scarce resources, such as operating rooms, radiological suites, and laboratories.
- Providers that may need to make treatment decisions based on clinical judgment. For example, if laboratory resources for testing or radiology resources for x-rays are exhausted, treatment based on physical exam, history, and clinical judgment will occur.
- The psychological impact of the emergency on providers. Short- and long-term stress management measures (e.g., Critical Incident Stress Management programs) are essential for providers and their families.
- Current documentation standards that will be impossible to maintain. Providers may not have time to obtain informed consent or have access to the usual support systems to fully document the care provided, especially if the healthcare setting is damaged by the emergency.
- Backlog in processing fatalities. It may not be possible to accommodate cultural sensitivities and attitudes toward death and handling bodies. Numbers of fatalities may make it difficult to find and notify next of kin quickly. Burial and cremation services may be overwhelmed. Standards for completeness and timeliness of death certificates may need to be lifted temporarily."

For more information on healthcare surge ethical principles, allocation of scarce resources and guidelines designed to alleviate, to the extent possible, concern over the liability associated with making such difficult decisions see Foundational Knowledge, Section 8: Transitioning from Individual Care to Population-Based Care.

2.2. Standard of Care Defined

The "standard of care" in California is based on what a reasonably prudent person with similar knowledge and experience would do under similar circumstances. Standard of care is a legal concept that requires licensed healthcare personnel, when caring for patients, to adhere to the customary skill and care that is consistent with good medical (or other healthcare) practice. As such, it is dependent to a certain degree on the type of provider and their respective scope of practice each provider is licensed or authorized to provide. The standard of care provides a framework to identify and evaluate objectively the professional responsibilities of licensed personnel, and permits individual licensed personnel to be rationally evaluated to ensure that is safe, ethical and consistent with the professional practice of the licensed profession in California.[6] Standard of care is a legal concept that encompasses the diagnosis and treatment of patients and the overall management of patients.[7] For the purposes of this document:

The standard of care during a healthcare surge is defined as the utilization of skills, diligence and reasonable exercise of judgment in furtherance of optimizing population outcomes that a reasonably prudent person or entity with comparable training, experience or capacity would have used under the circumstances.

3. General Emergency Response Planning

The planning activities required for general emergency response include planning at the facility, local, state and national levels. This section gives an overview of the general emergency response structure in which hospitals operate during a healthcare surge. This includes the National Incident Management System (NIMS), the Standardized Emergency Management System (SEMS), and the Hospital Incident Command System (HICS).

3.1. National Incident Management System Implementation Activities for Hospitals and Healthcare Systems

Homeland Security Presidential Directive/HSPD-5 Management of Domestic Incidents called for the establishment of a single, comprehensive National Incident Management System (NIMS). NIMS is a system that improves response operations through the use of Incident Command Systems and other standard procedures and preparedness measures. It also promotes development of multi-jurisdictional, statewide and interstate regional mechanisms for coordinating incident management and obtaining assistance during large-scale or complex incidents. Homeland Security Presidential Directive/HSPD-5 mandates that Federal departments and agencies shall make adoption of the NIMS a requirement for the provision of Federal preparedness assistance funds.

All hospitals and healthcare systems receiving federal emergency preparedness and response grants, contracts or cooperative agreements (e.g., Hospital Preparedness Program funds, Department of Homeland Security grants) must work to implement NIMS. Individual hospital and healthcare systems are defined as healthcare facilities that are licensed to provide basic emergency and/or trauma care on a daily basis.

Homeland Security Presidential Directive/HSPD-5 also established and designated the NIMS Integration Center as the lead federal agency to coordinate NIMS compliance. One of the primary functions of the NIMS Integration Center is to ensure NIMS remains an accurate and effective management tool through refining and adapting compliance requirements to address ongoing preparedness needs. To accomplish this, the NIMS Integration Center relies on input from federal, state, local, tribal, multi-discipline and private authorities to assure continuity and accuracy of ongoing efforts. The National Integration Center, in conjunction with the federal Department of Health and Human Services and HICS working group, developed NIMS implementation activities for hospitals and healthcare systems that were released on September 12, 2006[8].

Organizational Adoption

- Element 1 - Adoption of NIMS: Adopt NIMS at the organizational level for all appropriate departments and business units, as well as promote and encourage NIMS adoption by associations, utilities, partners and suppliers.

Command and Management

- Element 2 - Incident Command System: Manage all emergency incidents, exercises and pre-planned (recurring/special) events in accordance with the Incident Command System organizational structures, doctrine, and procedures, as defined in NIMS. Incident Command System implementation must include consistent application of Incident Action Planning and Common Communication Plans.
- Element 3 – Multi-agency Coordination System: Coordinate and support emergency incident and event management through the development and use of integrated multi-agency coordination systems. That is, develop and coordinate connectivity capability with Hospital Command Center and local Incident Command Posts, local 911 centers, local Emergency Operations Centers, the state Emergency Operations Center and others as applicable.
- Element 4 - Public Information System: Implement processes and/or plans to communicate timely accurate information through a Joint Information System and Joint Information Center.

Preparedness Planning

- Element 5 – NIMS Implementation Tracking: Hospitals and healthcare systems will track NIMS implementation annually as part of the organization's emergency management program.
- Element 6 – Preparedness Funding: Develop and implement a system to coordinate appropriate hospital preparedness funding to employ NIMS across the organization.
- Element 7 – Revise and Update Plans: Revise and update plans (i.e. Emergency Operations Plan) and standard operating procedures to incorporate NIMS components, principles and policies, to include planning, training, response, exercises, equipment, evaluation, and corrective actions.
- Element 8 – Mutual-Aid Agreements: Participate in and promote interagency mutual-aid agreements, to include agreements with public and private sector and/or nongovernmental organizations.

Preparedness Training

- Element 9 – IS-700 NIMS: This course should be completed by the hospital personnel who would have a leadership role in emergency preparedness, incident management, and/or emergency response during an incident.

- Element 10 – IS-800. An introduction to a National Response Plan: This course should be completed by personnel whose primary responsibility is emergency management within a hospital or healthcare system.
- Element 11 – ICS 100 and 200: ICS 100 should be completed by the hospital personnel who would have a direct role in emergency preparedness, incident management, and/or emergency response during an incident. ICS 200 should be completed by personnel whose primary responsibility is emergency management, to include (at a minimum) middle management within a hospital or healthcare system.

Preparedness Exercises

- Element 12 – Training and Exercises: Incorporate NIMS/Incident Command System into internal and external local, regional, and state emergency management training and exercises.
- Element 13 – All-Hazard Exercise Program: Participate in an all-hazard exercise program based on NIMS that involves responders from multiple disciplines, multiple agencies and organizations.
- Element 14 – Corrective Actions: Hospitals and healthcare systems will incorporate corrective actions into preparedness and response plans and procedures.

Resource Management

- Element 15 – Response Inventory: Maintain an inventory of organizational response assets.
- Element 16 – Resource Acquisition: To the extent permissible by law, ensure that relevant national standards and guidance to achieve equipment, communication, and data interoperability are incorporated into acquisition programs.

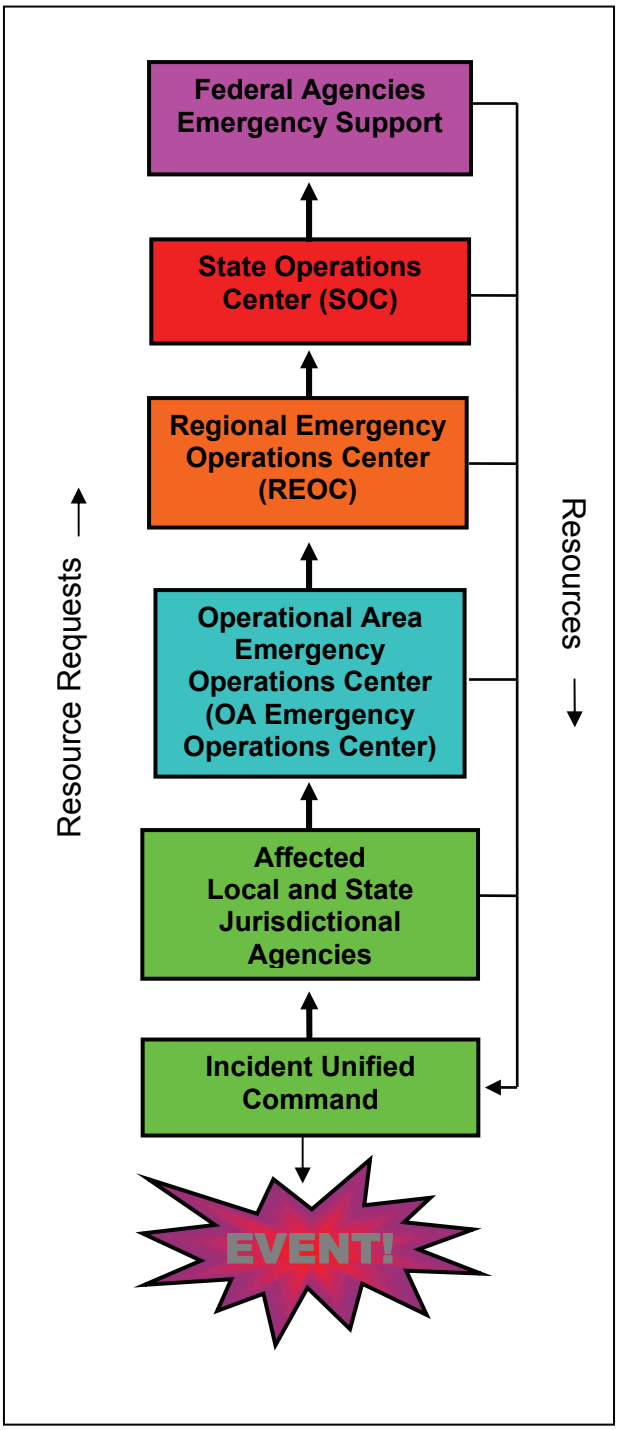
Communications and Information Management

- Element 17 – Standard and Consistent Terminology: Apply standardized and consistent terminology, including the establishment of plain English communication standards across the public safety sector.

Elements 7, 9, 10 and 11 must be adopted and/or implemented by September 30, 2007 for those hospitals receiving fiscal year 2006 federal preparedness and response grants, contracts, or cooperative agreements. Hospitals receiving federal Hospital Preparedness Program funds for fiscal 2007 have until August 8, 2008, to fully implement all 17 NIMS activities.

3.2. Standardized Emergency Management System

SEMS is a system for managing the response to multi-agency and multi-jurisdictional emergencies in California.[9] This system integrates NIMS, the Incident Command System, and the support and coordination system developed under SEMS. All State agencies are required to use SEMS to coordinate multiple jurisdiction or multiple agency emergency and disaster operations.[10] Every local agency, in order to be eligible for any funding of response-related (i.e., personnel) costs under disaster assistance programs, must also use SEMS to coordinate multiple jurisdiction or multiple agency emergency and disaster operations.[11] This means that local emergency plans must also incorporate SEMS, assuming the local government wants to be reimbursed for emergency personnel costs.



SEMS is based on the concept of the Incident Command System.[12] The Incident Command System provides a standardized management structure with accompanying processes that can be used by any organization(s) to respond to emergencies and requires five management functions be performed:

1. Management – the function of setting priorities and policy direction and coordinating the response
2. Operations – the function of taking responsive actions based on policy
3. Planning/Intelligence – the function of gathering, assessing and disseminating information
4. Logistics – the function of obtaining resources to support operations
5. Finance/Administration – the function of documenting and tracking the costs of response operations

Unified Command is a management concept under the Incident Command System that occurs when there is more than one agency with jurisdictional responsibility (for example, public health, law enforcement, and fire) for the emergency or when emergency incidents expand across multiple political boundaries. Agencies work through the designated members of the Unified Command located at an Incident Command Post to establish a common set of objectives and strategies and a single Incident Action Plan.

SEMS is designed to foster the coordination of public and private sector resources at all levels of its structure. As such, requests for resources flow upward from the local level to the federal level and assistance to meet these request flows downward from the federal level to the local level. To facilitate the request and assistance for resources, it is imperative that each coordination level above the requesting level be contacted in order to effectively supply and account for available resources. The diagram on the right depicts this flow of request and assistance for resources using SEMS during catastrophic emergencies.

The Operational Area, defined in the Emergency Services Act, is a required concept of SEMS.[13] In accordance with SEMS and the Emergency Services Act, the Operational Area consists of a county and all political subdivisions within the county area, and serves as an intermediate level of the State emergency response organization.[14] The governing bodies of each county and the political subdivisions in the county are authorized to organize and structure their Operational Area. An Operational Area is used by the county and the political subdivisions comprising the Operational Area for the coordination of emergency activities and to serve as a link in the communications system during a state of emergency or a local emergency.[15] In addition to the Operational Area, political subdivisions within a county may have their own Emergency Operations Center.

Under SEMS, an Operational Area Emergency Operations Center does not manage the emergency operations of any single government entity, but exists as an organization to facilitate the emergency management coordination of all government entities within the Operational Area. A multi-agency coordination group at the Operational Area comprised of high-level decision makers from governmental agencies with responsibilities to mitigate the impact of an emergency establishes policies and sets priorities for management of the emergency response.

The Operational Area Emergency Operations Center must be distinguished from department operations centers. Under SEMS, a department operations center is an emergency operations center used by a district discipline (e.g., flood operations, fire, medical, hazardous material) or a governmental unit (e.g., Department of Public Works or Department of Health). Department operations centers may be used at all SEMS levels above the field response level (the level at which diverse local response organizations use their own resources to carry out tactical decisions and activities) depending upon the impacts of the emergency.[16] There may be as many department operations centers as there are public agencies involved in the response above the field level.

California SEMS meets NIMS requirements. Therefore, SEMS will be referred to as SEMS/NIMS from this point forward.

3.3. Planning for the Incident Command System

In order to successfully implement the Incident Command System, there are key roles that must be planned for ahead of time. The first step in planning should include determining which roles a hospital will staff. It is recommended that at a minimum the following four roles be staffed at every hospital:

1. Operations Section Chief
2. Planning Section Chief
3. Logistics Section Chief
4. Finance / Administration Chief

For a list of key Incident Command System roles from which hospitals can identify positions to staff, see the Reference Manual, Section 4: Applying the Incident Command System to the Hospital.

Another consideration when staffing these key roles is the scalability of the staffing structure. It is recommended that hospitals plan key roles to be five people deep to ensure that each key role will be adequately staffed during a healthcare surge. In determining who should serve these roles, hospitals may want to keep in mind that during a healthcare surge, Executive Managers will need to continue to fulfill their responsibilities as hospital managers and may not be the best choices for managing the Incident Command System. Hospitals may want to consider reserving these executives for policy decisions and staffing the Incident Command System with experienced hospital operations managers.

3.4. The Hospital Incident Command System

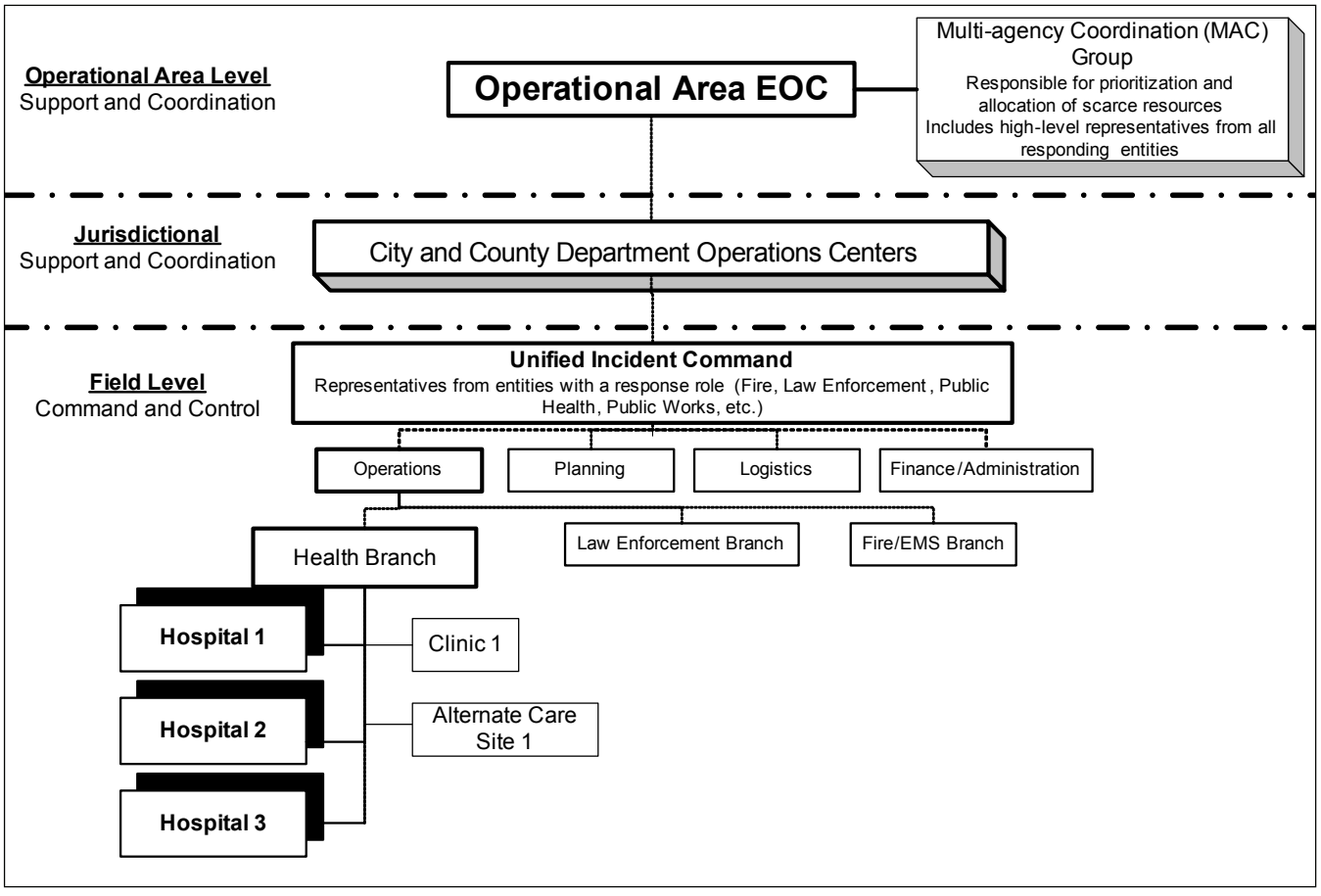
HICS is a system management tool that has been created by adapting the Incident Command System for the hospital environment. HICS can be used by hospitals, regardless of their size or patient care capabilities, to assist in all hazards emergency planning and response. The August 2006 update to the Hospital Incident Command Guidebook[17] provides specific guidance for incorporating an incident management system including:

- The function of the Emergency Operations Plan
- Procedures for event recognition and activation of the Incident Command System

- Position descriptions including surge roles and job action sheets
- Scenario-specific Incident Planning Guides
- Incident management forms for documentation needs associated with hospital response to an incident

Although HICS provides guidance for hospitals in developing their emergency management plan, it is not a template hospital emergency management plan nor is it a hospital emergency operations plan. For additional information on the use of HICS during surge events, see the Reference Manual Section 4: Applying the Incident Command System to the Hospital.

Additional HICS resources and training materials can be found at www.emsa.ca.gov/hics/hics.asp and at www.hicscenter.org.



3.5. Relationship Between the Hospital Incident Command System and the National Incident Management System

Using HICS as the hospital Incident Command System will assist hospitals in meeting some, but not all, of the 17 NIMS Compliance requirements. In particular, HICS covers topic areas for hospitals with regards to planning, responding, decision-making, and documentation. HICS functionally uses the Incident Command System, but has translated it to meet the specific needs of hospitals. Hospitals should update their plans, procedures, and/or policies and conduct training as necessary to reflect NIMS compliance. For a listing of the 17 elements for NIMS Compliance requirements see Section 3.1: National Incident Management System Implementation Activities for Hospitals and Healthcare Systems.

3.6. How Hospitals Connect to the Emergency Response Structure

Under the SEMS/NIMS structure, once the impact of an emergency is sufficient to involve multiple emergency response disciplines (law enforcement, fire, public health), these responding entities form a Unified Command close to the incident to manage the tactical operations of mitigating the response.

All healthcare providers must be integrated into this Unified Command that coordinates the movement of patients, establishes priorities and allocates scarce resources, services and supplies among all healthcare providers. To accomplish this, an authorized local official, or designee, will notify healthcare facilities that the Unified Command has been established and provide a contact within the Operations Section of the Unified Command for coordination of patient movement and requests for resources, services and supplies. The chart on the previous page illustrates how the hospital connects to the emergency response structure through the Unified Command. For additional information on SEMS/NIMS, see Foundational Knowledge, Section 3.9: Standardized Emergency Management System.

3.6.1. Hospital Expansion versus Alternate Care Sites

When a catastrophic emergency occurs, patients requiring care will be transported or seek care at local healthcare facilities. As time passes, these healthcare facilities may experience an influx of patients that exceeds capacity. When this occurs, there are two ways to address the increased demand for healthcare: 1) expand existing healthcare facilities to increase capacity for patient care, or 2) establish temporary healthcare facilities to provide care in non-healthcare locations.

Hospital expansion involves the immediate steps a hospital can take to increase capacity to meet the needs of an increase in patients including converting existing buildings to temporary hospitals and building temporary facilities for patient care. Hospitals should activate

emergency operations plans and mobilize to manage the actual or anticipated influx of patients and the increased resource demand. If conditions within hospitals are sufficiently strained, hospitals may consult with State regulatory agencies to determine if specific requirements related to staffing and patient management can be flexed to expand the hospital's response capabilities.

Upon facility overload, individuals may be transferred to additional healthcare facilities within the jurisdiction. When the healthcare resources within the jurisdiction are overwhelmed, State and/or federal resources will be requested through the SEMS/NIMS structure to help alleviate the patient demand on the local healthcare system. When it is anticipated that all other healthcare resources are exhausted, government-authorized Alternate Care Sites will be established.

An Alternate Care Site is defined as:

A location that is not currently providing healthcare services and will be converted to enable the provision of healthcare services to support, at a minimum, outpatient and/or inpatient care required after a declared catastrophic emergency. These specific sites are not part of the expansion of an existing healthcare facility (i.e., extensions of general acute care hospitals), but rather are designated under the authority of the local and/or State government.

The objective for establishing government-authorized Alternate Care Sites is to absorb the excess patient load until the local healthcare system (e.g., hospitals, clinics, and long-term care facilities) can manage the demands for patient care. Setting up Alternate Care Sites may require 72 hours or more once a decision has been made that they are needed.

A government-authorized Alternate Care Site will be established only when it is anticipated that all other healthcare resources are exhausted. The services provided at a government-authorized Alternate Care Site will vary, based on resource availability and event-specific patient needs. Since an Alternate Care Site, except for a mobile field hospital, will operate in a non-healthcare facility, it cannot fully replicate a hospital setting.

When the demand for patient care within the system subsides and there is no ongoing healthcare surge capacity need, patients will either be discharged or transported back to existing facilities for continued care and the Alternate Care Site will be closed.

3.7. Community Surge Planning

According to a report by the Joint Commission, *Health Care at the Crossroads: Strategies for Creating and Sustaining Community-wide Emergency Preparedness Systems* (2003),

“managing a mass casualty or bioterrorism situation is no job for a single provider organization. This is, in fact, the responsibility of ‘the community’ – an as yet ill-defined composite that, at a minimum, includes emergency medical services, fire, police, the public health system, local municipalities and government authorities, and local hospitals and other healthcare organizations.”

Some emergencies can escalate unexpectedly and strain not only the organization but the entire community. In order to mitigate risks and sustain an effective response, a hospital must prepare its staff and collaborate with the community, suppliers and external response partners. Such an approach will aid the organization in developing a scalable response capability and in defining the timing and criteria for decisions involving sheltering in place, patient transfer, hospital closings or evacuation.

The chart on the following page outlines the Joint Commission’s recommendations for community-planning activities and the community organizations that should take action and be accountable for the results.[18]

Recommendations

Tactics	Accountability
• Initiate and facilitate the development of community-based emergency preparedness programs across the country.	→ municipalities → emergency management agencies → hospitals → public health agencies
• Constitute a community organization that comprises local government officials, emergency management officials, public health authorities, health care organizations, police, fire, public works (e.g. water, electricity), emergency medical services, local industry leaders, and other key participants – as appropriate to the community – to develop the community-wide emergency preparedness program.	→ community organization participants
• Encourage the transition of community health care institutions from an organization-focused approach to emergency preparedness to one that encompasses the community.	→ community organization
• Provide the community organization with necessary funding and other resources and hold it accountable for overseeing the planning, assessment and maintenance of the preparedness program.	→ federal and state government agencies
• Encourage the pursuit of substantive collaborative activities that will also serve to bridge the gap between the medical care and public health systems.	→ health care and public health membership organizations → federal government agencies
• Develop and distribute emergency planning and preparedness templates for potential adaptation by various types of communities.	→ federal and state government agencies

To maximize overall medical surge capacity and capability, the federal Department of Health and Human Services Hospital Preparedness Program requires that efforts extend beyond optimizing internal operations of healthcare facilities and focus on integrating individual healthcare facilities with each other and with non-medical organizations within each jurisdiction or Operational Area. In order to respond effectively, hospitals, community-based health centers, and other healthcare provider organizations must be able to work both within their own organization and collaboratively as a cohesive local team during an emergency. The local

Hospital Preparedness Program entities or coalitions of entities must convene planning groups and are encouraged to consider including representatives of the following organizations:

- Local Health Department Public Health Emergency Preparedness Coordinators
- Healthcare facilities, including hospitals, clinics, and long-term care facilities
- The Medical Health Operational Area Coordinator, or other appropriate designee
- Local emergency medical services agencies
- The Operational Area emergency operations center staff
- First responders, including law enforcement, fire, public and private ambulance providers, metropolitan medical response system, and hazardous materials resource teams
- Local emergency management systems
- Regional Disaster Medical Health Specialists
- Pandemic Influenza Councils
- Mental health programs
- Private sector healthcare professionals
- Poison control
- Regional and county hospital councils/associations
- Regional clinic associations
- Maternal and child health programs
- Universities
- County medical societies
- Tribal entities
- Veterans Health Administration

In a report by the CNA Corporation, *Medical Surge Capacity and Capability: A Management System for Integrating Medical and Health Resources during Large-Scale Emergencies* (August, 2004), “research has shown that most individual healthcare facilities possess limited surge supplies, personnel and equipment, and that vendors or anticipated ’backup systems’ for these critical assets are often shared among local and regional healthcare facilities. This 'double counting' of resources diminishes the ability to meet individually projected surge demands across multiple institutions during a healthcare surge.” Therefore, community partners such as those listed above must collaboratively develop plans to increase jurisdictional capacity.

Collaborative planning does not preclude or diminish the need for individual hospitals to have a comprehensive emergency management program that addresses mitigation, preparedness,

response and recovery activities. An emergency management program implements the mission, vision, and strategic goals and objectives as well as the management framework of the hospital. The emergency operations plan explains how the hospital will coordinate its response and recovery to all hazards. To ensure the hospital is an active participant in this community planning process, those involved with hospital emergency planning should identify key contacts within their Operational Area prior to an emergency. Contact information for the following organizations should be maintained in the hospital's emergency operations plan:

- The Local Health Department and Health Officer
- The Medical Health Operational Area Coordinator, or other appropriate designee (see Foundational Knowledge, Section 3.10.6: Medical Health Operational Area Coordinator for more information)
- The Local Emergency Medical Services agency administrator and medical director
- The Operational Area emergency operations center staff

To integrate with other healthcare and non-healthcare assets in the community, public and private, communities should consider developing memoranda of understanding to formalize partnerships between hospitals and other facilities to assist in managing the treatment of patients during a healthcare surge.

3.8. Developing a Hazard Vulnerability Analysis

The Hazard Vulnerability Analysis is the needs assessment for an organization's emergency preparedness program. Conducting a Hazard Vulnerability Analysis involves identifying all hazards that may affect a hospital and its surrounding community, assessing the probability of hazard occurrence and the consequence for the organization associated with each hazard and analyzing the findings to create a prioritized comparison of hazard vulnerabilities. The vulnerability is related to both the impact on organizational function (staff, suppliers, operational systems, infrastructure, and the like) and the likely service demands created by the hazard impact.

In *Emergency Management Principles and Practices for Healthcare Systems*[19], the following points are described to illustrate how the nature of the hospital contributes to its vulnerability:

- Healthcare facilities are heavily occupied buildings; they house patients, staff, medical personnel, and visitors and are occupied 24 hours a day.
- Many patients are helpless and require trained care. In addition, they may be surrounded by special equipment, using potentially hazardous gases such as oxygen, or they might be connected to life support equipment, which is dependent upon power.

- Healthcare facilities are very complex buildings combining the functions of a hotel, office, laboratory, and warehouse. Their planning is complicated because of the presence of many small rooms. After an incident occurs, patients and visitors will be very confused, lights may be out, and hallways and room exits may be blocked.
- Many healthcare facility supplies (pharmaceuticals, splints, bandages, etc.) are essential for patient survival and crucial for treatment of victims. Patient records are vital for accurate patient treatment, particularly in the event of patient evacuation to other facilities. Damage to storage and records areas may render these items unavailable at the time they are most needed.
- Healthcare facility function is dependent upon utilities such as power, water supply, waste disposal, and communication. Radiology, monitoring, life support, sterilization, and other equipment must be powered.
- Many items in a healthcare facility are hazardous if overturned or damaged (drugs, chemicals, heavy equipment, and radiation devices).
- In addition to internal problems caused by damage to the facility itself, community impact will result in an influx of injured people, as well as friends and relatives seeking information about hospital patients. Facility staff are likely to be injured or killed by the catastrophic event as well, potentially resulting in a shortage of trained staff at the facility.

The diagram below is an example of a natural disaster Hazard Vulnerability Analysis. This analysis identifies the risk of the catastrophic emergency by quantifying the probability of the natural disaster occurring and then estimating its potential severity. This diagram can be adapted to assess vulnerability for other emergencies such as bioterrorism, pandemic influenza, technological or chemical hazards. Hospitals can use this information to assess which hazards are most likely to impact their specific facility and focus preparedness and mitigation activities on those hazards with the highest relative threat.

The Sample Hazard Vulnerability Analysis is shown below. The complete tool can be found in the Hospital Operational Tools Manual on pages 172-175.

Within the analysis there are four categories used to calculate the potential impact of each hazard. These are:

- Probability
- Magnitude
- Mitigation
- Risk

The first three categories use a point system for each hazard, ranging from zero (N/A) to three (high). The last category, risk, is calculated based on the points given in the first three categories. This calculation is explained below.

Issues to consider for probability include:

- Known risk
- Historical data
- Manufacturer/vendor statistics

Issues to consider for magnitude include:

- Human Impact:
    - Potential for staff death or injury
    - Potential for patient death or injury
- Property Impact:
    - Cost to replace
    - Cost to set up temporary replacement
    - Cost to repair
    - Time to recover
- Business Impact:
    - Business interruption
    - Employees unable to report to work
    - Customers unable to reach facility
    - Company in violation of contractual agreements
    - Imposition of fines and penalties or legal costs
    - Interruption of critical supplies
    - Interruption of product distribution
    - Reputation and public image
    - Financial impact/burden

Issues to consider for mitigation include:

- Preparedness
    - Status of current plans
    - Frequency of drills
    - Training status
    - Insurance
    - Availability of alternate sources for critical supplies/services

- Internal Response:
  - Time to marshal an on-scene response
  - Scope of response capability
  - Historical evaluation of response success
  - Types of supplies on hand
  - Volume of supplies on hand
  - Staff availability
  - Coordination with any medical office buildings (e.g., doctors' offices and clinics)
  - Availability of back-up systems
  - Internal resources ability to withstand disasters/survivability
  - Types of agreements with community agencies/drills
  - Coordination with proximal healthcare facilities
  - Coordination with treatment specific facilities
- External Response:
  - Coordination with local and state agencies
  - Community resources

The risk associated with each hazard, or the relative threat of each hazard to the organization, can be calculated using the following equation: Risk = Probability X Severity, where Severity is Magnitude - Mitigation.

The sample hazard vulnerability analysis on the next page demonstrates how this risk is calculated.

Sample Hazard Vulnerability Analysis

EVENT	PROBABILITY	SEVERITY = (MAGNITUDE - MITIGATION)						RISK
		HUMAN IMPACT	PROPERTY IMPACT	BUSINESS IMPACT	PREPARED-NESS	INTERNAL RESPONSE	EXTERNAL RESPONSE	
	Likelihood this will occur	Possibility of death or injury	Physical losses and damages	Interuption of services	Preplanning	Time, effectivness, resouces	Community/ Mutual Aid staff and supplies	Relative threat*
SCORE	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = High 2 = Moderate 3 = Low or none	0 = N/A 1 = High 2 = Moderate 3 = Low or none	0 = N/A 1 = High 2 = Moderate 3 = Low or none	*0 - 100%*
Hurricane	0	0	0	0	0	0	0	0%
Tornado	1	1	1	1	2	2	2	17%
Severe Thunderstorm	1	1	1	1	2	2	2	17%
Snow Fall	0	0	0	0	0	0	0	0%
Blizzard	0	0	0	0	0	0	0	0%
Ice Storm	0	0	0	0	0	0	0	0%
Earthquake	3	3	3	3	1	1	2	72%
Tidal Wave	1	0	0	0	0	0	0	0%
Temperature Extremes	0	0	0	0	1	1	1	0%
Drought	1	0	0	0	1	1	1	6%
Flood, External	1	1	1	1	1	1	1	11%
Wild Fire	0	0	0	0	1	0	0	0%
Landslide	1	0	0	0	0	0	0	0%
Dam Inundation	1	1	1	1	1	1	1	11%
Volcano	0	0	0	0	0	0	0	0%
Epidemic	2	2	0	1	1	1	1	22%
AVERAGE SCORE	0.75	0.56	0.44	0.50	0.69	0.63	0.69	5%

**Threat increases with percentage.*

RISK = PROBABILITY * SEVERITY		
0.05	0.25	0.19

4. Hospital Emergency Management Program

An emergency management program is defined as “a program that implements the organization’s mission, vision, management framework, and strategic goals and objectives related to emergencies and disasters. It uses a comprehensive approach to emergency management as a conceptual framework, combining mitigation, preparedness, response and recovery into a fully integrated set of activities.”[20] The emergency management program applies to all departments and organizational units within the organization that have roles in responding to a potential emergency. Emergency management standards provide hospitals with a structure for development of emergency management programs, including emergency management plans, so that they may adequately and effectively respond to a catastrophic event. These emergency management standards, while promulgated by a variety of organizations, have many commonalities and some of the standards most critical to surge planning are described in this section.

Building a Hospital Emergency Management Program includes the development of an Emergency Operations Plan. The Emergency Operations Plan provides the structure, defines the processes and outlines the activities hospitals may use during a response to and recovery from any event that could severely challenge or exceed the normal healthcare system management and/or operations. The Hospital Emergency Management Program provides hospitals with an understanding of activities the organizations can implement during a disaster response while continuing an effective interface with outside emergency response systems.

The following sections outline the components of emergency management programs from the Joint Commission's Environment of Care Standards, the National Fire Protection Association and Title 22 of the California Code of Regulations, Division 5 (22 CCR), the title and division that outline the requirements for licensing and certification of health facilities.

4.1. The Joint Commission’s Environment of Care Standards

The Joint Commission’s Environment of Care standards provide the following guidance and criteria for standards for community-based surge capacity. These standards are applicable to accredited facilities and will become effective January 1, 2008.

- Environment of Care.4.11: The organization plans for managing the consequences of emergencies.

  An emergency at a healthcare organization or in its community can suddenly and significantly affect demand for its services or its ability to provide those services. The organization’s emergency management program defines a comprehensive approach to identifying risks and mobilizing an effective response within the organization and in collaboration with essential response partners in the community.

- Environment of Care.4.12: The organization develops and maintains an emergency operations plan.

  A successful response relies on planning around the management of six critical areas: communications; resources and assets; safety and security; staffing; utilities; and clinical activities. While the Emergency Operations Plan can be formatted in a variety of ways, it must address these six critical functions to serve as a blueprint for managing care and safety during an emergency.

- Environment of Care 4.14: The organization establishes strategies for managing resources and assets during emergencies.

  During emergencies, healthcare providers that continue to provide care, treatment and services to their patients must sustain essential resources, materials and facilities. The emergency operation plan should identify how resources and assets will be solicited and acquired from a range of possible sources, such as vendors, neighboring healthcare providers, other community organizations, State affiliates or a regional parent company.

4.2. National Fire Protection Association Standards

National Fire Protection Association emergency planning standards have gained international recognition and consensus between the public and private sectors. The standards are voluntary, but carry significant credibility across disciplines, including healthcare organizations.

The 9/11 Commission recommends that National Fire Protection Association Standard 1600 be adopted by the private sector. The 9/11 Commission further recommends that insurance and credit-rating industries look closely at a company's compliance with the National Fire Protection Association standard in assessing its insurability and creditworthiness. The 9/11 Commission recommends that compliance with the National Fire Protection Association standards should define the standard of care a company provides to its employees and the public for legal purposes.

National Fire Protection Association Standard 99 establishes minimum criteria for healthcare hospital emergency management in the development of a program for effective disaster preparedness, response, mitigation and recovery. Standard 1600 articulates the generic elements of these programs and serves as the basis for emergency management program evaluation and accreditation system in use by state, local and tribal governments. Standard 1600 also applies to hospitals. The 2005 revision to 99, Standard for Health Care Facilities, Chapter 12 - Health Care Emergency Management, incorporated the "program" emphasis of 1600, serving to differentiate an "emergency management program" for healthcare systems from the current emphasis by other hospital standards on an "emergency management plan."

National Fire Protection Association 99: Standard for Healthcare Facilities[21]

The scope of this document is to establish criteria to minimize the hazards of fire, explosion, and electricity in healthcare facilities providing services to human beings. National Fire Protection Association 99: Standard for Healthcare Facilities, Chapter 12, Health Care Emergency Management, defines minimum criteria for healthcare facility emergency management in the development of a program for effective disaster preparedness, response, mitigation, and recovery including:

- Each healthcare organization will have plans necessary to respond to a disaster or emergency and will have an individual or group (Emergency Management Committee) with the authority for developing, implementing, exercising and evaluating an emergency management program.
- The Emergency Management Committee will model the emergency operations plan on an Incident Command System in coordination with local emergency response agencies.
- When a facility declares itself in disaster mode, or when a state of emergency exists, the emergency operations plan will be activated.
- All personnel designated or involved in the emergency operations plan of the healthcare facility will be supplied with a means for identification including specific identification for Incident Command System staff (i.e. vests).
- Healthcare facilities will establish contingency plans for the continuity of essential building systems.
- Planning shall include the alerting and managing of all staff and employees in a disaster.
- Planning shall include provisions for patient management.
- Planning shall include minimum stockpiling or ensuring immediate/uninterrupted access to critical materials such as pharmaceuticals, medical supplies, food, linens and water.
- Planning to meet the security needs of the facility.
- The facility shall have plans to restore operational capability.
- Facilities shall have an educational program with an overview of the emergency management program and components of the Incident Command System.
- The emergency management program shall include drills of the emergency operations plans including one mass casualty event.

National Fire Protection Association 1600: Standard on Disaster/Emergency Management and Business Continuity Programs[22]

According to this standard, the emergency management program should include the elements listed below pertaining to prevention, mitigation, preparedness, response, and recovery.

- The entity shall implement a strategy for addressing the need for revisions due to legislation, regulations, directives, policies, and industry codes of practice.
- The entity shall identify hazards, monitor those hazards, the likelihood of their occurrence, and the vulnerability of people, property, the environment, and the entity itself to those hazards.
- The entity shall conduct an impact analysis to determine potential detrimental impacts of the hazards on the health and safety of persons in the affected area at the time of the incident (injury and death), and that of personnel responding to the incident.
- The entity shall develop a strategy to prevent an incident that threatens people, property, and the environment.
- The entity shall develop and implement a mitigation strategy that includes measures to be taken to limit or control the consequences, extent, or severity of an incident that cannot be reasonably prevented.
- The entity shall establish resource management objectives consistent with the overall program goals and objectives for the hazards as identified and procedures to locate, acquire, store, distribute, maintain, test, and account for services, personnel, resources, materials, and facilities procured or donated to support the program.
- The need for mutual aid/assistance shall be determined and, as needed, agreements shall be established.
- The program shall follow a planning process that develops plans for the strategy, prevention, mitigation, emergency operations/response, business continuity, and recovery.
- The entity shall develop an incident management system to direct, control, and coordinate response and recovery operations.
- Communications systems shall be established and regularly tested to support the program.
- The entity shall develop, coordinate, and implement operational procedures to support the program and execute its plans.
- The entity shall establish a primary and an alternate emergency operations center, physical or virtual, capable of managing continuity, response, and recovery operations.
- The entity shall develop and implement a training/educational curriculum to support the program.
- The entity shall evaluate program plans, procedures, and capabilities through periodic reviews, testing, and exercises.
- The entity shall develop procedures to disseminate and respond to requests for pre-incident, incident, and post-incident information, as well as to provide information to internal and external audiences, including the media, and deal with their inquiries.
- The entity shall develop financial and administrative procedures to support the program before, during, and after an emergency or a disaster.

4.3. California Code of Regulations Title 22, Division 5: Licensing and Certification of Health Facilities, Home Health Agencies, Clinics and Referral Agencies

22 CCR 70741 requires licensed general acute care hospitals, as a condition of licensure, to develop and maintain a written disaster and mass casualty program in consultation with representatives of the medical staff, nursing staff, administration and fire and safety experts. The program shall be in conformity with the California Emergency Plan of October 10, 1972, developed by the State Office of Emergency Services, and the California Emergency Medical Mutual Aid Plan of March 1974 developed by the Office of Emergency Services and the Department of Health Services [now Public Health]. The program shall be approved by the medical staff and administration of the facility.

The program shall cover disasters occurring in the community and widespread disasters. It shall provide for at least the following:

- Availability of adequate basic utilities and supplies, including gas, water, food and essential medical and supportive materials.
- An efficient system of notifying and assigning personnel.
- Unified medical command.
- Conversion of all usable space into clearly defined areas for efficient triage, for patient observation and for immediate care.
- Prompt transfer of casualties, when necessary and after preliminary medical or surgical services have been rendered, to the facility most appropriate for administering definite care.
- A special disaster medical record, such as an appropriately designed tag, that accompanies the casualty as he is moved.
- Procedures for the prompt discharge or transfer of patients already in the hospital at the time of the disaster who can be moved without jeopardy.
- Maintaining security in order to keep relatives and curious persons out of the triage area.
- Establishment of a public information center and assignment of public relations liaison duties to a qualified individual. Advance arrangements with communications media will be made to provide organized dissemination of information.

22 CCR Section 70743 requires a written fire and internal disaster program, incorporating evacuation procedures, to be developed with the assistance of fire, safety and other appropriate experts.

22 CCR Section 70746 regarding the disruption of services requires each hospital to develop a written plan to be used when a discontinuance or disruption of services occurs. The

administrator shall be responsible for informing the California Department of Public Health (CDPH), via telephone, immediately upon being notified of the intent of the discontinuance or disruption of services or upon the threat of a walkout of a substantial number of employees, or earthquake, fire, power outage or other calamity that causes damage to the facility or threatens the safety or welfare of patients or clients.

5. Managing Facility Space and Operations During a Healthcare Surge

During a healthcare surge, hospitals will face facility and operational challenges as they try and meet the demands of the healthcare surge. Patient care capacity will be expanded to set up care areas for an influx of a large number of patients. This will mean that facilities may be unable to comply with certain regulatory requirements and standards, including those for:

- Licensed capacity
- Space conversion
- Infection control
- Decontamination
- Hazardous Waste Management
- Medical Waste Management
- Mass Fatalities
- Structural safety

The ways in which hospitals can expand to accommodate a healthcare surge will depend on how they are configured and the availability of their assets. Ideally, hospitals will surge within their own facility first, to their organizational assets next (e.g., affiliated hospitals, long-term care facilities or clinics), to other hospitals and healthcare facilities inside and outside of their system and then, lastly, to government-authorized alternate care sites.

5.1. Increasing Surge Capacity in Hospitals

According to a report by Health Systems Research Inc., *Altered Standards of Care in Mass Casualty Events,* an Agency for Healthcare Research and Quality publication, April 2005, and the recommendations of an expert panel on inpatient and outpatient healthcare surge capacity, *Guidelines for Managing Inpatient and Outpatient Surge Capacity*, State of Wisconsin, November 2005, if a healthcare facility determines it is experiencing a healthcare surge, it should use the following guidelines to assess, prepare, and mobilize to meet the need for increased patient care capacity:

- Rapid discharge of Emergency Department and other outpatients who can continue their care safely at home
- Cancel elective surgeries and procedures, with reassignment of surgical staff members and space
- Reduce usual utilization of imaging, laboratory testing, and other ancillary services
- Transfer patients to other institutions in the region, State, or other states

- Group like-patient types together to maximize efficient delivery of patient care
- Expand critical care capacity by placing select ventilated patients on monitored or step-down beds; use pulse oximetry (with high/low rate alarms) in lieu of cardiac monitors; or rely on ventilator alarms (which should alert for disconnect, high pressure, and apnea) for ventilated patients, with spot oximetry checks
- Convert single rooms to double rooms or double rooms to triple rooms if possible.
- Designate wards or areas of the facility that can be converted to negative pressure or isolated from the rest of the ventilation system for cohorting contagious patients or use these areas for healthcare providers caring for contagious patients to minimize disease transmission to uninfected patients
- Use cots and beds in flat space areas (e.g., classrooms, lobbies) within the hospital for noncritical patient care
- Avert elective admissions at hospitals and discharge patients to a rehabilitation or a long-term care facility or to home-based care
- Fill obstetrics, considered a “clean” unit (no infectious patients should be placed in Obstetrics), with other “clean” patients as a last resort
- Use any unit for immuno-suppressed patients in the same way as the Obstetrics unit and, thus, not counted as inpatient healthcare surge capacity beds
- Do not consider nursery beds as potential inpatient healthcare surge capacity beds even for infants, since these beds are used only for neonates younger than 28 days. If an infant with an infectious disease or with trauma is admitted, place the infant in pediatrics

Healthcare facilities need to identify wings, areas and spaces that could be opened and/or converted for use as patient/inpatient treatment areas. These potential treatment areas include such areas or spaces as:

- Outpatient clinics
- Waiting rooms
- Wings previously used as inpatient areas that can be reopened
- Conference rooms
- Physical therapy gyms
- Medical office buildings
- Temporary shelters on facility premises (cots in tents)

Healthcare facilities should identify which areas will be used first as patient/inpatient healthcare surge capacity treatment areas. Procedures for accomplishing this expansion should be included in the hospital’s emergency operations plan. Areas should be selected based on the

intensity of the incident and the anticipated number of healthcare surge patients a hospital may receive. Collaboration with local emergency operations centers, emergency medical services and first responders will provide hospitals with the necessary information to establish the appropriate number of outpatient/inpatient healthcare surge capacity treatment areas.

Section 5.3: Hospital Compliance Requirements and Existing Flexibility provides an overview of the current compliance requirements for the use of these areas as well as a list of applicable waivers and available liability protections.

5.2. Patient Management

5.2.1. Patient Transfer

In some circumstances, emergency departments may need to divert patients to alternative triage sites, urgent care clinics or primary care clinics, reserving the emergency department for life-threatening emergencies. During surge events, a hospital may also need to transfer patients to other facilities to meet the demand for patient care. Hospital emergency operations plans should consider both of these alternatives and the point at which patient transfers are coordinated through the Unified Command structure to ensure coordination of response efforts.

The patient-transferring healthcare facility is responsible for coordinating transportation of patients to the receiving healthcare facility through the Local Emergency Medical Services Agency or appropriate emergency response authority. Once admitted, that patient becomes the receiving healthcare facility's patient and is placed under care of the receiving healthcare facility's admitting physician until discharged, transferred or reassigned. Transfer plans may need to include alternative resources as emergency vehicles may not be available.

5.2.2. Emergency Medical Treatment and Active Labor Act

In 1986, Congress enacted the Emergency Medical Treatment and Active Labor Act to ensure public access to emergency services, regardless of ability to pay. Section 1867 of the Social Security Act imposes specific obligations on Medicare-participating hospitals that offer emergency services to provide a medical screening examination when a request is made for examination or treatment for an emergency medical condition, including active labor, regardless of an individual's ability to pay. Hospitals are then required to provide stabilizing treatment for patients with emergency medical conditions. If a hospital is unable to stabilize a patient within its capability, or if the patient requests, the hospital should arrange an appropriate transfer.

The Emergency Medical Treatment and Active Labor Act sets forth civil monetary penalties on hospitals and physicians for:

- Failing to properly screen an individual seeking medical care.
- Negligently failing to provide stabilizing treatment to an individual with an emergency medical condition.
- Negligently transferring or releasing from care an individual with an emergency medical condition.

The regulations define hospitals' responsibilities with respect to Emergency Medical Treatment and Active Labor Act as follows:

- When an individual presents to a hospital's emergency department and a request is made on the individual's behalf for examination or treatment of a medical condition, the hospital must provide for an appropriate medical screening examination to determine whether or not an emergency medical condition exists.
- If the hospital determines that an emergency medical condition exists, the hospital must provide further medical examination and treatment in order to stabilize the individual.
- If the hospital does not have the capability to stabilize the individual, a transfer to another facility is permitted.
- A transfer is appropriate when the benefits of the transfer outweigh the medical risks of the transfer.
- A hospital may transfer an unstable patient who makes an informed written request.

In the event of a declared emergency (e.g. healthcare surge), State or local governments may develop community response plans that designate specific entities (hospitals, public health facilities, etc.) with the responsibility to handle certain types of patients (e.g. those who have been potentially exposed to a chemical agent) during catastrophic events. These community response plans may dictate that a hospital transfer or refer patients to these designated entities. In situations where patients are transferred or referred to other facilities as part of a community response plan, the hospital is not at risk for sanctions under the Emergency Medical Treatment and Active Labor Act and should act in accordance with the community response plan that is in place.[23]

5.3. Hospital Compliance Requirements and Existing Flexibility

5.3.1. Licensed Capacity

22 CCR 70809 states that no hospital shall have more patients or beds set up for overnight use than its approved licensed capacity except in the case of a justified emergency when temporary permission may be granted by the Director of CDPH or his or her designee. Beds not used for overnight stay, such as labor room beds, recovery beds, beds used for admission screening or beds used for diagnostic purposes in x-ray or laboratory departments, are not included in the approved licensed bed capacity.

Permission to temporarily exceed licensed bed capacity, however, may be granted upon the facility's submission and CDPH Licensing and Certification District Office approval of an application for increased patient accommodations. See the Reference Manual, Section 5: All Facilities Letter 06-33: CDPH Licensing and Certification Temporary Permission for Increased Patient Accommodations Request Review and Approval Sheet for this application.

5.3.2. Space Conversion

Guidance on how a facility may use its space and whether it may be converted, for example, from a non-clinical area to a clinical area, is provided by both regulatory requirements and industry standards.

22 CCR 70805 states that spaces in hospitals approved for specific uses at the time of licensure shall not be converted to other uses without the approval of CDPH. CDPH will work with facilities to temporarily convert space in a surge event provided that the facility provides a plan for returning to compliance with approved space usage.

5.3.3. Flexibility for Hospital Expansion through Governor's Suspension

To the extent that existing program flexibility provisions would not adequately allow hospitals to expand their licensed capacities or to convert their space for medical use, or waive structural safety standards during a surge, it may be necessary to invoke Government Code Section 8571. Government Code Section 8571 provides the Governor with the authority during a state of emergency or a state of war emergency to suspend any regulatory statute, or statute prescribing the procedure for conduct of state business, or the orders, rules or regulations of any state agency, where the Governor determines and declares that strict compliance with any statute, order, rule or regulation would in any way prevent, hinder or delay the mitigation of the effects of the emergency.

5.4. Structural Safety

Before considering facility expansion to meet the demand for patient care after a disaster, hospitals must determine if the healthcare facility is structurally sound. The California Building Standards Code (24 CCR 102, Part 2, Volume 1) states that all buildings or structures regulated by this code, including hospitals, that are structurally unsafe or not provided with adequate egress, or constitute a fire hazard or are otherwise dangerous to human life, are, for the purpose of this section, unsafe. Any use of buildings or structures constituting a hazard to safety, health or public welfare by reason of inadequate maintenance, dilapidation, obsolescence, fire hazard, disaster, damage or abandonment is, for the purpose of this section, an unsafe use.

Health and Safety Code Section 129990 states that the Office of Statewide Health Planning and Development has the authority to order the vacating of any building or structure found to have been in violation of the adopted regulations of the Office. In addition, the Office of Statewide Health Planning and Development may order the use of the building or structure discontinued within the time prescribed upon the service of notice to the owner or other person having control or charge of the building and structure. Any owner or person having control of the building who makes a request within 15 days of receipt of the written notice is entitled to a hearing pursuant to Government Code Section 11506.

California hospitals are vulnerable to earthquakes and state statute establishes seismic standards for hospitals. In 1973, as a direct result of the devastation caused by the 1971 Sylmar quake (65 deaths and a hospital collapse), the California Legislature passed the Alfred E. Alquist Hospital Seismic Safety Act. The act requires that acute care hospitals be designed and constructed to withstand a major earthquake and remain operational immediately after the quake. After the 1994 Northridge earthquake, in which many older (pre-1973) hospital buildings performed poorly and sustained considerable damage, the Legislature amended the Alquist Act to strengthen seismic requirements for hospitals.

Health and Safety Code Section 129680(a), which codifies the Alquist Act, states that it is the intent of the Legislature that hospital buildings that house patients who have less than the capacity of normally healthy persons to protect themselves, and that must be reasonably capable of providing services to the public after a disaster, shall be designed and constructed to resist, insofar as practical, the forces generated by earthquakes, gravity and winds. In order to accomplish this purpose, the Office of Statewide Health Planning and Development proposed proper building standards for earthquake resistance based upon current knowledge and provide an independent review of the design and construction of hospital buildings.

By 2001, hospitals reported approximately 40 percent of hospital buildings are at risk of collapse in a major earthquake. Hospitals submitted compliance plans to the Office of Statewide Health Planning and Development indicating their intent to do one of the following by January 1, 2002:

- Retrofit the buildings for continued acute care operation beyond 2030.
- Partially retrofit the building for initial compliance with closure or replacement by 2002, 2008 or 2030.
- Relocate acute care services or close or demolish the building. Hospitals may request an extension of the 2008 deadline to 2013.

The Office of Statewide Health Planning and Development will activate its emergency response plan following an emergency such as an earthquake in a major metropolitan area[24] as follows:

- Provide emergency structural, critical nonstructural and fire and life safety assessment of Acute Care Hospitals and Skilled Nursing Facilities.
- Ensure rapid inspection postings of facilities in a disaster area.
- Arrange priority review, approval and permitting of hospital repair and reconstruction of those affected facilities for a limited time period following a disaster.

Because healthcare facilities are resources needed following a disaster, the Office of Statewide Health Planning and Development will close these facilities only as a last resort and only if a threat to life safety exists. The Office of Statewide Health Planning and Development will not participate in emergency repair decisions made by healthcare facilities and for a specified time period following an earthquake, unobserved repair of healthcare facilities will be allowed. The time period will be determined by the severity of the earthquake and dictated by the length of the emergency period. Office of Statewide Health Planning and Development response teams will not interfere with local efforts to keep a healthcare facility open and providing service to the community as long as there is no threat to life safety at the site. It is the Office of Statewide Health Planning and Development's intent to allow healthcare facilities to provide services to the public as best they can under emergency conditions without interference.

The number of hospitals which are not currently seismically safe, according to their own assessment, has critical implications for facility and community surge planning. It is important for hospitals and emergency planners to note which hospitals are likely to be adversely impacted by an earthquake to understand the probable post-earthquake healthcare system surge capacity for each hospital and the jurisdiction.

5.4.1. Facility Post-Disaster Status Assessment

It is recommended that hospitals develop plans to guide decision making around operating or abandoning a degraded environment. Plans should identify an organizational person to

perform an immediate assessment and include a list of "fatal deficiencies/flaws" that would trigger immediate evacuation. The following three tools can be used by hospitals to assess the safety and functionality of their facilities following a catastrophic event. Three separate tools are provided which offer varying levels of analysis that hospitals can use based on the level of assessment that is needed for each facility.

The Facility Damage Report (Limited Assessment) is shown below. The complete tool can be found in the Hospital Operational Tools Manual on pages 99-100.

The facility damage report is a high-level assessment of the structural integrity of a facility during a catastrophic emergency. This tool is to be completed by the hospital representative in consultation with CDPH Licensing and Certification District Office.

Facility Damage Report (Limited Assessment)

Facility Name &Type_____

Address:_____

Date and Time report given: _____Census_____

Contact Person: _____Title/Location:_____

Preferred Contact Method: _____Preferred Contact Number:_____

Complete the worksheet through interview or fax to facility completion and return ASAP.			
#	**Answer:**	**Questions:**	**Comments:**
1	Y/N Partial	Can you provide essential patient care? (routine as well as management of injuries or disaster related conditions, if any)	
2	Y/N Partial	Is your facility intact? (structural integrity intact, no obvious damage, access to all areas)	
3	Y/N Partial	Are essential services intact? (power, water, gas, communication)	
4	Y/N Partial	Do you have adequate staff, supplies and equipment for the next 72 hours? (food, water, medicines, O2, hygiene, fuel)	
5	Y/N Unsure	Can you function without assistance for the next 72 hours?	

If the answer to any question is “partial” or “no,” the Licensing and Certification District Office will ask the hospital to describe its plan for resolving the issue. If facility is preparing to evacuate, the Licensing and Certification District Office will obtain patient list and evacuation destination(s) and complete a facility transfer summary. A summary report will then be sent to CDPH's disaster preparedness coordinator and/or field branch chief.

Source: California Department of Public Health, Licensing and Certification Program, Emergency Preparedness & Response Plan

The Facility On-Site Damage/Operability form is shown below. The complete tool can be found in the Hospital Operational Tools Manual on pages 101-103.

The Facility On-Site Damage/Operability form is a comprehensive assessment and will aid in the decision for keeping the facility open or evacuating staff. A partial to total evacuation should be considered if the overall damage assessment is yellow or red. This tool is to be completed by the organizational assessment person in consultation with CDPH Licensing and Certification District Office.

Facility On-Site Damage/Operability Report (Comprehensive Assessment)

Facility Name: _____ Date of Visit: _____

Address: _____ Evaluator Names: _____

City: _____

Overall Damage Assessment: ☐ ☐ ☐

(See OSHPD Placards*) GREEN YELLOW RED

AVAILABLE VACANT BEDS MALE ☐ FEMALE ☐

PATIENT EVACUATION ORDERED BY:_____TITLE_____

TYPE OF EVACUATION: TOTAL ☐ PARTIAL ☐

BUILDING	YES	NO
PARTIAL COLLAPSE		
TOTAL COLLAPSE		
PHOTOS TAKEN		

C0MMUNICATIONS	YES	NO
EXTERNAL		
INTERNAL		
ELEVATORS OPERATIONAL		

WATER AVAILABILITY	YES	NO
FROM UTILITY		
DRINKING WATER		
HOT WATER		

BUILDING SYSTEMS	YES	NO
ELECTRICITY		
EMERGENCY POWER		
FUEL RESERVE		
HEAT/ COOLING		
SEWAGE DISPOSAL		

SUPPLIES	YES	NO
FOOD		
MEDICATIONS		
INEN		
OTHER SUPPLIES		

STAFF AVAILABILITY	YES	NO
ADMINISTRATION		
NURSING		
DIETARY		
HOUSEKEEPING		

EVALUATOR COMMENTS AND DIAGRAM (IF NECESSARY):

_____

_____

Recommend Referral To: _____

*Green: Habitable, minor or no damage.

Yellow: Damage which represents some degree of threat to occupants

Red: Not habitable, significant threat to life safety

Source: California Department of Public Health, Licensing and Certification, Emergency Preparedness & Response Plan

HICS provides a tool (Form 251) to thoroughly assess facility status for the operational period of the incident. Per HICS instructions, it should be completed by the person(s) designated as the Infrastructure Branch Director at the start of the operational period, as conditions change, or more frequently as indicated by the situation. Additional guidance, including instructions, is available through the HICS Guidebook which can be found through the Emergency Medical Services Authority website, http://www.emsa.ca.gov.

The HICS 251 Facility System Status Report is shown below. The complete tool can be found in the Hospital Operational Tools Manual on pages 140-146.

Instructions

Purpose: Record facility status for operational period for incident.

Origination: Infrastructure branch director.

Original to: Situation unit leader.

Copies to: Operations section chief, business continuity branch director, planning section chief, safety officer, liaison officer, and documentation unit leader.

Print legibly, and enter complete information.

1. **OPERATIONAL PERIOD DATE/TIME:** Identify the operational period during which this information applies. This is the time period established by the hospital's Incident Commander, during which current objectives are to be accomplished and at the end of which they are evaluated. For example, a 12-hour operational period might be 2006-08-16 18:00 to 2006-08-17 06:00.
2. **DATE PREPARED:** Use the international standard date notation **YYYY-MM-DD**, where YYYY is the year, MM is the month of the year between 01 (January) and 12 (December), and DD is the day of the month between 01 and 31. For example, the fourteenth day of February in the year 2006 is written as **2006-02-14**.
3. **TIME PREPARED:** Use the international standard notation **hh:mm**, where hh is the number of complete hours that have passed since midnight (00-24), and mm is the number of complete minutes that have passed since the start of the hour (00-59). For example, 5:04 PM is written as **17:04**. Use local time.
4. **BUILDING NAME:** Provide name or other identifier of building for which this status report is being prepared.
5. **SYSTEM STATUS CHECKLIST:** For each system listed, use the following definitions to assign Operational Status:

   Fully functional: 100% operable with no limitations

   Partially functional: Operable or somewhat operable with limitations

   Non-functional: Out of commission

   Comment on location, reason, and time/resource estimates for necessary repair of any system that is not fully operational. If inspection is completed by someone other than as defined by policy or procedure, identify that person in the comments.
6. **CERTIFYING OFFICER:** Use proper name and identify the position title of the person preparing this form.
7. **FACILITY NAME:** Use when transmitting the form outside of the hospital.

WHEN TO COMPLETE: At start of operational period, as conditions change, or more frequently as indicated by the situation.

HELPFUL TIPS: Data may be obtained from inspections by Infrastructure Branch personnel. The hospital determines overall facility functionality.

HICS 251 – FACILITY SYSTEM STATUS REPORT			
1. Operational Period Date/Time	**2. Date Prepared**	**3. Time Prepared**	**4. Building Name**
5. SYSTEM STATUS CHECKLIST			

COMMUNICATION SYSTEM	**OPERATIONAL STATUS**	**COMMENTS** *(If not fully operational/functional, give location, reason, and estimated time/resources for necessary repair. Identify who reported or inspected.)*
Fax	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Information Technology System (email/registration/patient records/time card system/intranet, etc.)	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Nurse Call System	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Paging - Public Address	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Radio Equipment	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	

HICS 251 – FACILITY SYSTEM STATUS REPORT		
Satellite System	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Telephone System, External	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Telephone System, Proprietary	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Video-Television-Internet-Cable	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Other	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
INFRASTRUCTURE SYSTEM	**OPERATIONAL STATUS**	**COMMENTS** *(If not fully operational/functional, give location, reason, and estimated time/resources for necessary repair. Identify who reported or inspected.)*
Campus Roadways	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Fire Detection/Suppression System	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	

HICS 251 – FACILITY SYSTEM STATUS REPORT		
Food Preparation Equipment	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Ice Machines	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Laundry/Linen Service Equipment	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Structural Components (building integrity)	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Other	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
PATIENT CARE SYSTEM	**OPERATIONAL STATUS**	**COMMENTS** *(If not fully operational/functional, give location, reason, and estimated time/resources for necessary repair. Identify who reported or inspected.)*
Decontamination System (including containment)	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Digital Radiography System (e.g., PACS)	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	

HICS 251 – FACILITY SYSTEM STATUS REPORT		
Ethylene Oxide (EtO)/Sterilizers	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Isolation Rooms (positive/negative air)	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Other	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
SECURITY SYSTEM	**OPERATIONAL STATUS**	**COMMENTS** *(If not fully operational/functional, give location, reason, and estimated time/resources for necessary repair. Identify who reported or inspected.)*
Door Lockdown Systems	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Surveillance Cameras	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Other	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
UTILITIES, EXTERNAL SYSTEM	**OPERATIONAL STATUS**	**COMMENTS** *(If not fully operational/functional, give location, reason, and estimated time/resources for necessary repair. Identify who reported or inspected.)*

HICS 251 – FACILITY SYSTEM STATUS REPORT		
Electrical Power-Primary Service	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Sanitation Systems	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Water	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	(Reserve supply status)
Natural Gas	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Other	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
UTILITIES, INTERNAL SYSTEM	**OPERATIONAL STATUS**	**COMMENTS** *(If not fully operational/functional, give location, reason, and estimated time/resources for necessary repair. Identify who reported or inspected.)*
Air Compressor	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Electrical Power, Backup Generator	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	(Fuel status)

HICS 251 – FACILITY SYSTEM STATUS REPORT		
Elevators/Escalators	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Hazardous Waste Containment System	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Heating, Ventilation, and Air Conditioning (HVAC)	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Medical Gases, Other	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Oxygen	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	(Reserve supply status)
Pneumatic Tube	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Steam Boiler	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Sump Pump	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	

HICS 251 – FACILITY SYSTEM STATUS REPORT		
Well Water System	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Vacuum (for patient use)	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Water Heater and Circulators	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Other	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
6. CERTIFYING OFFICER		
7. FACILITY NAME		

5.5. Infection Control

Under 22 CCR 70739, each general acute care hospital is required to have a hospital infection control program for surveillance, prevention and control of infections. Even with formalized programs in place, during recent decades healthcare facilities across the nation have seen a steady increase in the risk of hospital acquired infections. The risk of infection is even greater following a catastrophic event due to the dramatic increase of patients. These risks may be exacerbated due to operational changes in patient care that hospitals are required to implement to accommodate disaster relief efforts.

22 CCR 70739 directs hospitals to evaluate and augment existing infectious disease control programs and implement new standards to prevent healthcare acquired Infections. These new standards include those established by the Centers for Disease Control and Prevention (CDC)

Healthcare Infection Control Practices Advisory Committee. 22 CCR 70739 references standards set by the Healthcare Infection Control Practices Advisory Committee and places the following requirements on general acute care hospitals:

- Use Healthcare Infection Control Practices Advisory Committee standards to address healthcare acquired Infections, such as those associated with catheters, blood stream infections associated with central venous lines, pneumonia associated with the use of ventilators, and surgical site infections.
- Prepare written reports on existing resources and evaluation measures (once every three years and updated annually)
- Develop a pandemic influenza component in the hospital's disaster plan

Hospital should be made aware that the requirements for these new standards will be phased in over 18 months as follows:

By July 1, 2007 hospitals must:

- Offer annual free onsite influenza vaccinations for all employees
- Institute respiratory hygiene and cough etiquette protocols
- Use procedures for the isolation of patients with influenza
- Adopt a seasonal influenza plan
- Revise an existing or develop a new disaster plan to include a pandemic influenza component, documenting any actual or recommended collaboration with local, regional, and state public health agencies or officials

By January 1, 2008 hospitals must:

- Pursue evaluating the judicious use of antibiotics
- Report annually to CDPH on implementation of specified infection surveillance and infection prevention process measures
- Submit data on implemented process measures to CDC's National Healthcare Safety Network or other valid national surveillance system recommended by CDC
- Utilize the CDC definitions and methodologies for surveillance of healthcare acquired infections
- For hospitals participating in the California Hospital Assessment and Reporting Task Force, publicly report healthcare acquired infection measures

By January 1, 2009 hospitals must:

- Develop, implement, and periodically evaluate compliance with policies and procedures to prevent surgical site infections
- Develop policies and procedures to implement CDC and Institute for Healthcare Improvement standards and process measures designed to prevent ventilator associated pneumonia
- Be subject to surveys by CDPH Licensing and Certification on compliance with new infection control procedures and reporting measures implemented under 22 CCR 70739.

Various federal and regulatory agencies, such as Joint Commission and CDC, also provide oversight in developing and monitoring infection control standards. Current Joint Commission standards for infection control specify requirements hospitals should address during emergency management activities:

- IC.6.10: As part of its emergency management activities, the hospital should prepare to respond to an influx, or the risk of an influx, of infectious patients.

  Healthcare providers are an important resource for the continued functioning of a community. A hospital's ability to deliver care, treatment and services is threatened when it is ill-prepared to respond to an epidemic or infections that are likely to require expanded or extended care capabilities over a prolonged period. Therefore, it is important for a hospital to have plans in place to prevent the introduction of infections into the hospital, to quickly identify whether existing patients have become infected and/or to contain the risk or spread of infection.

  These plans may include a broad range of options including the temporary halting of services and/or admissions, delaying transfer or discharge, limiting visitors within a hospital or fully activating the hospital's emergency management plan. The actual response depends on issues such as the extent to which the community is affected by the epidemic or infection, the types of services the hospital offers and the hospital's capabilities.

In addition, the Joint Commission's Comprehensive Accreditation Manual for Hospitals provides infection control standards under its Surveillance, Prevention, and Control of Infection chapter. This chapter outlines a hospital's obligation to:

- Incorporate its infection control program as a major component of its safety and performance improvement programs
- Perform an ongoing assessment to identify its risks for the acquisition and transmission of infectious agents

- Use an epidemiological approach that consists of surveillance, data collection, and trend identification
- Effectively implement infection prevention and control processes
- Educate and collaborate with hospital wide leaders to effectively participate in the design and implementation of the infection control program
- Integrate its efforts with healthcare and community leaders to the extent practicable, recognizing that infection prevention and control is a community-wide effort
- Remain a viable community resource by planning for responding to infections that potentially overwhelm its resources.

5.5.1. California Occupational Safety and Health Administration Infection Control Requirements

California Occupational Safety and Health Administration provides hospitals guidance on how to implement infection control programs. These standards, critical under normal operations, become increasingly important during a disaster, particularly one in which infectious material is prominent, for example during a pandemic influenza.

8 CCR 5193 provides guidelines for handling occupational exposure to blood or other potentially infectious materials and outlines specific requirements employers are to utilize to ensure compliance. These requirements include but are not limited to guidelines for hygiene, personal protective equipment and eye protection.

5.5.2. Draft Aerosol Transmissible Disease Exposure Control Plan

California Occupational Safety and Health Administration has proposed standards regarding aerosol transmissible diseases such as tuberculosis and severe acute respiratory syndrome. In the proposed addition to 8 CCR 5199, hospitals must establish and implement a written Aerosol Transmissible Disease Exposure Control Plan specific to the work place containing:

- A list of all job classifications in which employees have occupational exposure.
- A list of all high hazard procedures performed in the facility or operation, and the job classifications and operations in which employees are exposed to those procedures.
- A list of all assignments or tasks requiring personal and/or respiratory protection.
- Specific engineering, work practice, personal protective and respiratory protective control measures for each type or group of tasks, operations, or work areas in which occupational exposure occurs for routine procedures and for surge conditions, where applicable.

- A description of the source control measures to be implemented in the work operation or facility, and the method of informing people entering the work setting of the source control measures.
- Procedures for identifying, temporarily isolating, and referring or transferring airborne infectious disease suspect or confirmed cases to other facilities.
- Procedures for providing medical surveillance, including recommended immunizations and follow-up including the procedures the employer will use to document the lack of availability of a recommended vaccine.
- Procedures for employees and supervisors to follow in the event of an exposure incident, including how the employer will determine which employees had a significant exposure.
- Procedures the employer will use to evaluate each exposure incident, in order to determine the cause, and to revise existing procedures to prevent future incidents.
- Procedures the employer will use to communicate with its employees, and with the employers of other affected employees regarding the suspected or confirmed infectious disease status of persons to whom employees are exposed in the course of their duties.
- Procedures for communicating with other employers regarding exposure incidents, including procedures for providing or receiving notification to and from healthcare providers about the disease status of referred or transferred patients.
- Procedures the employer will use to ensure that there is an adequate supply of personal protective equipment and other equipment necessary to minimize employee exposure to aerosol transmissible pathogens, in normal operations, in foreseeable emergencies, and in surge situations.
- Procedures for providing initial and annual training to employees in job categories identified.
- Procedures for recordkeeping.
- Procedures the employer will use to involve employees in the review of the Plan.

Additional information on these requirements can be found at the Department of Industrial Relations' website: http://www.dir.ca.gov/dosh/doshreg/airborneinfectious%2Dmeetings.html.

5.5.3. Infection Control for Pandemic Influenza

The following infection control principles apply in any setting where persons with pandemic influenza might seek and receive healthcare services:

- Limit contact between infected and non-infected persons

  - Isolate infected persons (i.e., confine patients to a defined area as appropriate for the healthcare setting).
  - Limit contact between nonessential personnel and other persons (e.g., social visitors) and patients who are ill with pandemic influenza.
  - Promote spatial separation in common areas (i.e., sit or stand as far away as possible—at least three feet—from potentially infectious persons) to limit contact between symptomatic and non-symptomatic persons.
- Protect persons caring for influenza patients in healthcare settings from contact with the pandemic influenza virus. Persons who must be in contact should:
  - Wear a surgical or procedure mask for close contact with infectious patients.
  - Use contact and airborne precautions, including the use of N95 respirators, when appropriate.
  - Wear gloves (gown if necessary) for contact with respiratory secretions.
  - Perform hand hygiene after contact with infectious patients.
- Contain infectious respiratory secretions:
  - Instruct persons who have "flu-like" symptoms to use respiratory hygiene/cough etiquette.
  - Promote use of masks by symptomatic persons in common areas (e.g., waiting rooms in physician offices or emergency departments) or when being transported (e.g., in emergency vehicles).

For additional information see CDPH's *Pandemic Influenza Preparedness and Response Plan,* Chapter Five, Infection Control in the Healthcare Setting (http://www.cdph.ca.gov/healthinfo/discond/Documents/pandemic_influenza_preparedness_response_plan_06.pdf).

5.5.4. Cohorting Patients

During any infectious disease outbreak, natural or bioterrorist, other respiratory viruses may be circulating concurrently in the community. To prevent cross-contamination of respiratory viruses, hospitals should assign only patients with confirmed respiratory ailments of the same type to the same room. Hospitals should:

- Implement cohorting early in the course of an outbreak to accommodate an anticipated surge of patients;
- When determining areas to cohort patients, consult with facility engineers to address ventilation systems that are not shared with other areas or rooms;

- Ensure that personnel assigned to cohorted units do not "float" or otherwise work in other patient care areas; and
- Limit the personnel entering the cohorted areas to those necessary for patient care and support.

5.6. Decontamination

Similar to infection control, hospitals should have a plan or program for radioactive, biological, and chemical isolation and decontamination not only for normal operations, but also as a component of their emergency management plan. The Hospital and Healthcare System Disaster Interest Group and Emergency Medical Services Authority have developed *Patient Decontamination Recommendations for Hospitals*, July 2005. The document outlines recommendations for protecting healthcare providers and managing patients in the event of a hazardous materials exposure. Additionally, specific algorithms for different contamination situations are included. Some of the key recommendations for hospitals include:

- Hospitals are encouraged to establish relationships and notification procedures with appropriate local agencies (e.g., local Emergency Medical Systems and local health department) in order to:
    - Ensure communication between the field and hospital
    - Ensure that properly trained and equipped field/pre-hospital responders decontaminate patients in the field in order to protect the hospital as much as possible
    - Understand the local protocols and capabilities for field decontamination of patients
    - Ensure proper notification of a healthcare surge to appropriate local agencies (e.g., California Occupational Safety and Health Administration)
- The primary role of a hospital in a hazardous materials catastrophic emergency is to triage, treat, decontaminate and medically screen patients as necessary:
    - An influx of contaminated patients will overwhelm any hospital and, therefore, hospitals must work collaboratively with the community and local government to meet the challenges of a surge of contaminated patients.
    - Hospitals must be prepared for potentially contaminated patients who self-refer and present to the hospital.
- Additional planning considerations may include:
    - Establishing a "fast track" decontamination line for patients with severe or life-threatening symptoms, delivering basic life-saving treatment during decontamination if time and situation allow

- Establishing a separate decontamination area for patients that require secondary and/or technical decontamination if primary decontamination is not adequate
- Establishing a separate "lane" for patients arriving by Emergency Medical Services transport that have been decontaminated on scene so that these patients can be quickly assessed for adequacy of decontamination and be triaged to medical screening more quickly

The full guide may be accessed at http://www.emsa.ca.gov/aboutemsa/emsa233.pdf.

5.7. Hazardous Waste Management

Just as a plan or program for decontamination would be critical after a catastrophic emergency such as a nuclear attack, a plan for hazardous waste management is necessary as well. This section provides hospitals with an overview of the current standards and regulations that are applicable to hazardous waste management and offers a resource for additional information. In planning for and responding to a healthcare surge, hospitals should take these regulations and standards into consideration and implement plans and/or programs accordingly.

Emergency first responders, at the site of the release, are covered under California Occupational Safety and Health Administration State Plan Standards 8 CCR 5192(e). Depending on their roles, some hospital employees also are covered by the standard or the parallel Occupational Safety and Health Administration Standard on Hazardous Waste Operations and Emergency Response.

Federal Occupational Safety and Health Administration 1910.120 – Hazardous Waste Operations and Emergency Response – requirements apply to hospitals in at least three situations:

- When hospitals have an internal release of a hazardous substance which requires an emergency response
- When hospitals respond as an integral unit in a community-wide emergency response to a release of hazardous substance
- When a hospital serves as a Resource Conservation and Recovery Act-permitted Treatment, Storage and Disposal facility

The designation of an "emergency" under these provisions is dependent upon several factors, including the hazards associated with the substance, the exposure level, the potential for danger and the ability to contain the substance.

In addition to California Occupational Safety and Health Administration and federal Occupational Safety and Health Administration regulations, the Veterans Health Administration Center for Engineering and Occupational Safety and Health, in its *Emergency Management Program Guidebook*, 2002, provides extensive guidance around hazardous waste management (http://www1.va.gov/emshg/page.cfm?pg=114) and discusses key Occupational and Safety and Health Administration hazardous materials regulations related to hazardous waste management.

In addition to the regulations described above, the Guidebook discusses:

- 29 CFR 1910.101 -1910.126 Subpart H - Hazardous Materials: General requirements and guidelines for employers using hazardous materials, including compressed gases, acetylene, hydrogen, oxygen, nitrous oxide, flammable and combustible liquids, spray finishing using flammable and combustible materials, sip tanks containing flammable or combustible liquids, explosives and blasting agents. Guidance regarding storage and handling of liquefied petroleum gases and anhydrous ammonia as well as process safety management of highly hazardous chemicals.
- 29 CFR 1910.120 - Hazardous Waste Operations and Emergency Response (HAZWOPER): General requirements and guidelines regarding hazardous waste operations and emergency response.
- 29 CFR 1910.120 Appendix A - Personal protective equipment test methods: Non-mandatory examples of tests which may be used to evaluate compliance with paragraphs 1910.120(g)(4) (ii) and (iii), which state that totally-encapsulating suits shall be capable of maintaining positive air pressure and preventing inward test gas leakage of more than 0.5 percent.
- 29 CFR 1910.120 Appendix B: General description and discussion of the levels of protection and protective gear. General information regarding personal protective equipment protection levels which may be used to assist employers in complying with the protective equipment protection requirements of this section.
- 29 CFR 1910.120 Appendix C - Compliance guidelines: General compliance guidelines for the Occupational Safety and Health Program, Training, Decontamination, Emergency Response Plans, Personal Protective Equipment Programs, Incident Command System, Site Safety and Control Plans, Medical Surveillance Programs, and New Technology and Spill Containment Programs.
- 29 CFR 1910.120 Appendix D - References: References that may be consulted for further information on the subject of this standard.
- 29 CFR 1910.120 Appendix E - Training Curriculum Guidelines - (Non-mandatory): Non-mandatory general guidelines that may be used by employers for assistance in developing site-specific training curriculum used to meet training requirements.
- 29 CFR 1910.132 - 1910.139 Subpart I and Appendix B- Personal Protective Equipment: Guidelines and requirements for employers regarding protective equipment for employees

working in hazardous conditions, including protection for the eyes and face, respiratory system, head, feet and hands.

- 29 CFR 1910.132 - General Provisions: Guidelines and requirements for employers with regards to providing, using and maintaining sanitary and reliable protective equipment for employees working in hazardous conditions.
- 29 CFR 1910.133 - Eye and Face Protection: General requirements for employers regarding eye and face protection for employees exposed to hazards.
- 29 CFR 1910.134 - Respiratory Protection: General guidelines and requirements regarding respiratory protection for employees working in General Industry, Shipyards, Marine Terminals, Longshoring, and Construction.
- 29 CFR 1910.134 Appendix A - Fit Testing Procedures (Mandatory): General guidelines regarding the required procedures employers shall use when conducting fit testing.
- 29 CFR 1910.134 Appendix B - User Seal Check Procedures and Respirator Cleaning Procedures (Mandatory): Requirements of user seal checks for individuals using tight-fitting respirators and methods of performing these checks. General procedures for employers to follow when cleaning respirators.
- 29 CFR 1910.134 Appendix C - Occupational Safety and Health Administration Respirator Medical Evaluation Questionnaire (Mandatory): Requirements on completion of Occupational Safety and Health Administration Respirator Medical Evaluation Questionnaire by employees selected to use any type of respirator.
- 29 CFR 1910.134 Appendix D to Sec. 1910.134 (Mandatory): Information for Employees Using Respirators When Not Required Under the Standard: General guidance and information for employees using respirators when not required under the standard.
- 29 CFR 1910.136 - Occupational Foot Protection: General requirements and criteria for employers regarding protective footwear for employees working in areas where there is a danger of foot injuries.
- 29 CFR 1910.138 - Hand Protection: General guidance for employers regarding the requirement and selection of hand protection for employees exposed to hazards such as those from skin absorption of harmful substances, severe cuts or lacerations, severe abrasions, punctures, chemical burns, thermal burns, and harmful temperature extremes.
- 29 CFR 1910.1000-1910.1450 Subpart Z and Appendix B- Toxic and Hazardous Substances: Guidelines and requirements regarding employee exposure to toxic and hazardous substances, including but not limited to, air contaminants, asbestos, carcinogens, and lead. References to assist employers in the development of a Chemical Hygiene Plan.

- 29 CFR 1910.1200 - Hazard Communication: Guidance and requirements regarding the evaluation of all chemical hazards produced and imported, and transmitting information to employers and employees.
- 29 CFR 1910.1200 Appendix A - Health Hazard Definitions (Mandatory): Definitions and categorization of health hazards.
- 29 CFR 1910.1200 Appendix B - Hazard determination (Mandatory): Criteria that shall be used by chemical manufacturers, importers, and employers to make hazard determinations that meet the requirements of this standard.
- 29 CFR 1910.1200 Appendix D - Definition of “Trade Secret” (Mandatory): Definition of “Trade Secret” from a reprint of the “Restatement of Torts” section 757, comment b (1939).
- 29 CFR 1910.1200 Appendix E - Guidelines for Employer Compliance (Advisory): An appendix to serve as a general guide for employers to help them determine what's required under the Hazard Communication Standard and to provides a simplified outline of the steps an average employer would follow to meet those requirements.

5.8. Medical Waste Management[25]

Hospitals should also develop and implement a plan to effectively address medical waste management during a healthcare surge, understanding the current standards and guidelines that exist which can define the plan's appropriate parameters. The regulations for medical waste management under normal operations can be found in California’s Medical Waste Management Act (Health and Safety Code, Division 194, Part 14). However, during a catastrophic emergency, the potential for overloading the waste handling capacity of hospitals is greatly increased, a situation which could cause a secondary disaster if the medical waste is not properly managed. Because of this potential, each hospital should develop protocols that go beyond existing waste management plans to address the challenges associated with increased volume of medical waste during an emergency.

Issues to consider in developing protocols include (but are not limited to):

- Purchasing greater quantities of materials suitable for containing biological agents or infectious organisms. These materials are to include, but are not limited to:
  - Biohazard labeled bags
  - Sharps containers
  - Liquid handling containers
  - Rigid, closeable, leak-proof containers
  - All other associated supplies materials
- Developing a system to document the quantity of the materials above with an estimate of

how long these supplies will last for an inpatient population level determined by the hospital

- Develop procedures for obtaining additional material, regardless of whether the Hospital Emergency Operations Center is activated.

In regard to planning the waste storage component of medical waste management, hospitals are encouraged to consider the following options:

- Hospitals should consult with their medical waste disposal vendors for details of the vendor's ability to provide continued waste disposal services during a catastrophic emergency.
- Hospitals should consult with their county/environmental management office for protocols for storage of medical waste during a catastrophic emergency.
- Medical waste may need to be stored under refrigeration (<32^{o}F) to limit nuisance conditions. If a hospital has exhausted its refrigeration resources, it should request assistance through the SEMS/NIMS process.
- Medical waste should be separated from the solid waste stream.
- Combined waste streams are to be handled as medical waste.
- Chemical and radiological wastes must be separated and segregated from medical waste in order to avoid dual contamination.
- Waste stored on the premises of the hospital must be secure to prevent access by unauthorized persons and to prevent accidental spread of contamination.
- The designated storage area for medical waste must display the appropriate warning signs using wording required by Health and Safety Code Section 118310.
- Refrigerated storage areas need to be located away from external air intakes or need to be maintained with negative airflow.

5.9. Mass Fatality Management

5.9.1. State and County Fatality Response

Each California county has a Sheriff-Coroner, Coroner, or Medical Examiner to manage fatalities. These local government officials rely on the State's mutual aid system to meet their resource needs in events that overwhelm their response capacity. The mutual aid system for these officials is defined in the statewide Coroners Mutual Aid Plan. Recognizing that this plan is not a complete, statewide fatality management plan, the Office of Emergency Services has established the California State Mass Fatality Management Planning Committee. This committee has drafted a Mass Fatality Management Planning Concept of Operations as a first step in developing a broader plan to address all the topics for management of mass fatalities

during catastrophic events. In addition to the Coroners Mutual Aid Plan, California has established procedures for recording deaths in mass casualty events.

Local government may establish temporary morgue sites in the community in response to mass fatalities and a representative from the Unified Command will communicate the location and transfer procedures to the hospital. If needed, the State of California may request a federal Disaster Mortuary Operational Response Team to assist with the management of mass fatalities (see http://oep-ndms.dhhs.gov/teams/dmort.html for more information).

Until assistance can be obtained from local government resources to manage fatalities, hospitals must implement internal plans to manage the dead.

5.9.2. Hospital Fatality Management

When a catastrophic emergency occurs, hospital morgues will quickly reach capacity and hospitals will need to implement internal mass fatality plans. In addition, public coroners/medical examiners and private mortuaries may be unable to immediately respond to remove the dead. Some hospitals maintain memoranda of understanding with trucking companies to provide refrigerated trucks or convert areas in the hospital into temporary morgues in a mass casualty event.

Hospitals should plan for the appropriate bagging and storage of the dead, and consider the evidentiary needs (bodies stored with some space/distance between bodies, appropriate identification/labeling of the body). If the body is contaminated, special bagging, handling and labeling procedures must be ensured.

The hospital plan for management of mass fatalities must also include a procedure for providing information about viewing the dead by family members. Careful identification and tracking of the dead must be documented by the hospital and provided to authorities when requested.

As indicated in the Office of Emergency Services Mass Fatality Plan, a temporary morgue may need to be established if the number of dead exceeds the resources of the local mortuaries. Hospitals should be in contact with the Operational Area Emergency Operations Center to learn where temporary morgue sites have been established in their community.

5.10. Security Planning

Heightened security during a healthcare surge is needed to protect hospital personnel, patients, visitors, and the hospital facility and assets. Resources (personnel and material) for security are usually limited in hospitals; and therefore planning for an increase in security

requirements is essential. Hospitals must assess their current security status and project the security needs during multiple emergency scenarios that may cause a patient surge event (e.g., manmade/terrorism versus natural event). The hospital's Hazard Vulnerability Analysis can provide valuable information on high risk or high probability events which should be used to conduct security assessments and planning. See Section 3.8 Developing a Hazard Vulnerability Analysis for guidance on completing this analysis.

The Standardized Security Assessment/Vulnerability Tool is shown below. The complete tool can be found in the Hospital Operational Tools Manual on pages 187-188.

Hospitals can use this self-assessment tool to identify potential gaps in security and vulnerabilities at their facility, thereby ensuring the well-being and safety of patients and personnel during a healthcare surge.

				If No,		
#	Security Assessment / Vulnerability Tool	Yes	No	Why / Action Plan	By Whom	By When
1	The facility has a security plan, which includes, but is not limited to designated security staff...					
2	…additional security staff who can be deployed					
3	…security staff have vests for identification purposes					
4	…security staff have designated assignments					
5	…security staff have periodic training					
6	…security staff have job action sheets					
7	…security staff have protocols to provide security staffing in a sustained disaster					
8	The facility has a "lockdown" protocol.					
9	The facility has a protocol for the identification of physicians and staff who will enter the facility during a lockdown.					
10	The facility has a protocol for the identification of others such as fire, law enforcement, public health, etc. who will enter the facility during a lockdown.					
11	The facility has established a plan to set up a security perimeter and has the cooperation of law enforcement in the establishing and enforcement of this perimeter.					
12	There are designated ingress and egress routes into and out of the facility.					
13	The facility has a plan to establish a patient triage center at the security perimeter.					
14	The security plan includes signage that is ready to be posted.					
15	The facility has a plan to call-in security staff.					
16	Traffic flow patterns have been established in cooperation with law enforcement.					
17	The facility has public address systems to communicate with potential crowds outside the facility.					
18	Security knows where to direct media.					
19	Security has a log for all persons entering the facility through					

#	Security Assessment / Vulnerability Tool	Yes	No	If No, Why / Action Plan	If No, By Whom	If No, By When
	the security perimeter at which people log in time of entrance and time of departure.					
20	There is a protocol developed in collaboration with law enforcement on when and how to search persons or their belongings and who will be responsible for this function.					
21	There is a plan for communications with and among security personnel.					
22	There is a plan for armed security personnel.					

5.10.1. Supplemental Security Staffing

Supplemental personnel may be needed to assist the on-duty security staff, depending on the type and length of the incident. This need may be met by calling personnel in from home, reassigning non-security personnel to select tasks and requesting help from local law enforcement.

Planning should address when law enforcement will be able to assist and how they will be integrated into hospital operations and the hospital's Incident Command System. Their deployment assignments and pertinent response procedures, including rules of engagement, should be discussed upon their arrival along with what support they will require (e.g., personal security protective equipment, phone access). In addition to using local law enforcement to supplement staffing shortfalls, consideration should be given to having a contingency contract(s) with local or national private security firms to provide trained personnel during an emergency. Planning should address the deployment, supervision and needed support for these personnel along with associated utilization expenses. Planners should consider the need for armed security. During a healthcare surge, it may be difficult to get law enforcement services on site because of competing demands for their services and their responsibilities elsewhere. Hospitals should develop plans for how they will address security during a healthcare surge (i.e., private security companies, designated internal staff trained for this function) until additional security assets can be obtained.

5.10.2. Lock-Down vs. Restricted Access/Visitation

Pre-event surge planning must include development of policies and procedures for securing the facility. Implementing a lock-down requires that there is no entrance into or exit from the facility, while restricting access requires a control of the access and egress into the facility. A part of the planning process is determining under what conditions a hospital will decide to lock-down and under what conditions restricted access is sufficient. For example, if a disaster is of sufficient severity that civil unrest exists in the community, a lock-down may be required to protect hospital resources and staff, while in an event with minimal community access,

restricting access will enable a hospital to better respond to the disaster.

Locking down the hospital will require large numbers of personnel and resources to accomplish, can impact hospital operations (i.e., ambulance traffic), and may not be realistic. Restricting access to the facility may be more feasible than a lock-down, controlling and directing the flow of people into and out of the hospital through points of access. Limiting or restricting visitors may be necessary during a surge event to protect patient privacy and facility assets. Each hospital should outline the triggers for deciding to lock-down or restrict assess in its Emergency Operations Plan with supporting incident-specific hospital plans, policies and procedures.

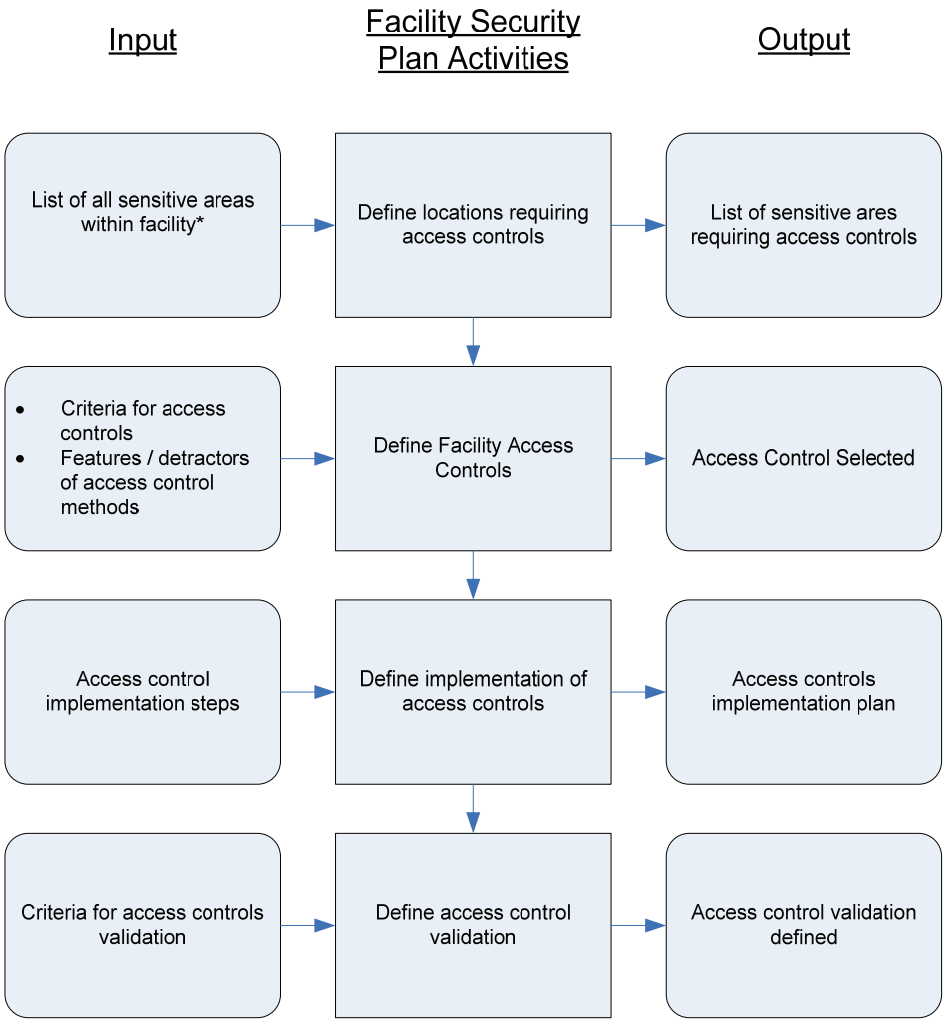
Security measures, restrictions, and procedures implemented should be announced to the staff, patients, visitors, and the public. Personnel assigned to implement security measures should be trained or provided "just in time" training to ensure effective security. Internal and external signage indicating the doors are NOT to be opened (and, where appropriate, redirecting would-be entrants) should be posted as soon as possible. Such signage can be created in advance and stored, ideally, by doors for rapid deployment. It is crucial to involve Life-Safety Engineers/Personnel in the planning and response to ensure adequate egress in the event of a fire or other internal emergency.

Hospitals may have electronically controlled doors or areas that can enhance security measures, however, these areas should be regularly monitored to ensure no compromise occurs. Heightened surveillance procedures may need to be implemented including inspecting suspect packages; closer scrutiny of personnel at checkpoints, verification that each individual, including staff, is wearing a proper identification badge; and assigning properly protected personnel at patient arrival points, including the decontamination sector if activated (Crowd Control Unit). Certain areas such as the Emergency Department, Pharmacy, and Hospital Incident Command Center (e.g., Hospital Command Center) should receive enhanced security support. Steps may need to include restricting staff entry into certain areas because of security concerns, unsafe conditions or because no additional staff is required.

A sample Facility Security Plan Process flow is below. This process flow can help hospitals identify and secure sensitive areas within their facilities that may require restricted access during a healthcare surge.

A sample Facility Security Plan Process Flow is shown below. The complete tool can be found in the Hospital Operational Tools Manual on pages 104-105.

Facility Security Plan Process Flow



* Sensitive areas in hospitals that may require additional security may include:

- Birthing Center (Maternity, Nursery, Labor and Delivery, Postpartum)
- Pediatrics
- Emergency Department
- Psychiatry (Inpatient)
- Psychiatry (Outpatient)
- Radiation Therapy
- Nuclear Medicine
- Pharmacy
- Medical Records
- Information Services
- Human Resources
- Surgical Services (Operating Room)
- Food Services

A sample Lock-Down policy and procedure is provided below to assist hospitals when a complete lock-down of the facility is required during a healthcare surge. A lock-down check list is included to document completion of the steps outlined in the procedure.

A Lock-Down Policy and Procedure Sample is shown below. The complete tool can be found in the Hospital Operational Tools Manual on pages 150-155.

I. PURPOSE

To provide procedures and guidance when the need to lock-down the facility exists for any reason – this type of situation could involve mass contamination, picketing, demonstrations, acts of violence, sit-ins, passive resistance, civil disobedience, gang activity or other disturbances.

II. POLICY

The primary goal in a lock-down situation is to isolate and control access to the facility while caring for the safety of the patients, visitors, staff and property.

III. RESPONSIBILITIES

A. LAW ENFORCEMENT

Management of a civil disturbance itself will be accomplished by law enforcement.

B. SECURITY

Security staff, augmented if necessary, will conduct the internal response in the event of a need for lock-down and will take measures to control access to and from the facility, whenever possible.

C. STAFF

All staff should separate themselves, if at all possible, from any involvement in a civil disturbance.

IV. PERSONNEL

This policy applies to all staff members

V. PROCEDURES

A. GENERAL – CIVIL DISTURBANCE

1. Regardless of how peaceful the intent or how righteous the cause of a civil disturbance, because of the strong emotional nature of the issues involved, these manifestations, on many occasions, end in rioting, violence and destruction/looting of property.
2. Based on the nature of the disturbance, it will be managed by security staff until the decision is made that management of the situation requires the activation of the Facility Incident Command System.

3. Upon becoming aware of a civil disturbance situation, the facility administrator or senior administrative person in the facility will be notified immediately.

B. MASS CONTAMINATION

1. Contaminated individuals/equipment entering the facility may require the total closure of operations of all or part of the facility.
2. In a mass contamination situation, only individuals or equipment which are KNOWN to be free of contamination will be allowed in the building

C. ACTIVATION/NOTIFICATION

1. The decision to initiate lock-down will be made by the administrator, if available, based on information provided by security and other staff members. In accordance with the policy established in the emergency management plan, the following individuals, in order of position rank, may initiate lock-down in the absence of the administrator:
    a. Administrator-on-call
    b. Appropriate administrative directors
    c. Safety officer or designee
    d. Emergency management chairperson
    e. Operations supervisor during off hours and weekends
2. Announcement/Notification
    a. Upon specific guidance from the administrator or designee, the operator will announce the civil disturbance three times via the public address system. The proper announcement is:

        <<Code Name for Lock-Down>> “Nature and Location of Disturbance”

        Repeat the statement every 15 minutes for the first hour, or as often as the incident commander directs.
    b. When directed by the incident commander, the operator will contact the appropriate law enforcement office and request immediate assistance.
    c. The operator will contact <<Facility Name>> Relations at the phone numbers provided for that purpose.
    d. When so directed by the incident commander or the senior administrative individual in the facility, the All Clear will be announced of the public address system as follows:

        “<<Code Name for Lockdown>>, Location, ALL CLEAR” (three times)
3. Upon announcement of lock-down, the Incident Command Center and other designated portions of the Incident Command System organization will be activated. This will normally include, at a minimum, a portion of the planning section and the public information officer.

D. SECURITY OPERATIONS

1. In the case of a civil disturbance, the senior security representative present will immediately assess the situation and provide that information to the administrator or incident commander.
2. In the case of a mass contamination situation, the infection control coordinator, or designated clinical staff member will assess the situation and recommend appropriate action.
3. If required, security augmentation will be initiated either through recall of off-duty security, appointing other available staff to perform security duties or by obtaining augmentation from security companies.
4. Security will immediately commence locking all exterior doors and will advise staff to close ground-floor window coverings if possible.
5. A single entry point will be established. Staff guarding other exterior doors will be instructed to not allow anyone in or out of those doors. A security representative or other designated individual will allow individuals with legitimate reason into and out of the single entry point based on the situation. In the case of mass contamination, only those individuals KNOWN to be free of contamination will be allowed in the building.
6. A security officer will be stationed in the primary treatment area (emergency department or urgent care).
7. If anyone exits the building, a staff or security member must ensure the door is firmly closed and locked after the individual.
8. Security representatives will provide escorts for staff members to and from the parking areas. In the case of mass contamination, anyone leaving the building, including security representatives, must be determined to be free of contamination before being allowed to reenter the building.

E. COMMAND CENTER OPERATIONS

1. All information from local law enforcement, fire department and other sources will be provided to the Incident Command Center.
2. Actions to be taken will be based on the evaluation of this information by the Incident Commander.
3. The incident commander will determine what information will be disseminated to facility staff.
4. The public information officer will coordinate all releases of information to the media.
5. In the case of mass contamination, the decontamination procedures will be initiated.
6. In the event the disturbance is in one of the area's prisons and/or jails and the facility is to receive a large number of prisoners to be treated, plans will be developed to set aside an area for these patients to remain under guard in order to preclude interfering with other facility operations.

7. In the event of an extended disturbance causing all or part of the staff to remain in the facility, provisions will be made for housing and feeding these individuals.

F. FACILITY OPERATIONS

1. Patients, visitors and staff will be moved from the immediate area of the disturbance if at all possible.
2. In patient care areas, access will be limited to staff and others authorized by the incident commander to be in those areas.
3. Based on guidance provided by the incident commander, visiting hours may be reduced or eliminated and any visitors will be strictly controlled.
4. Staff will be informed to avoid the area and to not involve themselves in the disturbance.

G. POST-CRISIS MANAGEMENT

After cancellation of the lock-down, a debriefing by a crisis intervention team and/or mental health professionals should be provided as needed for all individuals involved in managing the disturbance.

LOCK-DOWN CHECKSHEET

Mission: The primary goal in a lock-down situation is to isolate and control the situation while caring for the safety of the patients, visitors, staff and property. The following checksheet should be filled out by security, or other appropriate staff, to confirm that lock-down has been completed.

____ Personnel discovering the lock-down situation will promptly notify their supervisor, who will pass the information to the administrator or designee.

____ Staff will not become involved, if possible, in any manner with the civil disturbance.

____ Isolate the situation by locking all exterior doors to your unit and closing all ground-floor windows.

____ Do not allow any entry or exit from other than through the single entry point, which will be controlled by security.

____ Only individuals KNOWN to be free of contamination will be allowed to enter the building in a mass contamination event.

____ If exiting the building, request an escort to and from the parking lot areas.

____ Allow law enforcement to quell the civil disturbance.

Source: This policy and procedure sample was adapted from CODE CD - Lock-Down for Scripps, San Diego.

5.10.3. Chain-of-Custody Considerations

For suspicious incidents, specific chain-of-custody procedures must be followed. "Chain of custody" refers to the document or paper trail showing the seizure, custody, control, transfer, analysis, and disposition of physical and electronic evidence. Because evidence can be used in court to convict persons of crimes, it must be handled in a scrupulously careful manner to avoid later allegations of tampering or misconduct.

The hospital Emergency Operations Plan should outline a fundamental strategy of basic objectives and steps. These procedures should address everything from handling a patient's personal effects to packaging and transferring of laboratory specimens. Local law enforcement should be consulted when developing these procedures to ensure the outlined steps are consistent with accepted local practice. During an incident it will be important for hospitals to identify what procedures are to be employed and to quickly disseminate easily understood instructions.

5.11. Hospital Traffic Control during a Surge

Depending on the situation, individuals will likely be arriving by private automobiles accompanied by quickly escalating numbers of family and friends. The media may also arrive at some point and request special parking locations for their outside interviews and "live shots." The gravity of the situation may warrant inspecting all of these vehicles as they enter the campus. These inspections will require additional personnel and equipment needed to do the inspection. For hospitals sharing campuses with other healthcare facilities, the decision making associated with campus security should be done in a collaborative manner and employ optimal communication practices.

Traffic patterns may need to be revised to optimize emergency medical services and other emergency vehicle arrivals. The area in front of the Emergency Department should be kept clear along with areas assigned for decontamination. All available parking areas should be opened and consideration given to suspending gate-entry systems and fee payments. Planning for a surge event should address situations such as abandoned vehicles, including those with possible chemical contamination, and how they should be removed from outside the Emergency Department and other critical locations. It should also be anticipated that law enforcement may request vehicle information (tag number, make and model of the car and location) for the patients being seen.

5.12. Business Continuity Planning

Business continuity planning involves formulating an action plan that enables an organization to perform its routine day-to-day operations in the event of an unforeseen incident. The overall purpose of business continuity planning is to:

- Identify the essential functions required to be prepared at all times
- Resume vital operations within a specified time after the incident occurs
- Return to normal operations as soon as practical and possible
- Train personnel and familiarize them with emergency operations

The plan should consider various types of disasters, levels of casualties and varied durations of interruption of operations. It should detail the actions to be taken based on the level of damage that the hospital has sustained, rather than an individual type of loss.

The business continuity planning process should cover these main areas:

- Business Planning – Determines which aspects of the hospital's operations are most essential to its ability to provide care. This preliminary analysis phase assesses the potential risk and impact on hospital operations, identifies recovery requirements and lists alternative strategies. Different departments that comprise the hospital's business must be analyzed and the departments and functions that are most critical to the business's survival identified.
- Technical Support – Determines the feasibility of the plan from a technical standpoint and ensures that the different departments have the equipment and technical support to provide care.
- Implementation – Ensures that hospital personnel are able and willing to implement the plan. The plan should take personnel cross-training into account in order to avoid the situation where only one person knows the equipment or other needs of the departments and their processes.

The business continuity plan is a dynamic document that must reflect the continuing changes in daily operations of the hospital. Constant testing and adjusting are needed in order to ensure its continued viability.

The Joint Commission's Environment of Care Standards requires hospitals to address continuity of business operations as part of their emergency operations plan.

The checklist below summarizes areas to consider when developing a business continuity plan.

The Sample Business Continuity Plan Checklist is shown below. The complete tool can be found in the Hospital Operational Tools Manual on pages 163-164.

	Areas to Consider When Developing a Business Continuity Plan
☐	Identify essential functions within facility that must be maintained during an emergency. These essential functions will drive the business continuity plan.
☐	Clearly define individual responsibilities, including who has the authority to initiate the business continuity plan procedures
	Instruction on when, where and how to use the backup site including, but not limited to:
☐	– Procedures for establishing Information Systems processing in an alternate location including arrangements for office space
☐	– Replacement equipment
☐	– Telecommunications
☐	– Supplies
☐	– Transportation
☐	– Housing
☐	– Food and water
☐	Notification to personnel at the selected backup site
☐	List of contacts with work, home, cellular phone and pager numbers
☐	Identification of vital system software documentation at the backup site
☐	Procedures for retrieving and restoring medical record information and data from the off-site storage hospital
☐	List of vendor contact personnel
☐	Site of remote storage and related information
☐	Current listing of hardware and software
☐	Backup equipment requirements (contracts, compatibility, timeliness, availability)
☐	Interim procedures to be followed until systems are restored; procedures for catching up when systems are back in operation
☐	Evaluation of maximum outage tolerable for each major system and a restoration priority listing indicating the order in which to restore systems
☐	Verify that a copy of the business continuity plan is stored off-site

The Sample Business Continuity Plan Template is shown below. The complete tool can be found in the Hospital Operational Tools Manual on pages 165-171.

The following provides a sample template for a business continuity plan that hospitals can use as the basis for developing a business continuity plan at their facility. The template contains key elements that will enable an organization to perform its routine day-to-day operations in the event of an unforeseen incident. Business continuity planners should follow the template and collect the elements as instructed below. The elements include critical personnel and entity contact information, roles and responsibilities, vendor contact information, critical recovery functions, minimal resource requirements for the functions, dependent activities/entities of the function, vital records information, site requirements for business relocation, emergency notification protocols, security strategies, designated plan coordinator and review date.

Sample Business Continuity Plan Template

Section 1: Critical Contact Information: Identify personnel, vendors and entities* that are critical to maintaining business operations following a disaster.

* Note: entities could include governmental agencies and members of the hospitals' Incident Command structure.

Critical Personnel and Entities

Position	Name	Work Phone	Cell Phone	Home Phone	Personal e-mail	Site and Alternate Site Responsibilities
Critical Position #1:						
Alternate 1:						
Alternate 2:						
Alternate 3:						
Critical Position #2:						
Alternate 1:						
Alternate 2:						
Alternate 3:						
Critical Position #3:						
Alternate 1:						
Alternate 2:						
Alternate 3:						

Critical Position #4:						
Alternate 1:						
Alternate 2:						
Alternate 3:						

Critical Vendors

Vendor	Location	Contact	Work Phone	Cell Phone
Vendor Name				
Alternate Contact:				
Comments:				
Vendor Name				
Alternate Contact:				
Comments:				
Vendor Name				
Alternate Contact:				
Comments:				
Vendor Name				
Alternate Contact:				
Comments:				

Section 2: Essential Functions and Recovery Objectives: Identify the essential functions that are critical to business continuity and the corresponding rational for selecting these functions. Recovery objectives outline why continuity of these functions will promote overall business continuity following a catastrophic event.

Essential Functions	Recovery Objectives
Function 1	
Function 2	
Function 3	
Function 4	
Function 5	
Function 6	
Function 7	

Section 3: Minimum Resource Requirements: Identify the minimum resources needed to complete the critical functions identified above.

Minimum Resource Requirements		
	Minimum	Full Function
Function 1		
• Space Requirements		
• Equipment Requirements		
• Supplies Requirements		
• Essential Services Required		
• Personnel Requirements		
Function 2		
• Space Requirements		
• Equipment Requirements		
• Supplies Requirements		
• Essential Services Required		

• Personnel Requirements		
Function 3		
• Space Requirements		
• Equipment Requirements		
• Supplies Requirements		
• Essential Services Required		
• Personnel Requirements		
Function 4		
• Space Requirements		
• Equipment Requirements		
• Supplies Requirements		
• Essential Services Required		
• Personnel Requirements		
Function 5		
• Space Requirements		
• Equipment Requirements		
• Supplies Requirements		
• Essential Services Required		
• Personnel Requirements		
Function 6		
• Space Requirements		
• Equipment Requirements		
• Supplies Requirements		
• Essential Services Required		
• Personnel Requirements		
Function 7		
• Space Requirements		

• Equipment Requirements		
• Supplies Requirements		
• Essential Services Required		
• Personnel Requirements		

Section 4: All Agencies, Divisions and Vendors upon which Function Is Dependent: Identify the activities upon which the above functions are dependent for completion.

Essential Function	Dependent Activity/Entity	Business Continuity Plan (BCP) in place?	Comments
Function 1		Y/N	
Function 2		Y/N	
Function 3		Y/N	
Function 4		Y/N	
Function 5		Y/N	
Function 6		Y/N	
Function 7		Y/N	

Section 5: Vital Records: Identify the type or category of vital record (e.g., electronic medical record, financial record), a brief description of record, and the location where the record is backed-up or stored for emergencies.

Name/#	Description	Location

Section 6: Alternate Site for Function: Identify alternate site(s) for essential hospital function(s). The number and location of alternate sites will depend on the hospital and the emergency. Some functions can be moved to other locations within the hospital, and others may need to be moved to an entirely new facility.

Functions	Alternate Site
Function 1	
Function 2	
Function 3	
Function 4	
Function 5	
Function 6	
Function 7	

Section 7: Designated Plan Coordinator: Identify a business continuity plan coordinator. This may be someone from the hospital's Incident Command, or a specifically designated business continuity plan coordinator.

Name	Work Phone	Pager or Cell	Home Phone	Personal Email
Alternates:				

Section 8: Review Date: Record the last date the business continuity plan was reviewed. The plan should be reviewed periodically based on staff / vendor turnover and other changes within the environment.

Source: Adapted from Enterprise Business Continuity Planning, Department of Administrative Services, State of Oregon.

5.12.1. Development of Standard Operating Procedures for Maintaining Infrastructure During a Healthcare Surge

Standard operating procedures for key activities of equipment, plant and utilities should be developed as part of a hospital's business continuity planning. It is essential to involve hospital engineering personnel in the patient management planning processes in order to ensure a safe hospital environment is maintained for both hospital personnel and patients. Areas within the expertise of engineering that must be included in the planning process are:

- Alarm systems
- Electrical backup power
- Elevators-vertical transport
- Heating
- Ventilation and air conditioning
- Room/hood exhaust
- Steam distribution
- Internal transport system
- Medical gases system
- Roads and grounds
- Waste and debris
- Water delivery/portability

Development of these procedures is critical to the recovery of business operations. The standard operating procedure template below can be used in business continuity planning for equipment, plant and utilities.

The Standard Operating Procedure Template for Equipment, Plant and Utilities is shown below. The complete text can be found in the Hospital Operational Tools Manual on pages 185-186.

Standard Operating Procedure Template for Equipment, Plant and Utilities

1. Description of the Threat/Catastrophic Emergency
2. Impact on Mission Critical Systems
3. Operating Units and Key Personnel with Responsibility to Manage this Threat/Catastrophic Emergency
4. Mitigation/Preparedness Activities of the Threat/Catastrophic Emergency

a. Hazard Reduction Strategies and Resource Issues
b. Preparedness Strategies and Resource Issues

5. Response/Recovery from the Threat/Catastrophic Emergency
   a. Hazard Control Strategies
   b. Hazard Monitoring Strategies
   c. Recovery Strategies
6. Internal and External Notification Procedures by Entity Type
7. Specialized Staff Training
8. Review Date

Source: Veterans Health Administration Center for Engineering & Occupational Safety and Health in its Emergency Management Program Guidebook, 2002, provide extensive guidance around hazardous waste management (http://www1.va.gov/emshg/page.cfm?pg=114).

5.13. Spontaneous Blood Donor Volunteers[26]

A common motivation that drives spontaneous volunteers to converge on hospitals is the desire to donate blood. A plan should therefore be pre-established to divert these well-intentioned individuals to an appropriate blood bank resource, preferably one that is physically distant from the healthcare facility. Hospitals should work with blood banks to assure they have effective plans in place for large surge donation offers. This plan should include written public information and a system for staging donor volunteers to provide blood at a designated time in the future rather than immediately. This will avoid the glut of blood products that occurred in the U.S. after the September 11, 2001, terrorist attacks while maintaining the goodwill of the donor population.

6. Expanding the Workforce

Increasing staff during a disaster will be one of the greatest challenges that a healthcare facility must address. During a healthcare surge, a hospital's first option to address staffing demands is to depend on their existing staff (e.g., increasing the number of hours per work shift, calling back staff who have been on medical leave, etc.). When hospitals have maximized the productivity of their existing staff the next option would be to call upon external sources for temporary staff, as they normally would when there is a staff shortage. Hospitals may opt to collaborate with neighboring healthcare facilities to acquire staff through the development of Memoranda of Understanding or Memoranda of Agreement. These memoranda outline the terms of the agreements for sharing staff between facilities during times of need.

Additional sources of temporary staff may include nurse agencies and locum tenens registries. Hospital Human Resources and Medical Staff departments should use existing processes for contacting these sources. Once these sources are exhausted, additional staffing resources will be requested through the SEMS/NIMS structure like any other resource as discussed in Section 3.2: Standardized Emergency Management System.

In developing their emergency plans, it is recommended that hospitals consider the following:

- Staffing plans should encompass both clinical roles such as registered nurses and how they may be assigned to different duties based on designated patient care levels, and non-clinical staff.
- Matrices should be developed to assist staffing supervisors in identifying staff who possess specific skills or could rapidly acquire them.

In preparing these staffing plans and matrices, it should be noted, however, that "fewer ancillary staff would necessitate more nursing staff to accomplish tasks normally the responsibility of ancillary staff."[27]

Because of the complexity associated with expanding the workforce in an emergency, staffing issues have been divided into the following sections:

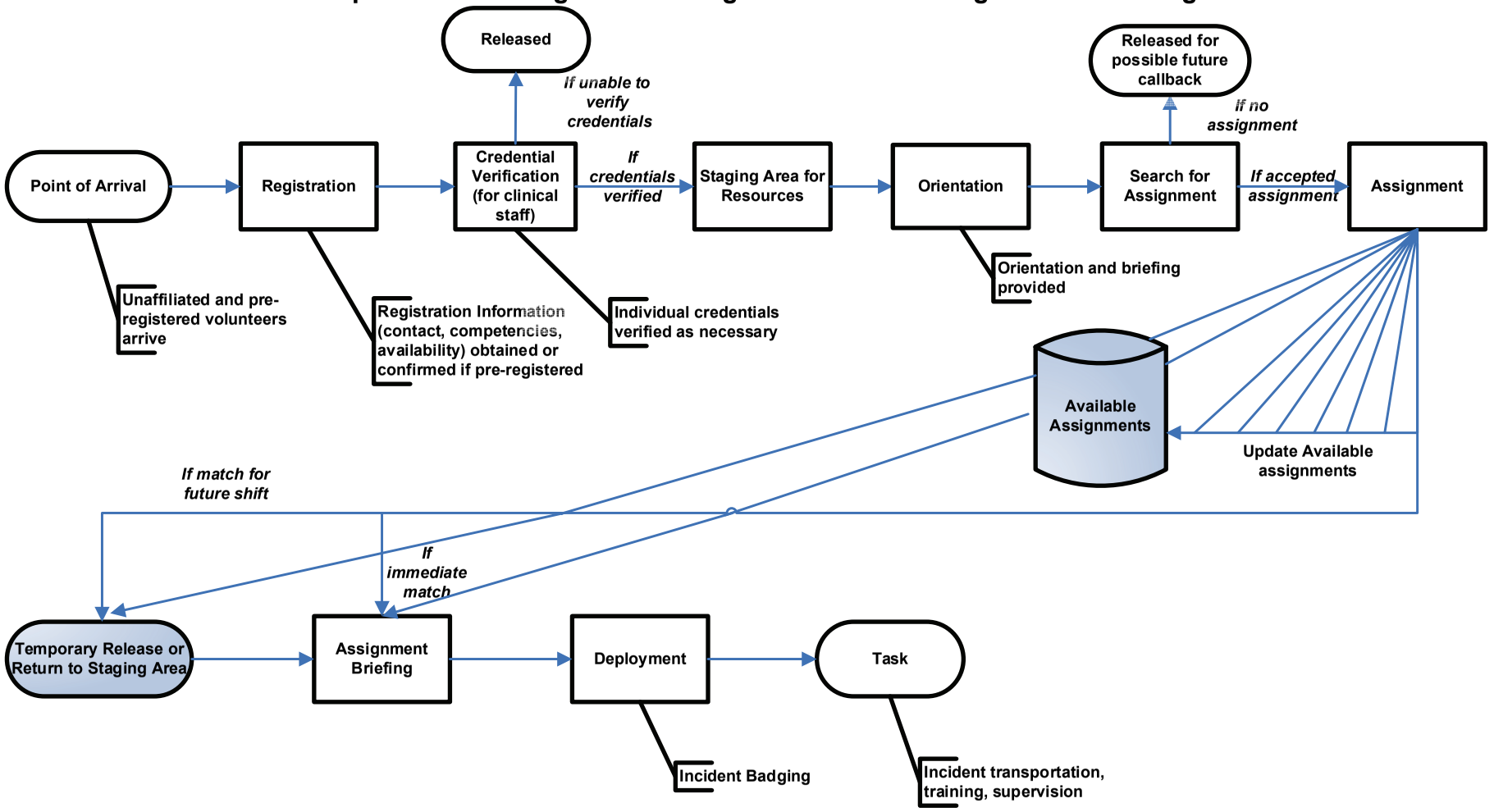
- Chapter 7: Augmenting Clinical Staff and Other Staffing Strategies. This section considers issues related to clinical staff (licensed and non-licensed) in terms of Scope of Practice, staffing ratios, staffing strategies for registered nurses, and pharmacists. In addition, streamlined credentialing and privileging processes for a healthcare surge are presented.
- Chapter 8: Augmenting Non-Clinical Staff. This section discusses verification processes for non-clinical staff and provides a non-clinical staff support matrix.

6.1. Process Flow for Acceptance and Assignment of Additional Staff During Healthcare Surge

The following diagram may assist planners and staffing coordinators at hospitals in understanding the process by which additional staff are accepted and deployed. Although the acquisition process for varying types of personnel may differ depending on the volunteer organization used, the acceptance and deployment process would essentially be consistent.

The Acceptance and Assignment of Augmented Staff During Healthcare Surge process flow is shown on the next page. The complete chart can be found in the Hospital Operational Tools Manual on pages 5-6.

Acceptance and Assignment of Augmented Staff During Healthcare Surge



6.2. Staffing Component Considerations for Development of a Mutual Aid Memoranda of Understanding with Neighboring Healthcare Facilities

In order to support the delivery of care at the onset of a healthcare surge, it may be necessary for hospitals to invoke pre-established Memoranda of Understanding with neighboring healthcare facilities. However, at the point in the healthcare surge that a Unified Command structure is activated, resources will be prioritized and allocated through that structure rather than through any pre-established memorandum of understanding.

Memoranda of Understanding between facilities and other organizations will contain sections including, but not limited to patient transfer; supplies, equipment and pharmaceuticals; and personnel.

Staffing Component Considerations for Development of Mutual Aid Memoranda of Understanding is shown below. The complete tool can be found in the Hospital Operational Tools Manual on pages 52-53.

Purpose: The following are areas hospitals should consider when developing memoranda of understanding with neighboring healthcare facilities include:

Medical Operations/Loaning Personnel

1. Communication of Request: The request for the transfer of personnel initially can be made verbally. The request, however, must be followed up with written documentation. This should ideally occur prior to the arrival of personnel at the recipient healthcare facility. The recipient healthcare facility will identify to the donor healthcare facility the following:
    a. The type and number of requested personnel
    b. An estimate of how quickly the request is needed
    c. The location where they are to report
    d. An estimate of how long the personnel will be needed
2. Documentation: The arriving personnel will be required to present their temporarily reassigned emergency healthcare facility identification badge at the check-in site designated by the recipient healthcare facility's command center. The recipient healthcare facility will be responsible for the following:
    a. Meeting the temporarily reassigned personnel (usually by the recipient healthcare facility's security department or designated employee)
    b. Providing adequate identification, e.g., "visiting personnel" badge, to the arriving reassigned personnel
3. Staff Support: The recipient hospital shall provide food, housing and/or transportation for temporarily reassigned personnel asked to work for extended periods and for multiple shifts. The costs associated with these forms of support will be borne by the recipient healthcare facility.

4. Financial liability: The recipient healthcare facility will reimburse the donor healthcare facility for the salaries and benefits of the donated personnel at the donated personnel's rate as established at the donor healthcare facility if the personnel are employees being paid by the donor healthcare facility. The reimbursement will be made within 90 days following receipt of the invoice.
5. Demobilization procedures: The recipient healthcare facility will provide and coordinate any necessary demobilization procedures and post-event stress debriefing.
6. Emergency privileging procedures: The medical director/medical staff office of the recipient healthcare facility will be responsible for providing a mechanism for granting emergency privileges for physicians, nurses and other licensed healthcare providers to provide services at the recipient healthcare facility.

6.3. Sample Policy for Surge Capacity Staffing Emergency Plan[28]

The following policy is an example from Scripps Mercy Hospital's surge capacity staffing plan. Components of HICS have been used to develop the plan/policy. However, it has been customized to this particular hospital's daily operations.

A Sample Policy for Surge Capacity Staffing Emergency Plan is shown below. The complete text can be found in the Hospital Operational Tools Manual on pages 41-45.

I. Purpose:

Provide guidelines for staffing during surges in the patient census and/or for critical needs in staffing.

II. Policy:

A. It is the policy of [Hospital Name] to maintain a state of readiness in the event of a health disaster or staffing emergency.

B. The Emergency Staffing Plan will be activated by the Logistics Section Chief if the Emergency Operations Plan is activated or by the Chief Nurse Executive (CNE) until the Emergency Operations Plan is activated.

C. This plan will be activated when there is a patient surge that overwhelms the current staffing resources and renders the facility unable to comply with regulated nurse to patient staffing ratios.

D. The Emergency Operations Plan and incident management team positions of the Hospital Incident Command System (HICS) will be activated during a surge event to manage and coordinate emergency staffing (see attached checklist).

III. Personnel:

All employees

IV. Procedures:

When the decision to activate the emergency staffing plan is made, the following roles will be implemented:

A. Incident Commander – Mission: To organize and direct Emergency Operations Center. The role of the Incident Commander is to provide and give overall direction. The role will be assumed by the staff available to maintain smooth hospital operations.

1. The administrator or designee, typically a nursing director, patient flow coordinator or operations supervisor will be appointed by the Incident Commander. The Incident commander needs to activate the Emergency Staffing Plan and they are responsible for the overall management and coordination of the response in conjunction with other team leader leaders. Responsibilities are to:
    i. Communicate with the Unified Command to ensure the facility is incorporated in the SEMS/NIMS system.
    ii. Communicate with the facility's corporate headquarters and sister hospitals to leverage information and sharing.
    iii. Coordinate activities with other [Hospital Name] hospitals if indicated.
    iv. Collaboration with the marketing department's (if this department exists at the hospital) release of appropriate information to media representatives.
    v. Collaborate with medical staff by reviewing all elective procedures and all potential patient discharges and transfers to lower levels of care establishing a priority list.
    vi. Collaborate with team members, and finance staff, to authorize the utilization of the financial resources necessary to maintain essential staffing levels.
    vii. Implement financial incentives and staffing plans to meet patient care needs.
    viii. Optimize utilizing existing staff in the hospital to promote safe patient care.
    ix. Coordinate and communicate the prioritization of non-essential meetings and tasks.
    x. Collaborate with regulatory resource staff for notification to licensing about the situation.

B. Patient care areas are to be designated under the direction of the Incident Commander and response team in collaboration with nursing leaders.

Note: Staffing will be based on patient acuity.

1. All monitored areas (portable and fixed) will be fully utilized based on patient need.
2. Infection control professionals to be consulted if indicated.

C. All departments will maintain an emergency staffing plan.

1. Staffing Office personnel will maintain a current list of all licensed patient care staff.
2. Staffing Office personnel will contact other [Hospital Name] affiliated facilities and

supplemental staffing agencies requesting personnel.

3. Staffing Office personnel will verify license, Basic Life Support (BLS) status and core competencies on all supplemental and/or volunteer RN/LVN/RCP staff.
4. Each department will activate the following action steps in coordination with the staffing office personnel, based on patient demand/acuity.
    i. Call all off-duty staff to report to work (each patient care area will maintain an emergency staff roster).
    ii. Offer incentives for staff to work overtime.
    iii. Inform Incident Commander of actual and available staff for deployment.
    iv. Provide basic orientation to supplemental staff.
5. All exempt licensed staff will be available to provide direct patient care and support.
6. All non-patient care staff not involved in the critical operations of the hospital may be assigned to patient care support duties as needed.
7. During Healthcare Surge Actions:
    i. All team members will observe co-workers for signs of stress and report concerns to the appropriate unit leaders (on duty manager or supervisor) and/or referral to Employee Assistance Program (EAP) or identified support staff will be made.
    ii. Support staff through recognition of efforts on an ongoing basis.
    iii. Communicate status of catastrophic emergency to employees frequently, to keep them informed.
    iv. If needed, hospital transfer agreements will be implemented by the Incident Commander. Transportation of patients will be coordinated with input from the Base Hospital Station and/or the [Hospital Name] Operations Center. Notify the County Medical Operations Center of intent to transfer patients and the request assistance in patient placement.

B. Planning/Communication Chief – Mission: To ensure distribution of critical information and data. Compile resource projections from all team leaders and effect short- and long- term staffing needs. Document and email or distribute daily action plans.

1. Nursing Director or designee coordinates a temporary nonclinical labor pool to assist with clerical and support functions as appropriate.
2. Maintain a message center to coordinate communication for the hospital.
3. Act as custodian of all logged and documented communications relating to the catastrophic emergency.
4. Identify and coordinate public relations activities in conjunction with the Incident Commander.
5. Maintain current information on staffing needs of the hospital.

C. Finance Chief – Mission: Monitor the utilization of financial assets. Oversee the

procurement of supplies and services necessary to carry out the hospital's medical mission. Supervise the documentation of expenditures relevant to the incident.

1. Designee from access management or finance.
2. Maintain records of expenditures to be presented during a "cost to date basis" and at the incident debriefing.
3. Identify cost centers utilized to respond to the incident and separate these expenditures from normal operating expenses.
4. Prepare financial reports necessary for reimbursement if appropriate.

D. Logistics/Materials Management – Mission: Organize and direct operations associated with maintenance of the physical environment and adequate levels of food, shelter and supplies to support the medical objectives.

1. Designee from materials management or hospitals.
2. Obtain materials, supplies and food during the catastrophic emergency
3. Coordinate the physical environment needed to provide additional patient care and treatment areas.
4. Coordinate transportation of supplies and equipment within the institution within [Hospital Name] or with other sources as indicated.
5. Work with security to identify additional needs for patient or staff safety and for parking for additional staff.
6. Collaborate with all clinical departments (Pharmacy, Lab, EVS, Radiology, etc.) to assure patient care needs can be met.

E. Medical Staff – Mission: Promote patient flow with medical and house staff.

1. President of medical staff or designee works closely with the director of medical education to set priorities during high census healthcare surge.
2. Provides communication to medical staff as indicated.
3. Discusses specific concerns with physician staff as needed.
4. In collaboration with Incident Commander, reviews all elective procedures for potential cancellation, potential discharges and transfers and helps execute the process.
5. Provide Employee Assistance Program.

F. Post-Healthcare Surge/Recovery Procedure for Hospital Leadership:

1. Debrief staff at scheduled charge nurse meetings.
2. Acknowledge contributions of staff.
3. Revise policy and plan based on lessons learned.

6.4. Requesting Staff through the Standardized Emergency Management System

Even with extensive planning, staffing a hospital during a surge may require resources beyond local availability. Additional staffing resources must be requested through SEMS/NIMS. Requests for staff will be made to the Unified Command. Staffing requests should be as specific as possible to ensure resource needs are met. For example, when requesting a registered nurse, a hospital should identify specific skill sets needed. During catastrophic events resulting in scarcity of resources, resource requests will be prioritized by policymakers within the SEMS/NIMS structure and some resource requests may be unfilled. For more information on the SEMS/NIMS structure, see Foundational Knowledge, Section 3.9: Standardized Emergency Management System.

Staffing resources that can be accessed through SEMS/NIMS are regional, state, and federal assets such as Medical Reserve Corps, Community Emergency Response Teams, Disaster Medical Assistance Teams/ California Medical Assistance Teams, Ambulance Strike Teams, and Mission Support Teams. The Emergency Medical Services Authority is implementing the California Medical Volunteers (formerly known as Emergency System for the Advanced Registration of Volunteer Health Professionals) which will serve as a registry for all licensed local, regional and State emergency response volunteer personnel. These potential staffing resources are described in more detail in the table below.

The List of Potential Staffing Sources during Healthcare Surge - Background & Activation Information is shown below. The complete listing can be found in the Hospital Operational Tools Manual on pages 17-20.

Organization Brief Background & History	Additional Information May Be Found at:
American Red Cross (ARC) The mission of American Red Cross Disaster Services is to ensure nationwide disaster planning, preparedness, community disaster education, mitigation and response that will provide the American people with quality services delivered in a uniform, consistent and responsive manner. The American Red Cross responds to disasters such as hurricanes, floods, earthquakes and fires, or other situations that cause human suffering or create human needs that those affected cannot alleviate without assistance. It is an independent, humanitarian, voluntary organization, not a government agency. All Red Cross assistance is given free of charge, made possible by the generous contribution of people's time, money and skills. The most visible and well-known of Red Cross disaster relief activities are sheltering and feeding.	http://www.redcross.org Information is available for both the national chapter as well as links to local chapters.
California Medical Assistance Team (CalMAT) Three 120-person California Medical Assistance Teams have been created under State control to respond to catastrophic disasters. Each California Medical Assistance Team consists of volunteers drawn from the private, not-for-profit and existing State and local government healthcare delivery sector.	http://www.emsa.ca.gov/def_comm/viii092706_d.asp

Organization Brief Background & History	Additional Information May Be Found at:
The California Medical Assistance Teams will maintain caches that contain medical supplies, medical equipment, tents, pharmaceuticals and interoperable (compatible) communications. The California Medical Assistance Team program will be supported on-site by an Emergency Medical Services Authority-led Mission Support Team for administrative direction and logistical direction and re-supply.	
Community Emergency Response Teams (CERT)/Neighborhood Emergency Response Teams (NERT) The Community Emergency Response Team program educates people about disaster preparedness for hazards that may impact their area and trains them in basic disaster response skills, such as fire safety, light search and rescue, team organization and disaster medical operations. Using the training learned in the classroom and during exercises, Community Emergency Response Team members can assist others in their neighborhood or workplace following an event when professional responders are not immediately available to help. Community Emergency Response Team members also are encouraged to support emergency response agencies by taking a more active role in emergency preparedness projects in their community. The Community Emergency Response Team concept was developed and implemented by the Los Angeles Fire Department in 1985. The Whittier Narrows earthquake in 1987 underscored the area-wide threat of a major disaster in California and confirmed the need for training civilians to meet their immediate needs. As a result, the Los Angeles Fire Department created the Disaster Preparedness Division and the Community Emergency Response Team program to train citizens and private and government employees.	http://www.citizencorps.gov/cert Information is available for the local chapter as well as links to the national chapter.
Disaster Medical Assistance Team (DMAT) Disaster Medical Assistance Team is a group of professional and para-professional medical personnel (supported by a cadre of logistical and administrative staff) designed to provide medical care during a disaster or other event. Each team has a sponsoring organization, such as a major medical center, public health or safety agency, nonprofit, public or private organization that signs a Memorandum of Agreement with the federal Department of Health and Human Services. Disaster Medical Assistance Teams are designed to be a rapid-response element to supplement local medical care until other federal or contract resources can be mobilized or the situation is resolved. Disaster Medical Assistance Teams deploy to disaster sites with sufficient supplies and equipment to sustain themselves for a period of 72 hours while providing medical care at a fixed or temporary medical care site. In catastrophic incidents, their responsibilities may include triaging patients, providing high-quality medical care despite the adverse and austere environment often found at a disaster site, and preparing patients for evacuation. Disaster Medical Assistance Teams are designed to be a rapid-response element to supplement local medical care until other federal or contract resources can be mobilized or the situation is resolved.	http://www.ndms.dhhs.gov/teams/dmat.html

Organization Brief Background & History	Additional Information May Be Found at:
Under the rare circumstance that disaster individuals are evacuated to a different locale to receive definitive medical care, Disaster Medical Assistance Team may be activated to support patient reception and disposition of patients to hospitals. Disaster Medical Assistance Team are principally a community resource available to support local, regional and State requirements. However, as a national resource they can be federalized.	
Disaster Service Worker (DSW) Disaster service worker includes public employees and can include any unregistered person pressed into service during a state of war emergency, a state of emergency, or a local emergency by a person having authority to command the aid of citizens in the execution of his or her duties.	http://www.oes.ca.gov/Operational/OESHome.nsf/PDF/Disaster%20Service%20Worker%20Volunteer%20Program%20(DSWVP)%20Guidance/$file/DSWguide.pdf
California Medical Volunteers (formerly Emergency System for the Advance Registration of Volunteer Health Professionals) California Medical Volunteers is an electronic database of healthcare personnel who volunteer to provide aid in an emergency. The California Medical Volunteer system: (1) registers health volunteers, (2) applies emergency credentialing standards to registered volunteers, and (3) allows for the verification of the identity, credentials and qualifications of registered volunteers in an emergency.	http://www.hrsa.gov/esarvhp/guidelines/default.htm California Medical Volunteer https://medicalvolunteer.ca.gov/ (currently serves as a volunteer registration site)
Los Angeles County Emergency System for the Advance Registration of Volunteer Health Professionals (ESAR VHP) Medical professionals that pre-register and are accepted as Los Angeles County Emergency System for the Advance Registration of Volunteer Health Professionals volunteers can be deployed rapidly and effectively to help following a disaster. The Volunteer Center of Los Angeles is working in partnership with the Los Angeles County Department of Health Services, Emergency Medical Services Agency and Department of Public Health (including the Health Alert Network) to provide volunteer registration and assist in volunteer accreditation of health professionals. Physicians, Dentists, Podiatrists, Clinical Psychologists, Physician Assistants or Advanced Practice Registered Nurses who wish to be on the Hospital Surge Capacity Team or the Alternate Care Site Team will have their information forwarded to CheckPoint Credentials Management for further credentialing. All other medical and mental health professionals do not require additional credentialing. As required by the national Emergency System for the Advance Registration of Volunteer Health Professionals program, all potential volunteers are screened using the Federal Exclusion List.	Los Angeles Emergency System for the Advance Registration of Volunteer Health Professionals http://www.vcla.net/esar

Organization Brief Background & History	Additional Information May Be Found at:
Medical Reserve Corps (MRC) The Medical Reserve Corps program was created after President Bush's 2002 State of the Union Address, in which he asked all Americans to volunteer in support of their country. The Medical Reserve Corps comprises organized medical and public health professionals who serve as volunteers to respond to natural disasters and emergencies. These volunteers assist communities nationwide during emergencies and for ongoing efforts in public health. There is no "typical" Medical Reserve Corps unit. Each unit organizes in response to their area's specific needs. At the local level, each Medical Reserve Corps unit is led by an Medical Reserve Corps Unit Coordinator who matches community needs – for emergency medical response and public health initiatives – with volunteer capabilities. Local coordinators are also responsible for building partnerships, ensuring the sustainability of the local unit and managing the volunteer resources.	http://www.medicalreservecorps.gov/HomePage

6.5. Tracking Staff Providing Services in the Hospital[29]

Once a staff member has been assigned a role during a healthcare surge, a process must be established to track that person while providing services in the hospital. This section provides sample tracking sheets for that purpose.

6.5.1. Staff Assignment Tracking Sheet

The Staff Assignment Tracking Sheet below allows staff coordinators at hospitals to assign roles and responsibilities during a healthcare surge. Members of the hospital staff can be pre-assigned to explicit roles for a healthcare surge. In addition, this sheet will allow additional staff to be assigned roles during a healthcare surge.

The Staff Assignment Tracking Sheet is shown below. The complete tool can be found in the Hospital Operational Tools Manual on pages 50-51.

Instructions for Use: For each staff person assigned to a role in the hospital, the staffing coordinator will document: name, assigned staff identification number if applicable, assigned roles and responsibilities, the name of the individual to whom the person reports (Supervisor), the time the staff member reported in to work and the time the staff member concluded work, and the location within the facility the staff member is assigned. This form can be used to track all staff members who may provide assistance during a surge, both internal hospital staff as well as external staff such as volunteers.

Staff Assignment Tracking Sheet

Name (Last, First)	Staff ID # (If Applicable)	Surge Roles & Responsibilities	Supervisor/Oversight	Time In	Time Out	Location

7. Augmenting Clinical Staff and Other Staffing Strategies

This section addresses areas pertaining to increasing clinical staff during a healthcare surge, both licensed and non-licensed staff. Issues addressed include scope of practice, staffing ratios, license verification (if applicable), and policies for surge capacity staffing.

7.1. Scope of Practice and Liability Protections

During a healthcare surge, when the demand for patient care is greater than the supply of providers needed to deliver healthcare, it may become necessary to allow healthcare professionals to practice outside of their licensed scope of practice in order to fulfill the overarching mission of ensuring the best population outcome or "the greatest good for the greatest number" of people. During a healthcare surge focus shifts from patient-based care to population-based care and the current standards that allow professional scope of practice to shift (in terms of waiving or flexing these standards) must be identified and addressed.

7.1.1. California Healing Arts Boards

The table below provides current emergency statutory flexibility in scope of practice and liability protections for selected California Healing Arts Boards. The list below includes only those Boards that provided guidance on current statutory flexibility in scope of practices and liability protections and is not a complete list of all California Healing Arts Boards.

Board	Current Scope of Practice	Scope of Practice/ Liability in an Emergency
Licensed Vocational Nurses	Business and Professions Code Section 2860.5 outlines the normal scope of practice for licensed vocational nurses.	Per the Board of Vocational Nursing and Psychiatric Technicians, a licensed vocational nurse may practice outside his/her scope of practice to save a life or limb if he/she can do so competently and safely. This determination would not apply to disaster or emergency situations in which an individual's life or limb was not in immediate danger.
Pharmacy	Business and Professions Code Sections 4052.1 – 4052.5 outline the normal scope of practice for pharmacists.	Per Business and Professions Code Section 4062(b), during a declared federal, state or local emergency, the board may waive application of any provisions of this chapter or the regulations adopted pursuant to it if, in the board's opinion, the waiver will aid in the protection of public health or the provision of patient care.
Physician Assistant	Business and Professions Code Section 3502 outlines the normal scope of practice for physician assistants.	In the event of an emergency (as defined by Government Code Section 8558), the scope of practice for physician assistants is defined by Business and Professions Code Section 3502.5, which states that they may perform those medical services permitted pursuant to Business and

Board	Current Scope of Practice	Scope of Practice/ Liability in an Emergency
		Professions Section 3502 "regardless of whether the physician assistant's approved supervising physician is available to supervise the physician assistant, so long as a licensed physician is available to render the appropriate supervision."
Podiatric Medicine	Business and Professions Code Section 2472 outlines the normal scope of practice for doctors of podiatric medicine.	Per Business and Professions Code Section 2397(d), immunity from liability for civil damages for injury or death caused in an emergency situation occurring in the licensee's office or in a hospital on account of a failure to inform a patient of the possible consequences of a medical procedure is not applicable to doctors of podiatric medicine.
Respiratory Care	Business and Professions Codes Sections 3702 and 3702.7 outline the normal scope of practice for a professional licensed by the Respiratory Care Board of California.	Per Business and Professions Code Section 3703, "respiratory care may also be provided during the transportation of a patient and under any circumstances where an emergency necessitates respiratory care." Per Business and Professions Code Section 3765, the Respiratory Care Practice Act does not prohibit respiratory care services in case of an emergency. Additionally, per Business and Professions Code Section 3706, "a person licensed under this chapter who in good faith renders emergency care at the scene of an emergency which occurs outside both the place and the course of employment shall not be liable for any civil damages as the result of acts or omissions by the person in rendering the emergency care. This section does not grant immunity from civil damages when the person is grossly negligent."

7.1.2. Flexed Scope of Practice

During a healthcare surge, the appropriate standard of care will vary based on the availability of resources, patient needs and environmental factors. As indicated in Section 2.2: Standard of Care Defined, the standard of care is also dependent on the scope of practice each available provider is licensed or authorized to provide. However, in some emergencies, healthcare professionals may need to function outside their specialties to meet the needs of the emergency and save the greatest possible number of lives.

Recognizing the need to provide liability protection to healthcare professionals during situations when they provide care outside their authorized scope of practice while responding to emergency healthcare needs, the following standby order was drafted. In addition, Section 7.1.4: Liability Protections During a Healthcare Surge outlines State and federal laws that provide immunity from liability for healthcare facilities, healthcare professionals and volunteers. Standby orders are directions issued by the Governor that make, amend, or rescind certain state laws that prescribe the conduct of state business that may in any way prevent, hinder, or

delay the mitigation of the effects of the emergency. A standby order must be approved by the Emergency Council and then issued during a proclaimed state of emergency. In some cases, standby orders delegate the authority to suspend requirements to a specific State official, for example the director of the Office of Emergency Services, the Emergency Medical Services Authority or CDPH. The proclamation of a state of emergency alone is not sufficient to effectuate a suspension of regulatory requirements, unless those requirements have a provision enabling their automatic activation upon such a proclamation. The proclamation would need to include a standby order or the Governor would need to issue a separate executive order issuing the standby order.

The standby order below for use by the Governor is intended to address the likely need for increasing the number of paid healthcare professionals able to provide services needed during a state of emergency in California. Under the proposed order, the Governor in collaboration with the State Health Officer will decide which licensed healthcare professionals should have expanded scope of practice to mitigate the extent of the emergency. Local health officers responsible for Alternate Care Sites or chief medical officers of healthcare facilities will decide who is qualified to perform services outside the scope of practice authorized under their license. By creating a flow of authority from the Governor to the local health officer or chief medical officer to the healthcare provider, this order will link the action of the providers to the protections provided in the Emergency Services Act.

The standby order addresses the following objectives:

- Liability protection for healthcare professionals: to provide to a broader class of licensed healthcare professionals to the extent possible under current law, the liability protections currently afforded under Government Code Section 8659, which provides liability protection to physicians, surgeons, hospitals, pharmacists, nurses, and dentists.
- Licensure protection for healthcare professionals: to protect to the extent prudent and reasonable under the circumstances, a healthcare professional's license if that individual renders emergency aid necessary to save lives, and without willful misconduct.
- Patient protection: to protect patients when receiving healthcare from licensed healthcare professionals that are inconsistent with their training, experience or abilities.
- The need to balance local decision making with State authority.

Text of the Standby Order for Expanded Scope of Practice:

It is hereby ordered that in the area proclaimed to be in a State of Emergency and/or that specific area(s) designated by the State Public Health Officer outside of the proclaimed area(s) but which is (are) essential to the relief and aid of the medical and health needs of the people within the proclaimed area, those rules that regulate the practice of licensed healthcare providers, including but not limited to _____* , _____*, shall be waived or amended as directed by the State Public Health Officer in order to increase the availability of

acute medical care. Pursuant to the State Public Health Officer's actions, the local health officer, or chief medical officer at a hospital, shall direct healthcare providers under their authority to mitigate the medical needs caused by the emergency.

***Instructions**

State Health Officer would fill in the blanks, based on the needs of the emergency, from a comprehensive list of licensed healthcare professionals:

- Acupuncturists
- Associate Clinical Social Worker
- Audiologists
- Clinical Nurse Specialists
- Licensed Clinical Social Worker
- Licensed Educational Psychologist
- Marriage and Family Therapist
- Marriage and Family Therapist Intern
- Occupational Therapists
- Optometrists
- Osteopaths
- Nurse Practitioners
- Pharmacists
- Pharmacist Interns and Pharmacy Technicians
- Physical Therapists
- Physician Assistants
- Physicians
- Podiatrists
- Psychiatric Technician
- Psychologists
- Registered Dental Assistant
- Registered Dental Assistant in Extended Functions
- Registered Dental Hygienist
- Registered Dental Hygienist in Alternative Practice
- Registered Dental Hygienist in Extended Functions
- Registered Dispensing Opticians

- Registered Nurse Anesthetists
- Registered Nurses
- Registered Veterinary Technicians
- Respiratory Care Practitioners
- Speech-Language Pathologists
- Veterinarians
- Vocational Nurses

Although the standby order for flexing the scope of practice will allow any included category of licensed healthcare providers to provide care beyond their current scope of practice, it is recommended that hospitals maintain an inventory of skills/experiences beyond the normal licensing scope for each staff member. The Skills and Abilities Assessment tool below is designed to facilitate that inventory and assist staffing coordinators at hospitals plan and allocate personnel resources during a healthcare surge. As part of the Hospital Emergency Management Plan, hospital planners should complete a skills inventory of existing staff and pre-registered volunteers to identify staff with experiences, skills or competencies beyond their licensed capacity that may be useful during a healthcare surge. This inventory can help the facility's Medical Director quickly make use of the standby order above and assign staff to particular patients or duties during an emergency by providing detailed information on staffing skills. Understanding the abilities of staff during an emergency will enable better decisions on what tasks should be performed by each staff member.

The Skills and Abilities Assessment tool is shown below. The complete tool can be found in the Hospital Operational Tools Manual on pages 48-49.

Instructions for Use:

Facility staffing coordinators or medical staff representatives should identify existing staff and pre-registered volunteers who may have useful skills, competencies or experience beyond their license or credentials.

Identify staff members or pre-registered volunteer as either credentialed or non-credentialed. In the column marked 'Current Position Title,' indicate the staff member or pre-registered volunteer's current position. In the column marked 'Competencies/Skills Beyond Licensing,' identify any known skills that may be relevant during a healthcare surge that are not part of the staff member's current scope of practice. Two examples are provided.

When complete, this plan should be included as part of the Hospital Emergency Management Plan.

Skills and Abilities Assessment		
Name	**Current Position Title**	**Competencies/Skill Sets Beyond Licensing**
Credentialed Staff		
Ex: Staff Person #1	*Respiratory Therapist*	*Military experience includes suturing*
Noncredentialed Staff		
Ex: Staff Person #2	*Laboratory Technician*	*Volunteer experience includes grief counseling*

As the scope of practice for licensed professionals is subject to change, the Healing Arts Board's websites are a useful resource for understanding the current scope of practice for any particular licensed healthcare professional.

Healing Arts Board	Website
Acupuncture Examining Committee Of The Board Of Medical Quality Assurance	http://www.acupuncture.ca.gov/
Board Of Behavioral Sciences	http://www.bbs.ca.gov/
Board of Occupational Therapy	http://www.bot.ca.gov/
Board Of Optometry	http://www.optometry.ca.gov/
Board Of Pharmacy	http://www.pharmacy.ca.gov/
Board Of Podiatric Medicine Of The Medical Board Of California	http://www.bpm.ca.gov/
Board Of Psychology	http://www.psychboard.ca.gov/
Board Of Registered Nursing	http://www.rn.ca.gov/

Board Of Vocational Nurse And Psychiatric Technician Examiners Of The State Of California	http://www.bvnpt.ca.gov/
Dental Board Of California	http://www.dbc.ca.gov/
Medical Board Of California	http://www.medbd.ca.gov/
Osteopathic Medical Board Of California	http://www.ombc.ca.gov/
Physical Therapy Board Of California	http://www.ptb.ca.gov/
Physician Assistant Examining Committee Of The Medical Board Of California	http://www.pac.ca.gov/
Registered Dispensing Opticians Of The Medical Board Of California	http://www.medbd.ca.gov/RDO_Program.htm
Respiratory Care Board Of California	http://www.rcb.ca.gov/
Speech-Language Pathology And Audiology Board	http://www.slpab.ca.gov/
Veterinary Medical Board	http://www.vmb.ca.gov/

7.1.3. Augmenting Staff Through Standby Orders

In addition to the Expanded Scope of Practice Standby Order above, this section provides a sample standby order that may be used to facilitate timely and appropriate regulatory assistance during a healthcare surge. The standby order below deems contractors working in a hospital as Disaster Service Workers. The decision to implement this measure and other standby orders is a decision made by the Governor and the Director of the Office of Emergency Services following a declared State of Emergency by the Governor.

Clarification of Governmental Agents Providing Services within a Hospital as Disaster Service Workers Standby Order Text

In the event a local governmental jurisdiction is required to assist a hospital in providing or arranging to provide treatment of disaster related victims when existing facilities are overloaded and cannot accommodate the patient load, all persons providing services at the hospital pursuant to an actual or implied request of the local governmental jurisdiction shall be agents of the local governmental jurisdiction, and as such, deemed Disaster Service Workers under the Emergency Services Act.

7.1.4. Liability Protections During a Healthcare Surge

Several statutes provide qualified immunity to persons rendering aid and healthcare facilities providing care during an emergency and address the need to provide liability protection to healthcare providers during an emergency. These immunity provisions instruct the courts not to impose liability in specified emergency circumstances. Thus, if the immunity applies, there can be no liability. This, in turn, may reduce the need for a suspension of regulatory requirements because the immunity already contemplates that the standard of care is dependent upon available resources.

The tables below highlight specific State and federal laws, and other regulatory activities that govern healthcare operations, that provide immunity from liability for healthcare facilities, healthcare professionals and volunteers. This table can assist hospitals and their legal counsel in developing healthcare surge response plans. For further information on these topics, see Reference Manual, Section 3: Surge Regulations and Compliance Legal Matrix.

Federal Statute/Regulation	Description of Statute/Regulation and Waiver Requirements
Liability of Healthcare Facilities	
California Civil Code Section 1714.5	Provides immunity from liability for disaster service workers as well as an owner or operator including a public agency that owns or maintains any building or premises which is used as a mass care center, first-aid station, temporary hospital annex or other necessary facility for mitigating the effects of an emergency. The immunity is from liability to any person who has entered to seek refuge, treatment, care or assistance, while in or upon the premises, for injuries sustained as a result of the condition of the building or premises, or as the result of any act or omission, or as a result of the use or designation of the premises as a mass care center, first-aid station, temporary hospital annex or other necessary facility for emergency purposes. The only exclusions from immunity are the willful acts of the owner or occupant or their employees.[30]
California Health and Safety Code Section 1317	By law, emergency services and care must be provided to any person upon request for any condition in which the person is in danger of loss of life, serious injury or illness at any health facility licensed by the State that maintains and operates an emergency department to provide emergency services to the public when the health facility has appropriate facilities and qualified personnel available to provide the services or care.[31] A medical screening examination and stabilization of an emergency medical condition is required.[32] However, the health facility and its employees, including any physician, surgeon, dentist, clinical psychologist and podiatrist, are immune from liability in any action arising out of a refusal to render emergency services or care if the refusal is based on the determination, exercising reasonable care, that the person is not suffering from an emergency medical condition or that the health facility does not have the appropriate facilities or qualified personnel available to render those services.[33] For purposes of the immunity provision, a “rescue team” is a special

Federal Statute/Regulation	Description of Statute/Regulation and Waiver Requirements
	group of physicians and surgeons, nurses, and employees of a health facility who have been trained in cardiopulmonary resuscitation and have been designated by the health facility to attempt, in cases of emergency, to resuscitate persons who are in immediate danger of loss of life.[34] So long as good faith is exercised, no act or omission of any rescue team established by any health facility, or operated by the federal or state government, a county, or by the Regents of the University of California, done or omitted while attempting to resuscitate any person who is in immediate danger of loss of life shall impose any liability upon the health facility, the officers, members of the staff, nurses, or employees of the health facility, including, but not limited to, the members of the rescue team, or upon the federal or state government or a county.
Liability of Healthcare Professionals	
California Emergency Services Act, Government Code Section 8659	Any physician or surgeon (whether licensed in this state or any other state), hospital, pharmacist, nurse or dentist who renders services during a state of war emergency, a state of emergency or local emergency at the express or implied request of any responsible state or local official or agency shall have no liability for any injury sustained by any person by reason of such services, regardless of how or under what circumstances or by what cause such injuries are sustained; provided, however, that the immunity herein granted shall not apply in the event of a willful act or omission.
California Business and Professions Code Section 1627.5	No licensed dentists, who in good faith renders emergency care at the scene of an emergency occurring outside the place of that person's practice, or who, upon the request of another person so licensed, renders emergency care to a person for a complication arising from prior care of another person so licensed, shall be liable for any civil damages as a result of any acts or omissions by that person in rendering the emergency care.
California Business and Professions Code Section 2395	No licensee (physician or surgeon), who in good faith renders emergency care at the scene of an emergency or during a medical disaster, shall be liable for any civil damages as a result of any acts or omissions by such person in rendering the emergency care. "The scene of an emergency," as used in this section, shall include, but not be limited to, the emergency rooms of hospitals in the event of a medical disaster. "Medical disaster" means a duly proclaimed state of emergency or local emergency declared pursuant to the California Emergency Services Act (Government Code Section 8550, Title 2, Division 1, Chapter 7). Acts or omissions exempted from liability pursuant to this section shall include those acts or omissions which occur after the declaration of a medical disaster and those which occurred prior to such declaration but after the commencement of such medical disaster. The immunity granted in this section shall not apply in the event of a willful act or omission.

Federal Statute/Regulation	Description of Statute/Regulation and Waiver Requirements
California Business and Professions Code Section 2727.5	A person licensed under this chapter [nurse] who in good faith renders emergency care at the scene of an emergency which occurs outside both the place and the course of that person's employment shall not be liable for any civil damages as the result of acts or omissions by that person in rendering the emergency care. The immunity from civil damages granted in this section shall not apply when the person is grossly negligent.
California Business and Professions Code Section 2861.5	A person licensed under this chapter [licensed vocational nurse] who in good faith renders emergency care at the scene of an emergency which occurs outside the place and during the course of employment shall not be liable for any civil damages as the result of acts or omissions in rendering the emergency care. This section shall not be construed to grant immunity from civil damage to any person whose conduct in rendering emergency care is grossly negligent.
California Business and Professions Code Section 3503.5	A person licensed under this chapter [physician's assistant] who in good faith renders emergency care at the scene of an emergency that occurs outside the place and during the course of that person's employment shall not be liable for any civil damage as a result of any acts or omissions by that person in rendering the emergency care. This section shall not be construed to grant immunity from civil damages to any person whose conduct in rendering emergency care is grossly negligent. In addition to the immunity specified in Business and Professions Code Section 3503.5 (a), the provisions of Business and Professions Code Section 2395, Chapter 5, Article 17 shall apply to a person licensed under this chapter when acting pursuant to delegated authority from an approved supervising physician.
Government Code Section 178, Article 5	This section addresses the liability of health professionals providing service outside the state by which they are licensed. This section indicates that no party, state or its officers or employees rendering aid in another state pursuant to this compact shall be liable on account of any act or omission in good faith on the part of such forces while so engaged; the Governor's suspension authority runs only to "statutes," not parts of statutes. Additionally, this provision of the Interstate Civil Defense and Disaster Compact applies to the liability of out-of-state disaster workers and is not a regulatory statute or one for the conduct of state business.
Liability of Volunteers Providing Uncompensated Care	
Federal Volunteer Protection Act of 1997, Section 4(a)	A volunteer of a nonprofit organization or government generally will be relieved of liability for harm if the volunteer was acting within the scope of his or her responsibilities and was properly licensed, certified or authorized for the activities (whenever such licensing, certification or authorization is appropriate or required). This statute is very broad and may apply in a variety of circumstances. If a volunteer is summoned by a proper authority, and possesses the required first aid and emergency care training, immunity from liability appears to exist while

Federal Statute/Regulation	Description of Statute/Regulation and Waiver Requirements
	providing any service that could fall within the definition of emergency services. For the purposes of this statute, emergency services include but are not limited to first aid and medical services, rescue procedures and transportation or other related activities necessary to insure the safety of the individual who is the object of a search or rescue operation. The Act preempts state law, but allows a state to apply its own law exclusively in any case that does not involve out-of-state parties. It does not protect volunteer organizations. As it is a federal provision, it cannot be suspended or flexed by the Governor. The Act provides immunity from liability to disaster service worker volunteers, protecting them from any civil litigation resulting from acts of good faith. The disaster service worker volunteer also has protection while providing disaster service (e.g., damage or destruction of property, injury or death of an individual). Immunity from liability does not apply in cases of willful intent, unreasonable acts beyond the scope of Disaster Service Worker training, or a criminal act if committed.
Good Samaritan statutes under Business and Professions Code Sections 2395, 2395.5, 2396 and 2398	No licensee, who in good faith renders emergency care at the scene of an emergency, shall be liable for any civil damages as a result of any acts or omissions by such person in rendering the emergency care. "The scene of an emergency" as used in this section shall include, but not be limited to, the emergency rooms of hospitals in the event of a medical disaster. "Medical disaster" means a duly proclaimed state of emergency or local emergency declared pursuant to California Emergency Services act. Volunteers who come forward to offer services and have not pre-registered or been impressed into service (known as convergent volunteers) and are not listed as Disaster Service Worker volunteers have some liability protection for disaster service under the Good Samaritan statutes.
Disaster Service Worker Volunteer Program Guidance,[35] Emergency Services Act Government Code Section 8657	Disaster service worker volunteers are provided limited immunity from liability while providing disaster service as it is defined in 19 CCR 2570.2 and 2572.2. The Disaster Service Worker Volunteer Program limits the ability of volunteers to be paid for any services provided, distinguishing a Disaster Service Worker from others who are compensated for their services.
California Civil Code Sections 1714.2 and 1714.21	A person is trained in basic cardiopulmonary resuscitation by the American Hospital Association or American Red Cross and in good faith renders cardiopulmonary resuscitation at the scene of an emergency, he or she is not liable for any civil damages unless grossly negligent. This provision is not applicable to those who expect to be compensated. A person is not liable for any civil damages if an automated external defibrillator is used at the scene of an emergency and the requirements for proper maintenance and use of the defibrillator defined in Health and Safety Code Section 1797.196 are complied with.

Federal Statute/Regulation	Description of Statute/Regulation and Waiver Requirements
Civil Code Section 1714.6	The violation of any statute or ordinance shall not establish negligence as a matter of law where the act or omission involved was required in order to comply with an order of the Governor promulgated under the California Emergency Services Act. No person shall be prosecuted for a violation of any statute or ordinance when violation of such statute or ordinance is required in order to comply with an order or proclamation of the Governor promulgated under the Emergency Services Act. The provisions of this section shall apply to such acts or omissions whether occurring prior to or after the effective date of this section. Therefore, to the extent an existing statute or ordinance delineates certain requirements (e.g., statutory scope of service), an order modifying that statute and authorizing altered scope of service could not, during the declared disaster, constitute a violation of law upon which to base a negligence cause of action against the licensed healthcare worker.

7.2. Augmenting Registered Nurse Staffing[36]

It is essential that hospitals plan for nursing shortages and augmentation of nursing staff. In developing a hospital emergency management plan, there are many staffing strategies that can be considered and implemented. Hospitals with bargaining units/unions are encouraged to utilize a collaborative approach when developing staffing plans. Planning for extraordinary emergencies should focus on maintaining the highest and best use of nursing skills needed to respond to the specific emergency, maintaining the maximum number of caregivers available to provide care and minimizing the stresses that will challenge nurse-to-patient ratios. Hospitals should use diligence and reasonable exercise of judgment when developing staffing strategies to optimize patient outcomes during a healthcare surge.

In developing nurse staffing strategies during extraordinary circumstances, hospitals should consider the following issues:

1. Patient and caregiver safety
2. Nursing fatigue
3. Nursing support and nurses' facility support
4. Nursing availability and training
5. The transition back to normal nurse-to-patient ratios as recovery from the emergency occurs.

Note that during a declared emergency and per Government Code Section 8567(a) “the Governor may make, amend, and rescind orders and regulations necessary to carry out the provisions of this chapter. The orders and regulations shall have the force and effect of law.”

The use of this authority is currently the only means of changing the nurse to patient ratios during a disaster or emergency.

In addition, pursuant to Government Code Section 8571, "During a state of war emergency or a state of emergency the Governor may suspend any regulatory statute, or statute prescribing the procedure for conduct of state business, or the orders, rules, or regulations of any state agency, where the Governor determines and declares that strict compliance with any statute, order, rule, or regulation would in any way prevent, hinder, or delay the mitigation of the effects of the emergency."

The Basic Plan for Augmenting Registered Nurse Staffing During Healthcare Surge is shown below. The complete tool can be found in the Hospital Operational Tools Manual on pages 7-8. Hospitals can incorporate this plan into their own hospital emergency management plan.

Purpose: Hospitals should consider the following strategies for staffing registered nurses during a healthcare surge:

- Extending current shifts from eight to 12 hours or from 12 hours to 16 hours.
- Call back off-duty staff and per diem staff.
- Define and prioritize essential tasks to be performed by nursing staff during a surge event. Eliminate non-essential tasks and concentrate staff on performing essential patient care.
- Reassign staff from less acute areas to areas of greater need (e.g., obstetrics/gynecology, outpatient clinic or procedural nurses reassigned to medical/surgical, emergency department or critical care areas).
- Reassign hospital or system nursing administrative staff with administrative roles (i.e., nursing supervisors, Risk Managers, Quality Managers) to patient care roles.
- Augment nursing staff by activating memoranda of understanding with local nurse registry agencies, temporary agencies and personnel from within the hospital system.
- Use hospice nurses to deliver care for expectant patients in the hospital or for lower level care.
- Assess the essential tasks of home health nurses and maintain only essential home health services. Reassign home health nurses to hospital clinical care duties.
- Credential self-presenting/convergent nurses to perform clinical duties in lower acuity areas.
- Use the SEMS/NIMS structure to request additional nursing resources.

7.3. Special Considerations for Pharmacists - The California State Board of Pharmacy Waiver of Pharmacy Practices

In response to the potential of a healthcare surge and to ensure an effective response to a local, State or national disaster, the California State Board of Pharmacy issued a Disaster Response Policy Statement in January 2007 to ensure proper preparation. The purpose of the policy statement and potential waivers as part of the California Business and Professions Code, Section 4062 (b) is to encourage pharmacists to do everything possible to do the most good for the largest amount of people during a healthcare surge.

In the event of a declared disaster or emergency, the board expects to use its authority under the California Business and Professions Code, including Sections 4005(b) and 4062, to encourage and permit emergency provision of care to affected patients and areas, including waiver of requirements that may be implausible to meet during surge events.[37] This policy takes into account what would otherwise be normal operating procedures that may not be able to be performed during a healthcare surge, such as record-keeping requirements, labeling requirements, employee ratio requirements, consultation requirements and other standard pharmacy practices and duties that may interfere with the most efficient response to those affected.

7.3.1. How the California State Board of Pharmacy Waiver is Communicated

In the event the pharmacy waiver is activated, the California State Board of Pharmacy will communicate this information to the Office of Emergency Services to be widely distributed. Information will also be posted on their website at www.pharmacy.ca.gov and communicated via phone at (916) 574-7900.

The Board expects licensed pharmacists to use their judgment and training when providing medication to patients in the best interest of the patients, with circumstances at the time dictating the extent to which regulatory requirements can be met in affected areas. The board also expects that the highest standard of care possible will be provided, and once the emergency has dissipated, its pharmacists will return to practices conforming to State and federal requirements.[38]

7.3.2. California State Board of Pharmacy Disaster Policy Statement

The California State Board of Pharmacy Disaster Policy Statement provided below can be used as a reference to better understand the purpose of the California State Pharmacy Board waiver and how it will be used in the event of a healthcare surge:

> The California State Board of Pharmacy wishes to ensure complete preparation for, and effective response to, any local, State, or national disaster, state of emergency, or other circumstance requiring expedited health system and/or public response. Skills, training, and capacities of board licensees, including wholesalers, pharmacies, pharmacists, intern pharmacists, and pharmacy technicians, will be an invaluable resource to those affected and responding. The board also wishes to encourage an adequate response to any such circumstance affecting residents of California, by welcoming wholesalers, pharmacies, pharmacists, intern pharmacists, and pharmacy technicians licensed in other states to assist with health system and/or public response to residents of California.
>
> The board encourages its licensees to volunteer and become involved in local, State, and national emergency and disaster preparedness efforts. City or county health departments, fire departments, or other first responders can provide information on local opportunities. The Emergency Preparedness Office of the California Department of Public Health is a lead agency overseeing emergency preparedness and response in California, particularly regarding health system response, drug distribution and dispensing, and/or immunization and prophylaxis in the event of an emergency. At the federal level, lead contact agencies include the Department of Health and Human Services, the Centers for Disease Control, and/or the Department of Homeland Security and its Federal Emergency Management Agency (FEMA). Potential volunteers are encouraged to register and get information at www.medicalvolunteer.ca.gov (California) and www.medicalreservecorps.gov (federal).
>
> The board also continues to be actively involved in such planning efforts, at every level. The board further encourages its licensees to assist in any way they can in any emergency circumstance or disaster. Under such conditions, the priority must be protection of public health and provision of essential patient care by the most expeditious and efficient means.
>
> Where declared emergency conditions exist, the board recognizes that it may be difficult or impossible for licensees in affected areas to fully comply with regulatory requirements governing pharmacy practice or the distribution or dispensing of lifesaving medications.

In the event of a declared disaster or emergency, the board expects to utilize its authority under the California Business and Professions Code, including Section 4062, Subdivision (b) thereof, to encourage and permit emergency provision of care to affected patients and areas, including by waiver of requirements that it may be implausible to meet under these circumstances, such as prescription requirements, record-keeping requirements, labeling requirements, employee ratio requirements, consultation requirements, or other standard pharmacy practices and duties that may interfere with the most efficient response to those affected.[1]

The board encourages its licensees to assist, and follow directions from, local, State, and national health officials. The board expects licensees to apply their judgment and training to providing medication to patients in the best interests of the patients, with circumstances on the ground dictating the extent to which regulatory requirements can be met in affected areas. The board further expects that during such emergency, the highest standard of care possible will be provided, and that once the emergency has dissipated, its licensees will return to practices conforming to State and federal requirements.

Furthermore, during a declared disaster or emergency affecting residents of California, the board hopes that persons outside of California will assist the residents of California. To facilitate such Expanded powers in the event of a disaster are also granted to the Governor and/or other chief executives or governing bodies within California by the California Emergency Services Act (Government Code Sections 8550-8668) and the California Disaster Assistance Act [Government Code Sections 8680-8690.7], among others. Government Code Section 8571, for instance, permits the Governor to suspend any regulatory statute during a state of war or emergency where strict compliance therewith would prevent, hinder, or delay mitigation. In the event of a declared California disaster or emergency, the board expects to use its powers under the California Business and Professions Code, including Section 900 and Section 4062 (b), to allow any pharmacists, intern pharmacists, or pharmacy technicians, who are not licensed in California but who are licensed in good standing in another state, including those presently serving military or civilian duty, to provide emergency pharmacy services in California.[2]

The board also expects to allow nonresident pharmacies or wholesalers that are not licensed in California but that are licensed in good standing in another state to ship medications to pharmacies, health professionals or other wholesalers in California.

Finally, the board also expects to allow use of temporary facilities to facilitate drug distribution during a declared disaster or state of emergency. The board expects that

its licensees will similarly respond outside of the state to disasters or emergencies affecting populations outside California, and will pursue whatever steps may be necessary to encourage that sort of licensee response.

[1]Expanded powers in the event of a disaster are also granted to the Governor and/or other chief executives or governing bodies within California by the California Emergency Services Act (California Government Code Sections 8550-8668) and the California Disaster Assistance Act (California Government Code, Section 8680-8690.7), among others. Section 8571 of the California Government Code, for instance, permits the Governor to suspend any regulatory statute during a state of war or emergency where strict compliance therewith would prevent, hinder, or delay mitigation.

[2]See also the Interstate Civil Defense and Disaster Compact (California Government Code, Section 177-178), the Emergency Management Assistance Compact (California Government Code, Sections 179-179.5), and the California Disaster and Civil Defense Master Mutual Aid Agreement (executed 1950), regarding cooperation among the states.

7.3.3. Distribution and / or Dispensing of Pharmaceuticals by Non-licensed Pharmacists During a Healthcare Surge

During a healthcare surge, there is a possibility that there may not be a licensed pharmacist available on-site to dispense pharmaceuticals. Business and Professions Code Section 4051 states that "it is unlawful for any person to manufacture, compound, furnish, sell, or dispense any dangerous device, or to dispense or compound any prescription pursuant to [Business and Professions Code] Section 4040 of a prescriber unless he or she is a pharmacist under this chapter."[39]

A licensed pharmacist may authorize non-licensed pharmacists/healthcare providers to fill a prescription when:

- The licensed pharmacist has access to prescription, patient profile, or other relevant medical information for purposes of patient and clinical consultation and advice.
- Access to the information is secure from unauthorized access and use.

To expand the dispensing of pharmaceuticals during a surge, the California State Board of Pharmacy may opt to waive application of any provisions of this chapter or the regulations adopted if, in the Board of Pharmacy's opinion, the waiver will aid in the protection of public health or the provision of patient care during a declared federal, State or local emergency as noted in California Business and Professions Code Sections 4005(b) and 4062.

7.3.4. Out-of-State Licensed Pharmacists, Intern Pharmacists and/or Pharmacy Technicians

The possibility for limited pharmacy staff in a catastrophic emergency may necessitate using volunteers from out-of-state to assist in providing services that a pharmacist, intern pharmacist

and/or pharmacy technician licensed in California would provide under normal operating procedures. To effectively utilize volunteers it is essential to be prepared and understand potential capacity issues and liability.

The California State Board of Pharmacy encourages persons outside of California to assist California residents during declared states of emergency. In the event of a declared disaster or emergency, the board expects to use its powers under the California Business and Professions Code, including Section 900 and Sections 4005(b) and 4062, to allow pharmacists, intern pharmacists or pharmacy technicians who are not licensed in California but who are licensed in good standing in another state, including those presently serving military or civilian duty, to provide emergency pharmacy services in California.[40]

7.3.5. Furnishing Medications without a Prescription

During a healthcare surge, there may be limited time to obtain a prescription for needed medication from a physician. Therefore, Business and Professions Code Section 4062(a) states that a pharmacist may, in good faith, furnish a dangerous drug or dangerous device in reasonable quantities without a prescription during a federal, State or local emergency to further the health and safety of the public.[41] This section states that a record containing the date, name and address of the person to whom the drug or device is furnished and the name, strength and quantity of the drug or device furnished shall be maintained. The pharmacist shall communicate this information to the patient's attending physician as soon as possible.

7.4. Credential Verification

7.4.1. Credential Verification During a Healthcare Surge

State and federal laws address credentialing and privileging responsibilities to ensure that healthcare professionals have the requisite education, training and experience to provide care. State and federal credential requirements can be found in Business and Professions Code Sections 2282, 2283; 22 CCR 70703; and 42 CFR 482.12 and 482.22. By law, these responsibilities are held by both the medical staff and the facility's governing body. Through prescribed processes and procedures, including primary source verification, healthcare professionals undergo an assessment and competency evaluation to credential and privilege. These same requirements are also addressed under Joint Commission accreditation standards.

The Joint Commission *Comprehensive Accreditation Manual for Hospitals* (2007) defines "credentialing" as the process of obtaining, verifying and assessing the qualifications of a healthcare professional in order to provide patient care services in or for a healthcare organization. "Privileging" is defined as the process whereby a specific scope and content of patient care services (that is, clinical privileges) are authorized for a healthcare professional by

a healthcare organization, based on evaluation of the individual's credentials and performance.[42]

Under normal operations, Joint Commission-accredited organizations are obligated to complete the credentialing procedure for each licensed independent health professional including, but not limited to, physicians and physician assistants. These standards are applicable to general, acute psychiatric, pediatric, critical access, surgical specialty, long-term acute care and rehabilitation hospitals as well as any component of these organizations.

The Joint Commission does not suspend accreditation requirements during a disaster. Hospitals continue to be required to verify competency and maintain oversight of the professionals and care delivered. If primary source verification cannot be obtained within 72 hours from the health professional presenting, the provider must keep records of the reasons for not completing the required verification check.

Although no existing authority has the power to waive Joint Commission requirements during a healthcare surge, it may be necessary to allow hospitals to use personnel that are not currently credentialed staff members. These staff may be pre-registered volunteers, Disaster Service Workers or out-of-state professionals and may be activated under the auspices of the SEMS/NIMS. Additional clinical staff may be walk-in volunteers.

In some instances, existing law automatically facilitates the use of these augmented staff. Government Code Section 178, Article 4 (Interstate Civil Defense and Disaster Compact), recognizes the licensure, credentialing or permit held by a healthcare professional in any state as evidence of qualifications to provide disaster assistance within the scope of service of the provider or health professional.

Government Code Section 179.5, Article 5 (Emergency Management Assistance Compact), provides deemed recognition to healthcare professionals holding a current license, certificate or other permit issued by another state that is part of the Mutual Aid Compact. By virtue of this deemed status as a licensed health professional, out-of-State professionals may assist during a disaster without the administrative delay required to verify qualifications of the healthcare professional.

Existing law may provide for use of certain staff, provided that specific conditions are met or in the event that the Governor would waive or suspend certain requirements.

Business and Professions Code Section 921, as part of the Health Care Professional Disaster Response Act, permits the use of providers with lapsed or inactive licenses in disaster areas where shortage exists. However, the administrative requirements associated with this permission may be prohibitive if time is of the essence.

7.4.2. Streamlined Credentialing and Privileging during a Healthcare Surge

Perhaps the greatest benefit of the credentialing process is its emphasis on verifying a healthcare professional's experience, abilities and competencies – an act that should not be omitted even during (or especially during) a healthcare surge. As such, the recommendations in this section for streamlining the credential verification process are not centered on the flexing or suspension of this process but are meant to provide a mechanism(s) by which the pool of potential personnel may be increased through a more rapid process. This may be accomplished in two ways:

- Implementing a streamlined credentialing/privileging process
- Collecting the minimum amount of information necessary

Emergency/disaster credentialing processes referred to in this section are based on Joint Commission standards and current best practices from various hospitals. Tools to implement these recommendations have been developed and are featured in this section and in the Hospital Operational Tools Manual.

Standard MS.4.110 in Joint *Commission Comprehensive Accreditation Manual for Hospitals* (2007) states that a hospital may grant disaster privileges to volunteers eligible to be licensed independent health professionals, which include, but are not limited to, physicians and physician assistants. This standard allows a hospital to implement a modified credentialing and privileging process for eligible volunteer health professionals (in this case, licensed independent health professionals) when a disaster plan has been implemented and the immediate needs of the patients cannot be met. The timing of the usual credentialing and privileging of health professionals would not allow a volunteer health professional to provide immediate care, treatment and services in the event of a disaster due to the length of time it would take to complete the process.

While Standard MS.4.110 provides a method to streamline the credentialing and privileging process, safeguards must be put in place to assure that volunteer health professionals are competent to provide safe and adequate care, treatment and services. Even in a disaster, the integrity of two parts of the usual credentialing and privileging process must be maintained. These are:

- Verification of licensure (if applicable)
- Oversight of the care, treatment and services provided

The Joint Commission does not outline any formal procedure for carrying out this process, nor does it make any commitment to suspend accreditation requirements during a disaster. Hospitals retain the obligation to verify competency and maintain oversight of health professionals and care delivered. If primary source verification cannot be obtained within 72 hours from the health professional presenting to the hospital for service, the hospital must

keep records of the reason for not completing the required verification check.

To implement this standard, healthcare organizations are held to the following criteria or performance expectations when streamlining the credentialing and privileging process:

- Disaster privileges are granted only when the following two conditions are present: (1) Emergency management plan has been activated and (2) the healthcare organization is unable to meet immediate patient needs.
- An individual(s) responsible for granting disaster privileges is identified.
- The medical staff describes, in writing, a mechanism (for example, direct observation, mentoring and clinical record review) to oversee the professional performance of volunteer health professionals who receive disaster privileges.
- The healthcare organization has a mechanism to readily identify volunteer health professionals who have been granted disaster privileges.
- For volunteers to be considered eligible to act as licensed independent health professionals, the healthcare organization must obtain for each volunteer practitioner at a minimum, a valid photo identification issued by a state or federal agency (e.g., driver's license or passport) and at least one of the following:
  - A current picture hospital identification card that clearly identifies professional designation
  - A current license to practice
  - Primary source verification of the license (if applicable)
  - Identification indicating that the individual is registered with the California Medical Volunteers or a member of a California Medical Assistance team, Disaster Medical Assistance Team, Medical Reserve Corps or other recognized state or federal organization or group
  - Identification indicating that the individual has been granted authority to render patient care, treatment and services in disaster circumstances (such authority having been granted by a federal, state or municipal entity)
  - Identification by a current hospital or medical staff member(s) who possess personal knowledge regarding a volunteer's ability to act as a licensed independent practitioner during a disaster.
- Primary source verification of licensure (if applicable) begins as soon as the immediate situation is under control and is to be completed within 72 hours after the volunteer practitioner presents to the healthcare organization. If primary source verification cannot be completed in 72 hours (e.g., no means of communication or a lack of resources), it is expected that it be done as soon as possible. In this extraordinary circumstance, there must be documentation of the following: why primary source verification could not be performed in the required time frame; evidence of a demonstrated ability to continue to provide adequate care, treatment and services; and an attempt to rectify the situation as soon as possible.

- The healthcare organization's medical staff oversees the professional practice of volunteer independent health professionals (licensed and unlicensed).
- The organization makes a decision (based on information obtained regarding the professional practice of the volunteer) within 72 hours related to the continuation of the disaster privileges initially granted.

Hospitals should review their current policies and procedures, bylaws, rules and regulations for credentialing staff and granting temporary disaster privileges to determine their compliance with accreditation standards. Additionally, current policies and procedures should be updated to reflect that under a declared state of emergency the Governor has the authority to waive certain requirements that would allow hospitals to call upon otherwise unavailable health professionals (e.g., physicians with inactive or retired licenses).

7.4.3. Volunteer Application for Clinical Staff

Hospitals may use the following application for volunteer clinical staff (licensed and non-licensed) during an emergency.

The Volunteer Application for Clinical Staff is shown below. The complete tool can be found in the Hospital Operational Tools Manual on pages 61-65.

Instructions for Use:

1. For clinical staff who present at a hospital, the medical staff office representative will provide him/her with the following application form.
2. All clinical staff must present to the medical staff office representative with proper identification including a valid photo identification issued by a state or federal agency (e.g., driver's license or passport) and at least one of the following:
    a. A current picture hospital identification card
    b. A current license to practice (if applicable) and a valid picture identification issued by a State, federal or regulatory agency
    c. Identification indicating that the individual is a member of the California Medical Assistance Team or a Disaster Medical Assistance Team
    d. Documentation indicating that the individual has been granted authority to render patient care in disaster circumstances by a federal, state or municipal entity.
    e. Presentation by current hospital or medical staff member(s) with personal knowledge regarding the practitioner's identity.
3. The completed application form is then given to the medical staff director or other designated individual for review and determination of the practitioner's duties and area of assignment.
4. Concurrently, the medical staff office representative will initiate the primary source verification process. This process must be completed within 72 hours from the time the practitioner presented to the organization.

VOLUNTEER APPLICATION FOR CLINICAL STAFF	
APPLICATION DATE: / /	DATE YOU CAN START: / /
PERSONAL INFORMATION	
Last Name:	First Name: Middle Initial:
Is there any additional information about a change of your name, use of an assumed name, or use of a nickname that will assist us in checking your work and educational records? □ No □ Yes - If *Yes*, explain:	
Current Address: Street: City: State: Zip:	Previous Address: Street: City: State: Zip:
Phone number: ( )	Pager/ Cell Phone: ( )
Are you 18 years or older? □ No □ Yes	Social Security number:
Birth Date (mm/dd/yyyy):	Birth Place (City, State):

NEXT OF KIN & EMERGENCY CONTACT		
Give name, telephone number and relationship of two individuals who we may contact in the event of an emergency.		
Name	Telephone Number	Relationship
1.	( )	
2.	( )	

DEPENDENTS List any dependents for which you are responsible.		
Name	Place of Residence/ Telephone Number	Relationship
1.		
2.		
3.		

LICENSURE/ CERTIFICATION/ REGISTRATION INFORMATION (If Applicable)

Do you now have or have you previously had a healthcare related license, certification, and/or registration?
☐ No ☐ Yes
If *Yes*, license, certification and/or registration type(s):
Issuing State(s):
Is your license/certification/registration currently in good standing? ☐ No ☐ Yes
If *No*, explain why not:
Has your license/certification/registration ever been revoked or suspended? ☐ No ☐ Yes
If *Yes*, explain reason(s), date of revocation(s) or suspension(s), and date of reinstatement(s):

Current Place of Practice: Street:	Location Internship/Residency: Street:	Drug Enforcement Administration (DEA) number:
	City: State:	National Provider Identification number (NPI):
City: State:	Zip:	Medical License Number:
Zip:	Year/Month of Graduation:	

AVAILABILITY & AFFILIATION

Indicate your availability:

☐ Sunday ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday

Times of day you may be available: _____

Are you registered with a volunteer organization? If Yes, select below:

☐ California Medical Volunteers
☐ California Medical Assistance Team
☐ Other. Specify _____
☐ Medical Reserve Corps
☐ Disaster Medical Assistance Team

EDUCATION & VOCATIONAL TRAINING

	High School	College/University	Graduate/Professional	Vocational/Business
School Name, City & State				
No. Years/Last Grade Completed				
Diploma/Degree				

Do you have any experience, training, qualifications or skills which you would assist labor pool coordinators in assigning an appropriate position? □ No □ Yes
-If *Yes*, specify.
Age Specific Practice Criteria:
Check the boxes below for each age group for which you have expertise in providing age-appropriate nursing care.

□ Newborn/Neonate (birth - 30 days) □ Infant (30 days - 1 year) □ Toddler (1 - 3 years)
□ Preschooler (3 - 5 years) □ School age children (5 - 12 years) □ Adolescents (12 - 18 years)
□ Young adults (18 - 39 years) □ Middle adults (39 - 64 years) □ Older adults (64+)

My experience is primarily in: (Indicate number of years.)

□ Critical Care year(s):____
□ Emergency Medicine year(s):____
□ Home Care year(s):____
□ Labor & Delivery year(s):____
□ Med Surg year(s):____
□ NICU year(s):____
□ Pediatrics year(s):____
□ Outpatient year(s):____
□ Surgery year(s):____
□ Trauma year(s):____

□ Other (specify):_____ year(s):____

Do you speak, write, and/or read any languages other than English? □ No □ Yes

If *Yes*, identify which other language(s) and rate your proficiency in these languages:

Language	Fluent	Speak	Read	Write
_____	□	□	□	□
_____	□	□	□	□
_____	□	□	□	□
_____	□	□	□	□

VERIFICATION OF TRUTHFULNESS AND UNDERSTANDING REGARDING VOLUNTEER AGREEMENT

_____ Initials

I agree that the information I provide and the representations I make will be truthful, complete, accurate, and free of any attempt to mislead. _

_____ Initials	I acknowledge that by completing this form that I am of sound physical and mental capacity, and capable of performing in an emergency/disaster setting. I acknowledge that emergency/disaster settings can pose significant psychological and physical hardships and risks to those volunteering their services and the emergency/disaster settings often lack the normal amenities of daily life and accommodations for persons with disabilities. In agreeing to volunteer my services, I agree to accept such conditions and risks voluntarily.
_____ Initials	I understand that I am required to abide by all rules and practices of this facility and affiliated entities as well as all applicable State and federal laws and regulations.
_____ Initials	I agree to service as a volunteer, without compensation or payment for my services. I agree to hold the State of California and any of its entities or subdivisions harmless from any claims of civil liability, including but not limited to claims of malpractice or negligence, criminal liability, injury or death.
	Signature of Volunteer: **Date:** / /

TO BE COMPLETED BY HUMAN RESOURCE (PERSONNEL VERIFICATION)/ MEDICAL STAFF (CREDENTIALING) ONLY

_____ Proper identification was verified and copied.

- ☐ Government issued photo identification (All Applicants)
- ☐ A current picture hospital identification card
- ☐ A current license to practice (if applicable)
  If applicant unable to present license, 2 witnesses from applicants current place of practice may attest to applicant's qualifications to practice.
- ☐ Identification indicating that the individual is a member of the California Medical Assistance Team or a Disaster Medical Assistance Team
- ☐ Documentation indicating that the individual has been granted authority to render patient care in disaster circumstances by a federal, state or municipal entity.

Presentation by current hospital or medical staff member(s) with personal knowledge regarding the practitioner's identity.

Witness 1 Signature _____ Date _____
Witness 2 Signature _____ Date _____

To be completed by Administrator or his/her authorized designee.

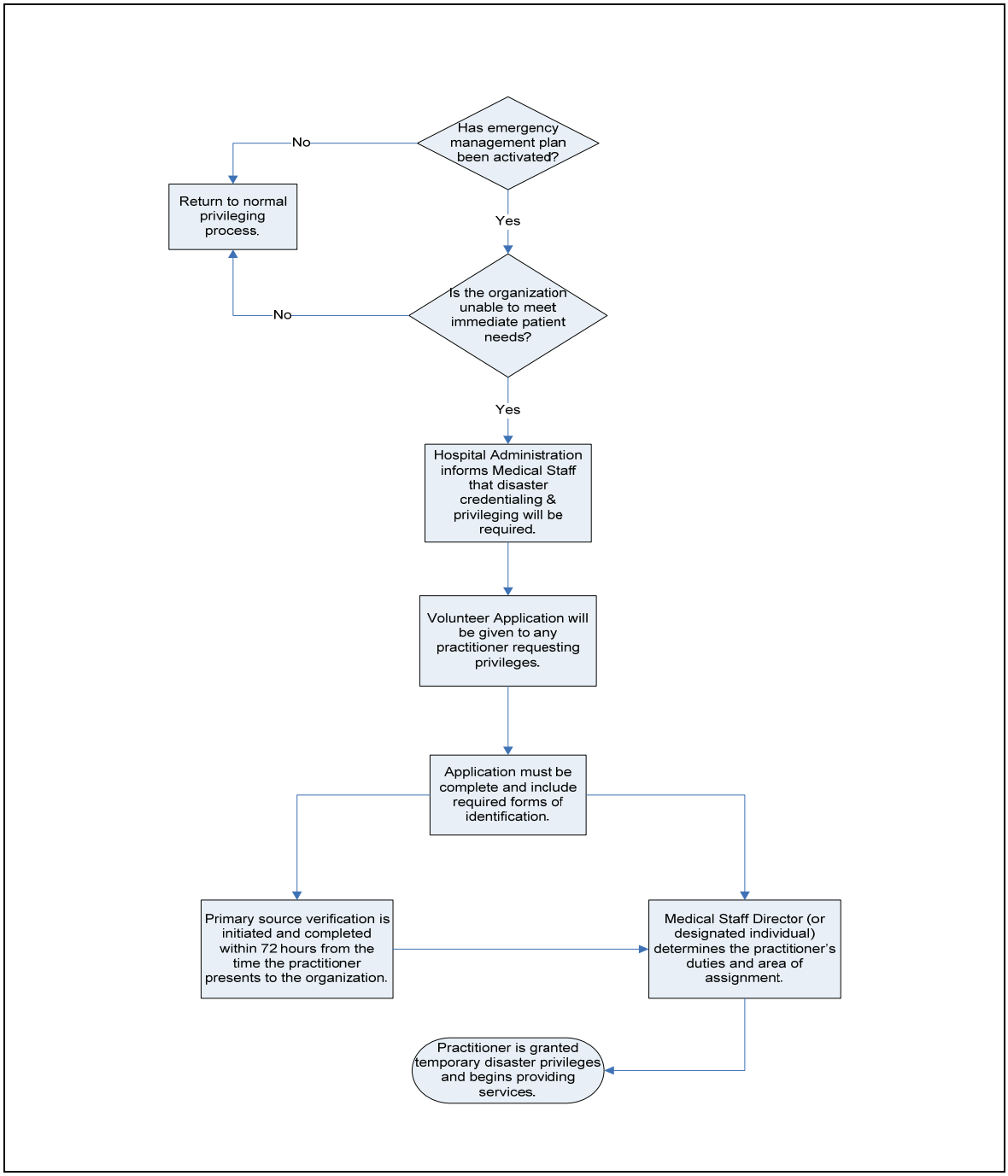
I authorize this individual to volunteer.

Signature of Administrator: **Date:** / /

7.4.4. Temporary Disaster Privileging Process Flow Diagram

The following process flow diagram depicts the process by which hospitals conduct the emergency credentialing process. It also provides clinicians with guidance on the process in which they may participate should they have the opportunity to provide services at a healthcare facility at which they are not currently credentialed.

The Temporary Disaster Privileging Process Flow Diagram is shown below. The chart can also be found in the Hospital Operational Tools Manual on pages 54-55.



7.4.5. Credentialing Log for Licensed Healthcare Professionals

The Credentialing Log for Licensed Healthcare Professionals is shown below. The complete tool can be found in the Hospital Operational Tools Manual on pages 12-13.

The following table provides hospitals with a template to verify that health professionals who have been granted temporary disaster privileges have provided the appropriate and required documentation.

Instructions for Use

For each licensed independent health professional (Medical Doctor, Doctor of Osteopathy, Advanced Practice Nurse or Physician Assistant) who presents at a hospital to apply for emergency credentials, the medical staff office representative will take the following information:

- Professional's full name
- Presence (by checking off the applicable box) of the identification requirements; a government-issued photo identification (e.g., a driver's license) is required in order to qualify for emergency credentials.
- Compare the government-issued photo identification to verify the other forms of identification indicating what authority the individual has to render patient care.
  - If the health professional submits other forms of identification, such as documentation indicating that the individual has been granted authority to render patient care in disaster circumstances (e.g., proof of volunteer participation in the California Medical Volunteers) or presentation by current hospital or medical staff member(s) with personal knowledge regarding the professional identity, these should be specified in the box labeled “Other.”

Once the practitioner’s identity and ability to practice has been verified, and the medical staff director determines the duties and area of assignment for each health professional, this information should be documented in the column labeled “Declared Competencies.”

Individual Name	Credentialing Requirements during Surge Proposed Minimum Identification Requirements During Surge (Select all applicable) Govt-Issued Photo ID (Required)	Hospital ID	Current Medical License	Volunteer (e.g., CalMAT, DMAT) ID	Other - Specify	Declared Competencies

8. Augmenting Non-Clinical Staff

In addition to clinical staff, the operation of a hospital requires non-clinical staff to carry out functions such as administration, food service, child care, laundry, traffic control, security, engineering, pastoral care, housekeeping, transport services and maintenance. In developing its emergency operations plan, hospitals should identify which functions can be performed by community-based organizations, volunteer staff, and/or private contractors.

The hospital may have memoranda of understanding with local staffing agencies to provide this support, which should include a verification process of the employee's background. In the event that a volunteer not registered with a staffing agency presents at the hospital to provide non-clinical support, the following application can be used.

8.1. Verification of Non-Clinical Staff

The Volunteer Application Form for Non-Clinical Staff should be used in registering all support staff volunteers. This form will serve as a tool to verify identification of volunteers, capture needed emergency information and identify skills of volunteer staff.

The Volunteer Application for Non-Clinical Staff is shown below. The complete tool can be found in the Hospital Operational Tools Manual on pages 56-60.

Instructions for Use

1. For all non-clinical volunteers who present at a facility to provide service, the Human Resources department representative should provide him/her with the following application form.
2. Each professional or volunteer must present to the Human Resources department representative with proper identification including a valid photo identification issued by a state or federal agency (i.e., driver's license or passport and at least one of the following below to grant temporary work during the emergency:
   a. A current picture hospital identification card that clearly identifies professional designation
   b. A current license and/or certification to work
   c. Identification indicating that the individual is a member of the California Medical Assistance Team, Disaster Medical Assessment Team, Medical Reserve Corps or other recognized state or federal organization or group.
   d. Documentation indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (if applicable)
   e. Identification by current hospital employee(s) who possess personal knowledge regarding the non-employee/volunteer's ability to act as a licensed independent

healthcare professional during a disaster (if applicable)

3. Completed application form is then given to the Human Resources director or other designated individual for review and determination of the professional's duties and area of assignment.

VOLUNTEER APPLICATION FOR NON-CLINICAL STAFF	
APPLICATION DATE: / /	DATE YOU CAN START: / /
Last Name:	First Name: Middle Initial:
Is there any additional information about a change of your name, use of an assumed name, or use of a nickname that will assist us in checking your work and educational records? □ No □ Yes - If Yes, explain:	
Current Address: Street: City: State: Zip:	Previous Address: Street: City: State: Zip:
Phone number: ( )	Pager/ Cell Phone: ( )
Are you 18 years or older? □ No □ Yes	Social Security number:
Birth Date (mm/dd/yyyy):	Birth Place (City, State):

NEXT OF KIN & EMERGENCY CONTACT Give name, telephone number and relationship of two individuals who we may contact in the event of an emergency.		
Name	Telephone Number	Relationship
1.	( )	
2.	( )	

DEPENDENTS List any dependents for which you are responsible.		
Name	Place of Residence/ Telephone Number	Relationship
1.		
2.		
3.		

Indicate your availability:

□ Sunday □ Monday □ Tuesday □ Wednesday □ Thursday □ Friday □ Saturday

Are you registered with a volunteer organization? If Yes, select below:

☐ California Medical Volunteers ☐ Medical Reserve Corps (MRC) ☐ California Medical Assistance Team (CalMAT) ☐ Disaster Medical Assistance Team (DMAT)
☐ Other Specify _____

Check the areas in which you are experienced and can provide services.
☐ Ability to supervise children ☐ Administrative/clerical duties
☐ Computer skills ☐ Facilities management (e.g., electrician, plumbing, maintenance)
☐ First aid (e.g., wound care) ☐ Other–specify _____

EDUCATION & VOCATIONAL TRAINING

	High School	College/ University	Graduate/ Professional	Vocational/ Business
School Name, City & State				
No. Years/ Last Grade Completed				
Diploma/Degree				

Do you speak, write, and/or read any languages other than English? ☐ No ☐ Yes
If Yes, identify which other languages and rate your proficiency in these languages:

Language	Fluent	Speak	Read	Write
_____	☐	☐	☐	☐
_____	☐	☐	☐	☐
_____	☐	☐	☐	☐
_____	☐	☐	☐	☐

VERIFICATION OF TRUTHFULNESS AND UNDERSTANDING REGARDING VOLUNTEER AGREEMENT

Initial	
	I agree that the information I provide and the representations I make will be truthful, complete, accurate, and free of any attempt to mislead.
	I acknowledge that by completing this form that I am of sound physical and mental capacity, and capable of performing in an emergency/disaster setting. I acknowledge that emergency/disaster settings can pose significant psychological and physical hardships and risks to those volunteering their

	services and the emergency/disaster settings often lack the normal amenities of daily life and accommodations for persons with disabilities. In agreeing to volunteer my services, I agree to accept such conditions and risks voluntarily.
	I understand that I am required to abide by all rules and practices of this facility and affiliated entities as well as all applicable State and federal laws and regulations.
	I agree to service as a volunteer, without compensation or payment for my services. I agree to hold the State of California and any of its entities or subdivisions harmless from any claims of civil liability, including but not limited to claims of malpractice or negligence, criminal liability, injury or death.

Signature of Volunteer Applicant: **Date:** / /

TO BE COMPLETED BY ASSIGNED DESIGNEE - PERSONNEL VERIFICATION

Proper identification was verified and copied.

- ☐ Government issued photo identification (All Applicants)
- ☐ Contractor License # (Human Resources - Unlicensed Personnel only)
- ☐ Union or Trade Association identification (Human Resources - Unlicensed Personnel only)
- ☐ Professional Certification (Human Resources - Unlicensed Personnel only)

To be completed by administrator or his/her authorized designee.

I authorize this individual to volunteer.

Signature of administrator: **Date:** / /

8.2. Non-Clinical Staff Support Matrix

The following sample staff utilization matrix is adapted from the Wisconsin State Expert Panel[1] in its guidance on healthcare surge capacity. It provides hospitals with a template and guidelines for inpatient non-clinical staffing needs for a facility operating in healthcare surge.

The Non-Clinical Support Matrix is shown on the following page. The complete tool can be found in the Hospital Operational Tools Manual on pages 21-23.

[1] State of Wisconsin. Guidelines for Managing Inpatient and Outpatient Surge Capacity, Recommendations of the State Expert Panel on Inpatient and Outpatient Surge Capacity. November 2005.

Instructions for Use

Non-clinical service departments are to consider not only the staffing necessary to care for patients, but also the staffing necessary to care for staff, patients' family members and visitors who may come to the healthcare facility with the surge of patients. The following non-clinical departments are to complete their staffing plans utilizing strategies listed above:

- Housekeeping
- Food Services
- Security
- Radiology
- Laboratory
- Admissions
- Billing
- Medical Records
- Pastoral Care
- Transport Services
- Day Surgery
- Chemotherapy
- Dialysis

Each department is to complete its own staff utilization matrix. It is recommended that departments collaborate to determine how to best allocate and assign staff among departments.

Non-Clinical Support Matrix – Housekeeping

Level	Number of Patients Expected	Critical Rooms	Complex/Critical Rooms	Basic and Supportive Rooms
I	1-10			
II	11-25			
III	26-50			
IV	51-100			
V	>100			

9. Maintaining the Workforce

9.1. Workforce Health and Safety and Workers Rights

A key component of healthcare surge response planning is the considerations that hospitals must make to ensure the health and safety of their workforce. This includes compliance with occupational safety and health requirements set forth in federal and State statutes and regulations, including the California Labor Code, California Occupational Safety and Health Administration and federal Occupational Safety and Health Administration regulations. Together, these authorities dictate the overarching primary obligation of employers, including hospitals, to provide for the health and safety of their employees.

One of the methods by which a hospital can protect the health and safety of their workforce is in the provision of personal protective equipment. Under Labor Code Section 6401, "every employer shall furnish and use safety devices and safeguards, and shall adopt and use practices, means, methods, operations, and processes which are reasonably adequate to render such employment and place of employment safe and healthful." Additional specific guidance for the provision of personal protective equipment is outlined in 8 CCR 3380.

Another workforce health and safety issue that may arise during a healthcare surge, such as a pandemic influenza, is the requirement that vaccinations be provided to all employees and volunteers. Health and Safety Code Section 1288.5 et seq. establishes the Hospital Infectious Disease Control Program which requires that CDPH, healthcare facilities and general acute care healthcare facilities implement various measures relating to disease surveillance and the prevention of healthcare-associated infection. The requirements under this statute, some of which are not yet effective, are subject to waiver by the Governor under his/her authority in a state of emergency. For example, this law requires healthcare facilities to provide influenza vaccinations to all employees. Facilities will be responsible for providing vaccinations to staff unless such requirements are waived by appropriate authority during a state of disaster.

The U.S. Department of Labor's Worker Safety and Health Support Annex provides guidelines for implementing worker safety and health support functions during potential or actual incidents of national significance. This annex describes the actions needed to ensure that threats to responder safety and health are anticipated, recognized, evaluated and controlled consistently so that responders are properly protected during incident management operations. The annex can be accessed at: http://www.osha.gov/SLTC/emergencypreparedness/nrp_work_sh_annex.html

Employers not only have an obligation to safeguard the health and safety of their workforce, they also have responsibility to honor employees' rights. A healthcare surge would affect the way in which employers (in this case facilities or public health) would be able to address workers' rights, for example requiring staff and administrators to remain at a facility or report to work during a disaster. The California Industrial Welfare Commission Order Number 4-2001, 3(B) (9)-(10) outlines the number of hours that healthcare personnel may work during a

healthcare emergency. Healthcare emergency is defined in this order as “an unpredictable or unavoidable occurrence at unscheduled intervals relating to healthcare delivery, requiring immediate action.” Order Number 4-2001, 3(B) (9)-(10) specifically states:

- No employee assigned to work a 12-hour shift established pursuant to this order shall be required to work more than 12 hours in any 24-hour period unless the chief nursing officer or authorized executive declares that:
  - A "healthcare emergency" exists; and
  - All reasonable steps have been taken to provide required staffing; and
  - Considering overall operational status needs, continued overtime is necessary to provide required staffing.
- No employee shall be required to work more than 16 hours in a 24-hour period unless by voluntary mutual agreement of the employee and the employer, and no employee shall work more than 24 consecutive hours until said employee receives not less than eight consecutive hours off duty immediately following the 24 consecutive hours of work.

This order is subject to modification or waiver under the Governor’s executive powers during a state of emergency.

In some cases, employers may need employees on disability leave to return to work during a disaster, or employees may wish to return to work early to help. 8 CCR 9776.1 addresses the general requirement that a return-to-work release with limitations and/or accommodations be completed before returning an employee to work. This release can be obtained from the workers' compensation approved physician. In order to respond to a healthcare surge, this standard may be waived by authority of the Governor under the Emergency Services Act. Doing so would allow facilities to potentially return certain staff members willing and able to work in an expedited manner, thereby increasing the workforce pool.

9.2. Occupational Safety and Health Planning

Hospitals are required to have a health and safety plan that includes, but is not limited to, the following:

- Infection control
- Life safety
- Emergency action plan
- Control of hazardous substances
- Personal protective equipment
- Fatigue

- Heat stress
- Provision of sanitary hospitals

For details of the requirements for health and safety plans, see 29 CFR 1910.120; Joint Commission Standards on Safe Environment, Worker Safety, Waste Management; California Occupational Safety and Health Administration 8 CCR 3203.

Health and safety is an integral part of any disaster and preparedness planning. During a declared emergency, it is likely that California OSHA will work with the Safety Officer in the State, Regional or Operational Area Emergency Operations Centers to assist with achieving compliance with occupational safety standards and regulations. Working through the Emergency Operations Center assures all affected facilities receive support in this area. The following are additional occupational safety and health planning resources for preparing for or responding to a healthcare surge.

- Hospitals should develop an employee health and safety checklist, which should be incorporated in their emergency operations plans. California Occupational Safety and Health Administration's "*Guide to Developing Your Workplace Injury and Illness Prevention Program with Checklists for Self-Inspection*" manual describes the employers' responsibilities in establishing, implementing and maintaining an Injury and Illness Prevention Program. It also outlines steps that can be taken to develop an effective program that helps assure the safety and health of employees while on the job. The manual can be found at http://www.dir.ca.gov/dosh/dosh_publications/iipp.html.

- U.S. Department of Labor - Occupational Safety and Health Administration's *Worker Safety and Health Support Annex* provides guidelines for implementing worker safety and health support functions during potential or actual incidents of national significance. This annex describes the actions needed to ensure that threats to responder safety and health are anticipated, recognized, evaluated and controlled consistently so that responders are properly protected during incident management operations. These can be adapted for use in the hospital emergency operations plans. The annex can be accessed at: http://www.osha.gov/SLTC/emergencypreparedness/nrp_work_sh_annex.html

9.3. Support Provisions for Staff

In the Joint Commission emergency management standards revisions that are effective January 1, 2008, Environment of Care 4.14 states that accredited healthcare facilities must establish strategies for managing resources and assets during emergencies. The Elements of Performance for Environment of Care 4.14 requires that the organization plan for:

- Managing staff support activities (e.g., housing, transportation, incident stress debriefing)
- Managing staff family support needs (e.g., child care, elder care, communication)

In order to meet their overarching obligation to support and safeguard the health and safety of their workforce, it is recommended that hospitals develop a workforce resiliency policy including incident stress management and dependent care.

The Considerations for Staff Support Provisions is shown below. The complete listing of considerations can be found in the Hospital Operational Tools Manual on pages 9-11.

Purpose: The following information provides an outline for healthcare surge planners when developing policies and provisions to support staff during a healthcare surge.

Staff Support Considerations

Hospitals should consider the following issues in developing staffing plans and strategies:

1. Some staff will not be able to report to work due to the fact that they, or their family/friends, may have been directly involved in the incident.
2. Normal childcare providers may not be able to provide services during an incident so dependent care options should be made (e.g., childcare/eldercare) to enable staff members to report to work.
3. Some staff may have concerns about the shelter and care of their pets. Considerations should be made to plan for pet care during a healthcare surge. Designated kennel or housing provisions should be part of the disaster preparedness plan.
4. Hospitals should consider the provision of rooms for staff for rest and sleep and for personal hygiene needs (blankets, pillows, sheets, showers, towels, soap, shampoo, etc.). In the case of a biological incident, there may be the need for work quarantine in addition to staff working longer shifts or not being able to go home. The hospital may also want to consider what is available in local hotels, churches and other such organizations for sleeping accommodations and showers.
5. Hospitals should have areas for staff to eat and have refreshments.
6. Staff may be away from home for extended shifts and need to communicate with family members and other loved ones. Hospitals should consider the availability of telephones to call home and computer access for email.
7. For staff working extended shifts or not able to go home, there may be the need for laundry services or the provision of scrubs. Staff members are also to consider having an “emergency kit” with personal items such as underwear, socks, toiletries, a supply of medications, etc., readily available.
8. Hospitals should encourage staff to have a family emergency plan so that everyone in the family knows what will happen and who is responsible for various duties if a family member who works at the hospital needs to work longer shifts or is quarantined at the hospital.
9. Hospital should consider back-up provisions for essential services such as food services, laundry, housekeeping and other service, especially if these services are out-sourced, the

incident affects the ability of the contractor to continue to provide these services and/or if the healthcare surge of patients and visitors overwhelms the capacity of these contractors.

Based on these recommendations, the following support provisions should be considered by healthcare surge planners:

- Behavioral/mental healthcare for staff
- Behavioral/mental healthcare for dependents
- Dependent care (children and adults)
- Meal provisions for 3-7 days
- Water for 3-7 days
- Pet care
- Designated rooms for resting/sleeping
- Designated restrooms
- Personal hygiene provisions (blankets, pillows, sheets, showers, towels, soap, shampoo, etc.)
- Designated eating areas
- Email/telephone access to communicate with family
- Clothing or laundry services for staff and dependents
- Emergency kits (personal items such as underwear, socks, toiletries, a supply of medications, and the like) for staff to store at the place of work
- Family emergency plan

In regard to the provision of child care and dependent care (adults requiring supervision or support), it is recommended that hospitals identify staff members who can provide child care and dependent care as needed during a healthcare surge. Using existing staff increases the likelihood that these individuals have undergone background checks as part of the employment process. In addition, it may be beneficial to establish contracts with outside agencies or vendors who will be responsible for providing qualified and licensed professionals for child and dependent care. In the event such contracts are not feasible or agencies are not accessible, additional community resources should be identified as part of healthcare surge planning. Community resources may include schools, faith-based organizations or other service organizations.

Hospitals are encouraged to utilize the following tools to assist in addressing workforce resilience during a disaster and developing a policy for provision of dependent care.

The Policy for Workforce Resilience during Disaster is shown on the following page.
The complete tool can be found in the Hospital Operational Tools Manual on pages 27-30.

Purpose:

This policy offers guidelines for dealing with needs and training to optimize workforce resilience in the event of a disaster. It provides minimum standards for existing facilities to incorporate into current workforce resiliency policies. This policy addresses facility personnel during a time of healthcare surge, which could consist of paid employees or volunteers.

Rationale:

The response to a disaster will pose substantial physical, personal, social and emotional challenges to healthcare providers. During an influenza pandemic, the occupational stresses experienced by healthcare providers are likely to differ from those faced by workers in the aftermath of other disasters. Globally and nationally, a pandemic might last for more than a year, while disease outbreaks in local communities may last 5 to 10 weeks. Workers and their families will be at personal risk for as long as a disaster continues in their community. Special planning is therefore needed to ensure that hospitals are prepared to help employees maximize personal resilience and professional performance.

Worker Needs

Physical:

- Rest areas for each department are located __(list departments and areas)___.
- Provisions for showers are _____.
- Food will be served or provided __(where and how often)___.
- Healthcare in case for illness or injury will be provided ___(where and when)___.
- Transportation to and from work will be provided ___(situation and contact)___.

For pandemic: (describe what will happen if the employee is too sick to be at work)

Personal:

- Telephones for personal calls are located __(include rules)___.
- Televisions, radios, and internet access for keeping apprised of events are located _(include rules)__.
- Childcare is provided at _____.
- Care for disabled or elderly family members is provided at _____.
- Pet care is provided at _____.

For pandemic: Guide sheets are provided for workers to deal with sickness in their homes.

Emotional:

- Management will provide all workers with regular updates of disaster status and response activities within the organization. Supervisors will brief workers at least once per shift.
- Managers and supervisors will be alert to recognize worker distress.
- Management will provide a stress control team to help workers deal with stress.

- Chaplain or other appropriate religious services.

For pandemic: Counseling will include techniques for dealing with the stigma that workers may face for working with individuals. Stress control teams will be trained in infection control precautions.

Training

There are four main categories of training to be addressed in preparation for response to a disaster: training for all workers; department specific training; training for ad hoc counselors; and information packets for handout.

1. All employees will receive training in the following:

- Stressors related to pandemic influenza
- Signs of distress
- Traumatic grief
- Psychosocial aspects related to management of mass fatalities
- Stress management and coping strategies
- Strategies for building and sustaining personal resilience
- Behavioral and psychological support resources
- Strategies for helping children and families in times of crisis
- Strategies for working with highly agitated patients

2. Department specific training will be developed by department managers as appropriate to the type of services provided.
3. If there are not enough behavioral health specialists available for response to staff needs in a disaster, __(Affiliate name)___ will provide basic counseling training to selected individuals to assist in meeting worker emotional needs.
4. ___(Affiliate name)___ has developed information regarding workforce resilience that will be available for distribution to workers and their families.

Deployed Workers

In the event of a major disaster, especially one that lasts for weeks, workers may be deployed to other departments of this organization or even to assist at other locations in the community. Workers may be requested to use transferable skills to do work that is not in their current job description or scope of practice. For instance, a nurse may be asked to work in the laboratory to assist with drawing blood.

Deployment within the organization

- Pre-deployment, workers will be briefed on stress management, coping skills and resilience.
- Supervisors will develop job description (just-in-time) training sheets that outline tasks for a borrowed worker or volunteer.
- Supervisors will ascertain competency of borrowed workers to do assigned tasks.
- Volunteers will be trained in the specific areas they are positioned in so adequate education

is provided.

- All deployed workers have a responsibility to advise the supervisor when they have been assigned a task for which they have no training or skills. Supervisors should train the employee to the task, if appropriate, or assign the task to someone else.
- A buddy system will be established to help employees support each other.
- Workers will be trained on self-help activities.

Deployment outside of the organization

Local or national government may require assistance and request that healthcare workers be deployed to other sites. ___(contact person within affiliate)___ is responsible for coordinating all external deployment of employees.

- (Contact person) will coordinate with the HICS commander to determine how many workers can be spared and then will send a call for volunteers for deployment.
- Pre-deployment, workers will be briefed on:
  - Status of community or agency to which they are going
  - Work that is expected of them
  - Stress management, coping skills and resilience
  - Self-help activities
  - Approximate time they will be needed

The Sample Policy for Dependent Care is shown below. The complete sample can be found in the Hospital Operational Tools Manual on pages 37-40.

Purpose:

This procedure outlines the process by which a hospital can provide shelter and food for dependents of staff and volunteers during a disaster or other emergency situation.

Definition:

Dependent care area is located in [facility-designated area].

Policy:

In the event of an extended emergency response or civil disturbance where staff will remain at [Facility Name] for long periods, dependents, including children, elderly and disabled persons, may be brought with the staff member and housed in the designated dependent care area if a responsible person is not available at home to provide care.

Responsibilities:

A dependent care unit leader should be assigned and be responsible for coordinating the Dependent Care Area activities.

Procedure:

A. Mobilization – Upon request by the operations chief or the incident commander, the dependent care unit leader shall mobilize sufficient staff and resources to activate a dependent care area.

B. Safety requirements – Prior to activation of the dependent care area, the dependent care unit leader, with assistance from the safety and security officer, shall conduct a safety inspection of the area to remove any unsafe objects and to secure any equipment that could pose a safety hazard.

C. Staff

1. The dependent care unit leader will oversee other staff or volunteers requested from the labor pool, taking into consideration registration of dependents and administration of medications.
2. Staff and volunteers shall sign in and out when reporting to assist.
3. Staff shall monitor the area continuously for safety issues and to respond to dependents' needs.
4. If additional assistance is needed, for example, supplementary support for dependents from the American Red Cross, staff will communicate those needs through the command structure.

D. Supplies – Dependent care area supplies shall be requested through the materials supply unit leader.

E. Food – Meals and snacks for dependents shall be arranged by the nutritional supply unit leader.

F. Registration

1. Post signs indicating "Dependent Care Area – Responsible Adult Must Register Dependent."
2. Assign each family a family number.
3. All dependents shall be assigned a dependent number and shall register using the dependent care registration form. Establish the dependent number by adding a letter (A, B, C, D, etc.) to the family number for each dependent in a given family.
4. Apply an armband to each dependent upon arrival with name and department number.
5. Take a picture of each dependent with person responsible for them and attach to dependent care registration form.
6. Special sign-in and sign-out procedures shall be provided for minor or incompetent dependents.

i. Implement a positive identification system for all children younger than 10.
ii. Provide matching identification for retrieving guardian to show upon release of child.

7. Tag medications, bottles, food and other belongings with dependent's name and dependent number and store appropriately.
8. Assign each dependent to a dependent care provider and record on form.

G. Medications
1. Ensure that dependents taking medications have a supply to last during the estimated length of stay.
2. Arrange for a licensed nurse to dispense medications as appropriate.

H. Psychological Support – Arrange for the psychological support unit leader (social services) to make routine contact with dependents in the shelter, as well as respond to specific incidents or individual needs.

I. Documentation
1. Document all care provided to individual dependents, such as medications, psychological services, toileting or dressing.
2. Document all other actions and decisions and report routinely to the dependent care unit leader.

J. Checking Out of Dependent Care Area
1. When dependent leaves area, compare picture with dependent and responsible person.
2. Check identification, verify name and obtain signature of responsible person picking up dependent.
3. Retrieve and send all medications and personal items with dependent.
4. Collect armbands.

The Sample Tracking Form for Dependent Care is shown below. The complete form can be found in the Hospital Operational Tools Manual on pages 46-47.

Check In Date	**Time**	
Check Out Date	**Time**	
Staff Name	**Relationship to Dependent**	**Family Number**
Dependent Name	**Age**	**Dependent Number**
Staff's Department	**Extension**	
Other Family, Relative, etc we can call in an emergency		
Name	**Phone Number**	
Name	**Phone Number**	
Special Needs **Allergies**		

Food **Toileting** **Medical Conditions**		
Medications you brought:		
Name	**Dose**	**Times to be given**
Name	**Dose**	**Times to be given**
People who may pick up dependent		
Name	**Relationship**	
Name	**Relationship**	
Name	**Relationship**	
For Dependent Care Area Staff Only:		
Dependent Care Staff: • Apply armband with name and registration number on each dependent. • Tag all medications, bottles, food and other belongings and store appropriately. • Photograph dependent with person responsible and attach photo to this form. • Use reverse side of this form to document care provided to this dependent. • Retain forms in dependent care area until "All Clear" is announced, then route to the Command Center.		
Dependent Care Providers Assigned		
Name of person picking up dependent		
Signature of person picking up dependent		

9.4. Hospital Staff Family Disaster Plan

It is unlikely that hospital staff will report for duty or remain at work during an emergency if they are concerned about the safety and welfare of their family. Therefore, healthcare facilities should encourage staff to plan with their families for what could happen in a disaster. Family disaster plan templates can be found at www.ready.gov, www.pandemicflu.gov and www.redcross.org. These websites provide detailed information about how families can be prepared for disasters. For samples of these templates see:

- **Hospital Operational Tools Manual pages 31-33: Sample Family Emergency Plan**
- **Hospital Operational Tools Manual pages 34-36: Sample Family Emergency Supply List.**
- **Hospital Operational Tools Manual pages 24-26: Pandemic Flu Planning Checklist for Individuals and Families.**

- **Hospital Operational Tools Manual pages 14-16: Family Emergency Health Information Sheet.**

For example, planning should include:

- Discussing the types of disasters and emergencies that are most likely to happen and what to do in each case.
- Establishing an out-of-town emergency contact so that all family members can call this contact in an emergency to check in.
- Arranging pet care as many emergency shelters will not accept pets other than service animals.
- Making an emergency supply kit (food, water, to last at least three days for each member of the household including prescription medications.)

10. Supplies, Pharmaceuticals, and Equipment

Managing a hospital supply chain involves getting the right product to the right place at the right time through collaboration of information sharing with supply partners. Under normal operating conditions, a hospital that accurately predicts demand will incur fewer inventory carrying costs associated with purchasing and storing supplies, pharmaceuticals and equipment. This push towards a "just in time" supply chain can have severe adverse consequences on a hospital's ability to provide services in a healthcare emergency.

The *Kaiser Daily Health Policy Report* stated in a January 12, 2006 report that the very rules of capitalism that make the U.S. an ultra-efficient marketplace also make it exceptionally vulnerable in a disaster, particularly a pandemic influenza. For example, many drugs are manufactured outside of the U.S. because of lower costs, while warehouses in the U.S. are generally kept nearly empty for efficiency reasons.

Michael Osterholm, Director of the Center for Infectious Disease Research and Policy at the University of Minnesota, said, "Most if not all of the medical products or protective-device companies in this country are operating almost at full capacity. That's the reality of today's economy -- just-in-time delivery with no surge capacity."[43] Thus, the first step in preparing for a healthcare surge is ensuring the hospital can function indepentently for 72-96 hours at surge levels.

As stated in Section 3.6: How Hospitals Connect to the Emergency Response Structure, once the impact of an emergency is sufficient to involve multiple emergency response disciplines (law enforcement, fire, public health), these responding entities form a Unified Command. An authorized local official or their designee will notify healthcare facilities that the Unified Command has been established and provide contact information.[2] Connecting to the Unified Command will be critical as during a healthcare surge the emergency response structure should manage resource allocation so that scarce resources and supplies can be prioritized among all healthcare providers. Hospitals will then go through this command structure to obtain additional supplies to provide services during a healthcare surge.

10.1. Maximizing Sustainability

Effective planning for hospital sustainability will help to mitigate the effects of limited resource availability during a healthcare surge. Hospitals should use the recommendations provided in this section to guide the types and quantities of supplies, pharmaceuticals, and equipment to acquire prior to a catastrophic event. In order to maximize sustainability:

[2] It is likely that this notification will be provided through California Health Alert Network alert. Hospitals can obtain more information about California Health Alert Network from their Local Health Department or Regional Hospital Preparedness Coordinator.

- Hospitals should have enough supplies, pharmaceuticals and equipment at their hospital to be self sufficient to operate at 20 to 25% above their average daily census for 72 hours at a minimum with a goal of 96 hours.
- When considering the type of catastrophic emergencies that may occur, hospitals may need to rely on the available market supply (e.g., Memorandum of Understanding, retailers or wholesalers) and state and federal stockpiles for specific resources.
- The type of inventory to be stockpiled should take into consideration some likely specific risks, for example, earthquake zones. This planning can be based on a Hazard Vulnerability Analysis. See Section 3.8: Developing a Hazard Vulnerability Analysis for more guidance on conducting this analysis.

10.2. Pharmaceuticals

One of the most challenging aspects of acquiring pharmaceuticals is determining which pharmaceuticals are needed and in what quantity. As with all departments in a hospital, pharmacy inventory levels are closely monitored to meet financial performance requirements and it is very difficult to increase inventory. Pharmacy wholesalers provide deliveries to hospitals five to six days per week in order to have critical stock on site. Information to guide hospitals in determining which pharmaceuticals are needed and in what quantity can be gathered from wholesalers who provide pharmacies access to historical purchase data and software tools to easily establish par levels, reorder points and reorder quantities. Par levels are the maximum amount of each type of pharmaceutical that the facility maintains in inventory for adequate supply and the reorder quantity equals the difference between the par level and the quantity on hand.[44]

Despite the frequency of deliveries, pharmacies must plan for gaps in delivery service. The decision as to which tool or tools to use to assist in determining which pharmaceuticals are needed and the quantity required is dependent on the existing complexity of services offered, volume expectations during a healthcare surge and the needs of the community. Because of the increased cost to the facility, the decision to increase existing pharmaceutical inventories to accommodate a healthcare surge should be made in conjunction with hospital leadership with consideration given to the specific risks that the hospital has identified in its Hazard Vulnerability Assessment.

Strong consideration should be given to involving key members of the hospital staff and suppliers in planning for determining pharmaceuticals to have available for a healthcare surge including:

- Clinical pharmacists
- Disaster coordinators
- Emergency Department directors

- Emergency Department physicians
- Respiratory therapists
- Pulmonologists
- Critical care director
- Infectious disease physicians
- Poison control specialists
- Drug information specialists
- Radiologists
- Radiation safety officers
- Hospital administrators
- Pediatric specialists (pediatric critical care/emergency medicine physicians)
- Vendors and distributors
- Materials manager/procurement
- Facilities/logistics
- Medical surge coordinator

10.2.1. Inventory Based Pharmaceuticals by General Classifications

The Inventory Based Pharmaceutical by General Classifications tool, in conjunction with a Hazard Vulnerability Assessment, can assist hospitals in determining the specific types and quantities of pharmaceuticals that a hospital should have on hand for a healthcare surge. Using inputs such as doses and days of therapy required, the tool can be used to calculate the number of patients to be treated, the doses required and the packages of pharmaceuticals to be stocked. The benefit of this tool is that it distinguishes potential pharmaceuticals needed by biological, chemical and nuclear catastrophic emergencies.

The Inventory Based Pharmaceuticals by General Classifications List is shown on the following pages. The complete tool can be found in the Hospital Operational Tools Manual on pages 78-84.

Description

A pharmaceutical list classified by types of drugs that may be needed for specific types of surge scenarios. The list serves as guidance in acquiring appropriate pharmaceuticals in *preparation for* and *during* a surge.

Instructions

Use this tool as a guide in conjunction with the facility's hazard vulnerability assessment. Pharmaceutical needs are site-dependent based on the complexity of services offered and the

potential needs of the community.

1. The columns in the tool need to be populated and are explained below:
   a. **Sample Pharmaceuticals Suggested during a Surge**
      i. This list is non-comprehensive and considers various surge scenarios including antidotes and vaccines for:
         1) Biological events
         2) Chemical events
         3) Radiological/nuclear events
      ii. Add/delete specific pharmaceuticals that may or may not be needed at specific site.
   b. **Package Size:** Identify the number of items in the package.
   c. **Wholesaler Item #:** Identify the number assigned to the item by the wholesaler the facility uses for ease of use in identifying and re-ordering.
   d. **Average Daily Census:** Quantify the average daily census of the facility (if applicable) to provide guidance in understanding quantity needs in a healthcare surge.
   e. **Potential Surge Patients:** Estimate how many healthcare surge patients may be expected. This will vary considerably from type of event, location of facility, and number and type of other facilities with the potential to provide care. The recommendation is that existing healthcare facilities should have enough supplies, pharmaceuticals and equipment at their facilities to be self-sufficient for 72 hours at a minimum with a goal of 96 hours and operate at 20 percent to 25 percent above their average daily census.
   f. **Employees:** Identify the number of employees. This may be important in understanding the total count of those that require treatment.
   g. **Total Potential Requiring Treatment:** Determine the total potential requiring treatment by considering all patients in a healthcare surge plus employees.
      i. A spreadsheet can be set up with formulas to determine the quantity needed by using the formula: *Average Daily Census +Potential Surge Patients + ED Capacity + Employees*.
   h. **Doses Needed per Patient per Day:** Calculate how many doses are needed per day to guide the amount that needs to be ordered.
   i. **Days of Therapy Required:** Calculate how many days of therapy are required to guide the amount of pharmaceuticals that need to be ordered.
   j. **Total Doses Required:** Calculate the Total Doses Required

      Total doses = Doses needed per patient per Day X Days of Therapy required.
   k. **No. of Packages to Stock:** Determine the number of packages to stock by considering the Total Doses Required.
   l. **Alternate Sources:** Identify other sources that may have the specific pharmaceuticals that the facility is aware of (e.g. nearby hospital).

Inventory Based Pharmaceuticals by General Classifications Table

Critical Pharmaceuticals That May Be Needed During a Surge													
Sample Pharmaceutical Suggested During a Surge	Strength	Route of Administration	Package Size	Wholesaler Item #	Average Daily Census	Potential Surge Patients	Employees	Total Potential Requiring Treatment	Doses Needed per Patient per Day	Days of Therapy Required (Max of 3 Days)	Total Doses Required	# Packages to Stock	Alternate Sources
Antidotes for Biological Agents													
Activated charcoal 50g slurry	N/A	Oral											
Cidofovir	75mg / ml	Injectable											
Ciprofloxacin	400mg	Injectable											
Ciprofloxacin	500mg	Oral											
Clindamycin	600mg	Injectable											
Doxycycline Hyclate	100mg	Injectable											
Doxycycline Hyclate	100mg	Oral											
Gentamicin Sulfate	10mg / ml	Injectable											
Gentamicin Sulfate	40mg / ml	Injectable											
Penicillin GK	20MU	Injectable											
Rifampin	300mg	Oral											
Streptomycin Sulfate	400mg / ml	Injectable											
Antidotes for Chemical Agents													
Amyl Nitrite 0.3ml. Crushable ampule	N/A	Inhaled											
Atropine Sulfate prefilled syringe	1mg / 10ml	Injectable											
Atropine Sulfate multidose vial	8mg / 20ml	Injectable											
Calcium Chloride	10mg / 10ml	Injectable											
Calcium Gluconate 10%	10mg / 100ml	Injectable											

Critical Pharmaceuticals That May Be Needed During a Surge													
Sample Pharmaceutical Suggested During a Surge	**Strength**	**Route of Administration**	**Package Size**	**Wholesaler Item #**	**Average Daily Census**	**Potential Surge Patients**	**Employees**	**Total Potential Requiring Treatment**	**Doses Needed per Patient per Day**	**Days of Therapy Required (Max of 3 Days)**	**Total Doses Required**	**# Packages to Stock**	**Alternate Sources**
Diazepam	5mg / ml	Injectable											
Dimeracaprol	100mg / ml	Injectable											
Diphenhydramine HCL	50mg / ml	Injectable											
Methylene Blue 1%	10mg / ml	Injectable											
Pralidoxime Chloride	1gm / 20ml	Injectable											
Pyridostigmine Bromide	30 0r 60mg	Oral											
Pyridoxine HCL	3g / 30ml	Injectable											
Sodium Nitrite	30mg/ml	Injectable											
Sodium Thiosulfate	12.5mg / 50ml	Injectable											
Antidotes for Radiological & Nuclear Agents													
Aluminum Hydroxide Suspension 240ml	N/A	Oral											
Calcium Carbonate	1g	Oral											
Chlorthalidone	100mg	Oral											
Deferoxamine Mesylate	1g	Injectable											
Edetic Acid	200mg / ml	Injectable											
Furosemide	100mg / 10ml	Injectable											
Magnesium Sulfate	N/A	Oral											
Magnesium Oxide	N/A	Oral											
Penicillamine	125 mg/250mg	Oral											

Critical Pharmaceuticals That May Be Needed During a Surge													
Sample Pharmaceutical Suggested During a Surge	**Strength**	**Route of Administration**	**Package Size**	**Wholesaler Item #**	**Average Daily Census**	**Potential Surge Patients**	**Employees**	**Total Potential Requiring Treatment**	**Doses Needed per Patient per Day**	**Days of Therapy Required (Max of 3 Days)**	**Total Doses Required**	**# Packages to Stock**	**Alternate Sources**
Potassium Iodide	130mg	Oral											
Prussian Blue	500 mg	Oral											
Sodium Iodide	130mg	Oral											
Trisodium Calcium Diethylenetriamine Pentaacetate	1g	Injectable											
Trisodium Zinc Diethylenetriamin epentaacetate	1g	Injectable											
Drugs for Treating Acute Radiation Syndrome													
Acyclovir Sodium	25mg/ml	Injectable											
Acyclovir	400mg	Oral											
Antidiarrheal	N/A	Oral											
Cefepime HCL	1g	Injectable											
Filgrastim	300ug / ml	Injectable											
Fluconazole	200mg / ml	Oral											
Ganciclovir	250-500mg	Oral											
Ganciclovir Sodium	500mg / ml	Injectable											
Granisetron HCL	1mg / ml	Injectable											
Granisetron HCL	1mg	Oral											
Ondansetron HCL	2mg / ml	Injectable											
Pegfilgrastim	6mg	Injectable											
Trimethoprim/ Sulfamethoxazole	160mg / 800mg	Oral											
Trimethoprim/ Sulfamethoxazole	16mg/ml/ 80mg/ml	Injectable											
Vaccines													
Tetanus Toxoid	N/A	Injectable											

Critical Pharmaceuticals That May Be Needed During a Surge													
Sample Pharmaceutical Suggested During a Surge	Strength	Route of Administration	Package Size	Wholesaler Item #	Average Daily Census	Potential Surge Patients	Employees	Total Potential Requiring Treatment	Doses Needed per Patient per Day	Days of Therapy Required (Max of 3 Days)	Total Doses Required	# Packages to Stock	Alternate Sources
Sources:													
1) Guidelines for Managing Inpatient and Outpatient Surge Capacity - State of Wisconsin, 2005													
2) Emergency Preparedness Resource Inventory (EPRI), A Tool for Local, Regional, and State Planners AHRQ Publication, 2005													
3) State of California Mass Prophylaxis Planning Guide, EMSA, June 2003.													
4) Organization of a health-system pharmacy team to respond to episodes of terrorism, Am J Health-Syst Pharm-Vol 60 Jun 15,2003													

There are pharmaceuticals to be considered that are unique to the pediatric population. In the specific tools for this section, the pediatric population is not segmented. To find specific information on the emergency care of the pediatric population, refer to http://www.emsa.ca.gov/def_comm/vii032807_a.asp.

10.2.2. Off-Label Drug Use

During a healthcare surge, there is the possibility that the indicated medication for a diagnosis is not available. There may be other medications that have demonstrated effectiveness in the primary literature, but have not yet been granted Food and Drug Administration approval for a particular diagnosis. For example, many medications that are Food and Drug Administration - approved for antiarrthymic use are also effective for treating hypertension. Some of the agents that are Food and Drug Administration-approved for depression also demonstrate effectiveness in treating pain.

There is no known statutory or regulatory prohibition against off-label use of a drug by a physician. Consequently, pharmacists may dispense pharmaceuticals for off-label purposes without being out of compliance. A proclamation of an emergency could include a provision making the standard of care the prevention of the greatest loss of life, which could allow some off-label uses even if not generally accepted by the medical community, but consistent with the goal of saving a life.

10.3. Supplies and Equipment

10.3.1. Determining Supplies and Equipment Needs

Supplies and medical equipment on hand will be critical to the hospital's ability to function in a disaster. Similar to pharmaceuticals, the decision regarding what supplies and equipment to maintain at the hospital is dependent upon the complexity of services offered and volume of patients expected during a healthcare surge. Information from the Hazard Vulnerability Assessment should be utilized to assist in understanding a hospital's needs.

When resources allow, or are available within the hospital, strong consideration should be given to involving key stakeholders in the planning for supplies and equipment such as:

- Disaster coordinators
- Emergency Department directors
- Emergency Department physicians
- Respiratory therapists
- Pulmonologists
- Critical care director
- Radiologists
- Radiation safety officers
- Hospital administrators
- Pediatric specialists (pediatric critical care/emergency medicine physicians)

- Vendors and distributors
- Materials manager/procurement
- Facilities/logistics
- Medical surge coordinator

10.3.2. Inventory Based – Detailed Supplies and Equipment List

The Supplies and Equipment List on the next page provides planners with a guide for ordering of specific supplies and equipment. Hospitals should consider resources used every day that may be needed in larger supplies during a healthcare surge. For example, saline solution will be in high demand during a healthcare surge because ensuring adequate hydration is vital both during and after a disaster. Many of these intravenous solutions are currently stocked in the hospital emergency departments (e.g., lactated ringers and normal saline), and planning should consider the potential volume of patients that may require hydration for a 72-hour period. Dehydration may result post-disaster due to diarrhea because of a lack of clean drinking water and sanitary facilities. Hospitals should also consider the potential volume of patients that may require oral hydration for the post-disaster period.

This list should not be considered comprehensive, but should be used as a guide when considering the types of supplies and equipment that are needed during a catastrophic emergency. In addition, there are supplies and equipment to be considered that are unique to the pediatric population. For more detailed information on the emergency care of the pediatric population, refer to http://www.emsa.ca.gov/def_comm/vii032807_a.asp.

The Detailed Supplies and Equipment List is shown below. The complete tool can be found in the Hospital Operational Tools Manual on pages 67-77.

The Disaster Resource Center Medical/Surgical Supply Cache list has four columns which represent the following:

1. **Current Supply:** Stock on hand.
2. **Total Potential Requiring Treatment:** An estimate should be made to determine the hospital's surge capacity.
3. **Package Size** (e.g., 100/box, or simply 100.)
4. **Quantity/Cache:** Besides what is currently in the supply at the hospital, what is the quantity that may be part of the hospital's supply inventory on-site or nearby.

   Example: If using Average Daily Census as a measure for a 100-bed hospital, a hospital may strive to be 25 percent above its normal Average Daily Census for 72-96 hours following Health Resources and Services Administration guidelines.

Using this example, this hospital would need to treat 125 patients for 72-96 hours.

The hospital should consider the following when determining which supplies and equipment to stock:

- What types of patients would a hospital expect given the results of their Hazard Vulnerability Analysis?
- What supplies and equipment would the hospital specifically choose to stock?
- What supplies and equipment are also apart of the hospital's supply inventory?
- What supplies and equipment should be considered for an all hazard catastrophic emergency?

Detailed Supplies and Equipment List

BANDAGES AND DRESSINGS	Current Supply	Total Potential Requiring Treatment	Package Size (if applicable)	Quantity / Cache
Adhesive strip, 1" X 3"				
Alcohol pads				
Bandage elastic (Ace wrap) 2"				
Bandage elastic (Ace wrap) 4"				
Bandage elastic (Ace wrap) 6"				
Bandage, gauze non sterile (kerlix) 4" X 10'				
Bandage, gauze non sterile 4X4				
Bandage 4X4 sterile				
Bandage 2X2 sterile				
Eye pad, oval sterile				
Eye Shields				
Morgan Lens				
Petroleum Gauze 5" X 9" (Xeroform)				
Vaseline gauze				
Gauze Pad 5" X 9" sterile				
Tape 1" transparent				

SURGICAL SUPPLIES	Current Supply	Total Potential Requiring Treatment	Package Size (if applicable)	Quantity / Cache
Scalpel with blade, disposable #10				
Scalpel with blade, disposable #15				
Sterile gloves, sizes 6.5, 7.0, 7.5, and 8.0				
Surgical scrub brushes with betadine				
Suture set (disposable)				
Suture removal kit				
Suture (Nylon sutures various sizes)				
ORTHOPEDIC SUPPLIES	**Current Supply**	**Total Potential Requiring Treatment**	**Package Size (if applicable)**	**Quantity / Cache**
Splint, cardboard 12”				
Splint, cardboard 18”				
Splint, cardboard 24”				
Splint, cardboard 34”				
Splint, fiberglass 3”				
Splint, fiberglass 4”				
Splint, fiberglass 5”				
IV SETS, NEEDLES AND SYRINGES	**Current Supply**	**Total Potential Requiring Treatment**	**Package Size (if applicable)**	**Quantity / Cache**
IV Start Kits				
IV catheter, 18 gauge				
IV catheter, 20 gauge				
IV catheter, 22 gauge				
IV catheter, 24 gauge				
IV administration set, adult				
IV administration set, pediatric				
IV piggyback tubing				
Needle disposable, 18 gauge				
Needle disposable, 22 gauge				
Needle disposable, 25 gauge				
Syringe, 1ml				
Syringe, 3 ml				
Syringe, 5 ml				
Syringe, 10 ml				

Syringe, 20 ml				
Syringe, 35cc, for wound irrigation				
Syringe/needle, 3 ml, 22gauge X 1 ½”				
Syringe/needle, 1 ml, 25 gauge X 5/8”				
Syringe/needle 1 ml, 29 gauge X ½”				
Sharps container				
AIRWAY MANAGEMENT SUPPLIES	**Current Supply**	**Total Potential Requiring Treatment**	**Package Size (if applicable)**	**Quantity / Cache**
Bag-valve-mask, adult				
Bag-valve-mask, pediatric				
Airway adjunct, OP Airway				
Airway adjunct, NP Airway				
Cricothyrotomy / Shiley 4				
Endotracheal tube, cuffed 8mm				
Endotracheal tube, cuffed, 7.5mm				
Endotracheal tube, cuffed 7mm				
Endotracheal tube, cuffed, 6mm				
Endotracheal tube, cuffed 2.5mm				
Endotracheal tube, cuffed 3mm				
Endotracheal tube, cuffed, 4mm				
Endotracheal tube, cuffed, 4.5mm				
Endotracheal tube, cuffed, 5mm				
Endotracheal tube, cuffed, 5.5mm				
Endotracheal tube, non-cuffed, 2.5mm				
Endotracheal tube, non-cuffed, 3mm				
Endotracheal tube, non-cuffed, 4mm				
Endotracheal tube, non-cuffed, 5mm				
ETT Holders				
Intubation kit, incl. Blades, medium handle, stylet and case – including magill forceps				
Intubation kit (Pediatrics) , incl. Blades, medium handle, stylet and case – including magill forceps				
Nasal cannula, adult				
Nasal cannula, pediatric				
02 mask with tubing, pediatric				
02 mask with tubing, adult				
02 mask - non-rebreather, adult				
Nebulizers – hand held				
Nebulizers – masks				

Ventilator circuits				
Suction machine, portable				
Suction catheters 10 french				
Suction catheters 12 french				
Suction catheters 14 french				
Yankauer suction				
Suction tubing				
Suction Canisters				
NG Tubes				
Thoracostomy Tubes, assorted sizes				
Pleurivac & Heimlich valves				
INFECTION CONTROL SUPPLIES	**Current Supply**	**Total Potential Requiring Treatment**	**Package Size (if applicable)**	**Quantity / Cache**
Cover/Isolation gowns				
Splash guard for wound irrigation				
Masks surgical				
Face shield with eye shield				
Masks N-95				
Patient exam gloves, small				
Patient exam gloves, medium				
Patient exam gloves, large				
Shoe covers				
Surgical caps				
Wipes, disposable				
MISCELLANEOUS SUPPLIES	**Current Supply**	**Total Potential Requiring Treatment**	**Package Size (if applicable)**	**Quantity / Cache**
Bags, plastic 30 gallon, 8 mil				
Batteries, C for laryngoscope handle				
Batteries, D for flashlights				
Blankets lightweight				
Clipboards				
Diapers, disposable large				
Diapers, disposable medium				
Diapers, disposable small				
Diapers, disposable, large, peds				
Diapers, disposable, medium, peds				
Diapers, disposable, small, peds				
Emesis basins, plastic				

Facial tissues				
Flashlights				
Gloves work type leather/canvas				
OB kits, disposable				
Paper towels				
Patient ID bands				
Styrofoam cups				
Tongue depressors, non sterile				
NON-DISPOSABLE MEDICAL SUPPLIES	**Current Supply**	**Total Potential Requiring Treatment**	**Package Size (if applicable)**	**Quantity / Cache**
Blood Pressure multi-cuff kit with adult, pediatric, infant and thigh cuff				
Glucometer kit with lancets, test strips and battery				
Portable Otoscope/Ophthalmoscope set with batteries				
Pulse Oximetry, portable				
Stethoscope				
Tourniquets 1”				
Trauma/paramedic scissors				
MISCELLANEOUS Equipment	**Current Supply**	**Total Potential Requiring Treatment**	**Package Size (if applicable)**	**Quantity / Cache**
Ventilators - dual use Adult/Pediatric				
Portable/disposable vents				
Equipment Trailer				
18 X 24 Tent				
10 X 10 Tent				
Temps Beds				
Simpler Life Cots				
Junkin Cots				
Blankets/Sleeping Bags/Linen				
Tables				
Chairs				
Lights				
Portable Generator				
Heating System/Fan				
HEPA Filtration System				
Staff Notification/Recall System				

HAM Radio Equipment				
Communication Equipment (radios, walkie talkie)				
Evacusleds				
Evacuation Chairs				
CBRNE Detection/Monitoring Equipment				
Emergency Food/Water Supply Cache				
Portable Toilets				
Portable hand washing				
Outdoor Lighting				
EZ Up Shades				
Security Upgrades and hardening				
Post Decontamination clothing sets				
Pharmacy Cache				
CHEMPACK location site				
Medical/Surgical Supply Cache				
Prime Mover (tow vehicle)				

10.3.3. Use of Supplies and Equipment beyond the Manufacturer's Recommended Use

In a healthcare surge, hospitals should be aware there is the possibility that medical supplies and equipment may be used in a different manner than their normal use, potentially impacting liability and reimbursement. An example is the use of an adult intubation kit on a pediatric patient. The Federal Food, Drug and Cosmetic Act, Chapter V, Subchapter E, Section 564, 21 USC Section 360bbb-3, - Authorization for Medical Products for Use in Emergencies subdivision states that the Secretary of Health and Human Services may authorize the introduction of a drug, device or biological product intended for use in an actual or potential emergency (referred to in this section as an “emergency use”) into interstate commerce during the effective period of a declaration under the Federal Food, Drug and Cosmetic Act, Chapter V, Subchapter E, Section 564(b). This authorization allows for an emergency use of a product that is:

- Not approved, licensed, or cleared for commercial distribution (i.e., an unapproved product) or
- Is approved, licensed, or cleared under such provision, but the use is not an approved, licensed, or cleared use of the product (i.e., an unapproved use of an approved product).

This authorization would require a request from the Governor or CDPH to the Secretary of Health and Human Services. In the event that the Secretary of Health and Human Services issues this authorization, hospitals will have greater flexibility to utilize supplies and equipment in the manner that most meets the demands of the healthcare surge.

10.4. Acquisition of Personal Protective Equipment

Healthcare workers risk occupational exposures to chemical, biological, or radiological materials when a hospital receives contaminated patients, particularly during a surge event. These hospital employees, who are called first receivers, can be exposed to the substances transported to the hospital on victims' skin, hair, clothing, or personal effects. Under California Labor Code Section 6401, every employer must furnish protective equipment, use safety devices and safeguards and provide training.
Occupational Safety and Health Administration provides guidelines that many hospitals currently use (see http://www.dir.ca.gov/occupational_safety.html). Employers are required by Occupational Safety and Health Administration to use personal protective equipment to limit employee exposure to hazards and employers must determine if personal protective equipment should be used for the protection of the employees.

Hospitals will be primarily dealing at the Occupational Safety and Health Administration Levels C and D and the acquisition of personal protective equipment and training should reflect those levels. Levels A-D and chemical types of equipment are described below.

- Level A: Greatest level of protection required for skin, eye and respiratory protection.
- Level B: Greatest level of respiratory protection, but a lesser level of skin protection.
- Level C: Emphasis is on airborne substances and the criteria for using air purifying respirators must be met.
- Level D: A work uniform that provides minimal protection to safeguard against contamination.
- Chemical Ensemble: Emphasis on providing protection against toxic products which may enter the body through skin absorption or inhalation.

Natural disaster/biological situations are infection control/ epidemiological issues. They require universal precautions and respiratory precautions may be required depending on the situation (e.g., N-95/N-100). Infection control practices should be followed. The 1995 Occupational Safety and Health Administration manual "*Best Practices for Hospital Based First Receivers*" (http://www.osha.gov/dts/osta/bestpractices/html/hospital_firstreceivers.html) should be used as a guide for hospitals to determine the personal protective equipment necessary for situations involving the release of hazardous substances. Training, personnel and storage are addressed in detail in this manual.

For additional guidance on the State and federal requirements for personal protective equipment, see Section 9.1: Workforce Health and Safety and Workers Rights.

10.4.1. Guidance on Selecting and Acquiring Personal Protective Equipment

Hospitals may face challenges in selecting, acquiring, managing and storing personal protective equipment because of uncertainty in the amount of personal protective equipment needed, questions about who should use personal protective equipment, and the reusability of such equipment during a healthcare surge. Additionally, hospitals may or may not have the space to store and maintain personal protective equipment once it has arrived and this should be considered in planning. Guidance on these and other challenges are provided below.

As personal protective equipment is likely to be in short supply during a healthcare surge, especially a pandemic influenza, hospitals should emphasize use of facial protection (eyes, nose, and mouth) and should prioritize respiratory protection, particularly for use during aerosol-generating procedures and for use with coughing/sneezing patients.

The 2006 Institute of Medicine report, "*Reusability of Facemasks During an Influenza Pandemic: Facing the Flu*," provides recommendations for hospitals and healthcare workers who must reuse facemasks during an influenza pandemic. The complete guide can be found at

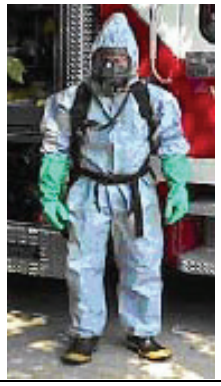
http://www.nap.edu/catalog.php?record_id=11637. Key recommendations from this report include:

- N95 respirators should be protected from external surface contamination when there is a high risk of exposure to influenza (i.e., by placing a medical mask or cleanable faceshield over the respirator so as to prevent surface contamination but not compromise the device's fit).
- N95 respirators should be used and stored in such a way that the physical integrity and efficacy of the respirator will not be compromised.
- Appropriate hand hygiene should be practiced before and after the removal of the respirator. If necessary and possible, appropriately disinfect the object used to shield the respirator.

Additional guidelines for hospitals to consider in selecting and acquiring personal protective equipment include:

- Hospitals should use a Hazard Vulnerability Analysis to contemplate hazards that may impact a hospital and the specific potential hazard to employees, e.g., skin, ingestion, inhalation, mucous membrane contact (eyes, nose, mouth). This will guide the hospital in determining the types of personal protective equipment needed. See Section 3.8: Developing a Hazard Vulnerability Analysis for more guidance.
- Hospitals should, at a minimum, be prepared for Occupational Safety and Health Administration Levels C and D, but equipment selection should be hospital-specific. This should guide hospitals on the general types of personal protective equipment that may be needed during a healthcare surge.
- Hospitals should consider using equipment similar to that used by local emergency responders to standardize personal protective equipment within a community/region for interoperability.

In a report by AHRQ on personal protective equipment, OSHA levels of protection and related personal protective equipment ensemble were defined as follows:[45]

Occupational Safety and Health Administration				
PPE Level	**Level A**	**Level B**	**Level C**	**Level D**
				
Definition/ Indicators	☐ The hazardous substance has been identified or is an unknown, and requires the highest level of protection for skin, eyes, and the respiratory system based on either the measured (or potential for) high concentration of atmospheric vapors, gases, or particulates; or the site operations and work functions involve a high potential for splash, immersion, or exposure to unexpected vapors, gases, or particulates of materials that are harmful to skin or capable of being absorbed through the skin, ☐ Substances with a high degree of hazard to the skin are known or suspected to be present, and skin contact is possible; or ☐ Operations must be conducted in confined, poorly ventilated areas, and the absence of conditions requiring Level A have not yet been determined. ☐ When an event is uncontrolled or information is unknown about: the type of airborne agent, the dissemination method, if	☐ The type and atmospheric concentration of substances have been identified and require a high level of respiratory protection, but less skin protection. ☐ The atmosphere contains less than 19.5 percent oxygen; or ☐ The presence of incompletely identified vapors or gases is indicated by a direct-reading organic vapor detection instrument, but vapors and gases are not suspected of containing high levels of chemicals harmful to skin or capable of being absorbed through the skin. ☐ A liquid-splash-resistant ensemble used with the highest level of reparatory protection ☐ The suspected aerosol is not longer being generated, but other conditions may present a splash hazard	☐ The atmospheric contaminants, liquid splashes, or other direct contact may adversely affect or be absorbed through any exposed skin; ☐ The types of air contaminants have been identified, concentrations measured, and an air-purifying respirator is available that can remove the contaminants; and ☐ All criteria for the use of air-purifying respirators are met.	☐ Selected when the atmosphere contains no known hazards ☐ Work functions preclude splashes, immersion, or the potential for unexpected inhalation of or contact with hazardous levels of any chemicals

Occupational Safety and Health Administration				
PPE Level	**Level A**	**Level B**	**Level C**	**Level D**
	dissemination is still occurring or it has stopped.			
Ensemble/ Component	☐ A fully encapsulated, liquid and vapor protective ensemble selected when the highest level of skin, reparatory and eye protection is required ☐ Positive pressure, full face-piece self-contained breathing apparatus, or positive pressure supplied air respirator with escape self-contained breathing apparatus, approved by the National Institute for Occupational Safety and Health. Closed-circuit Re-breather/ open circuit self-contained breathing apparatus. ☐ Totally-encapsulating chemical-protective suit. ☐ Gloves, outer, chemical-resistant. ☐ Gloves, inner, chemical-resistant. ☐ Boots, chemical-resistant, steel toe and shank, outer booties. ☐ Disposable protective suit, gloves and boots (depending on suit construction, may be worn over totally-encapsulating suit). ☐ Coveralls* ☐ Long underwear* ☐ Hard hat (under suit), personal cooling system, chemical resistant tape* * optional/as needed	☐ A liquid-splash-resistant ensemble used with the highest level of reparatory protection ☐ Positive pressure, full-face piece self-contained breathing apparatus self-contained breathing apparatus, or positive pressure supplied air respirator with escape self-contained breathing apparatus (National Institute for Occupational Safety and Health approved). ☐Hooded chemical-resistant clothing (overalls and long-sleeved jacket; coveralls; one or two-piece chemical-splash suit; disposable chemical-resistant overalls). ☐ Gloves, outer, chemical-resistant. ☐ Gloves, inner, chemical-resistant. ☐ Boots, outer, chemical-resistant steel toe and shank. ☐ Boot-covers, outer, chemical-resistant ☐ Hard hat, personal cooling system, chemical resistant tape* ☐ Coveralls* ☐ Face shield* * optional/as needed	☐ A liquid-splash-resistant ensemble, with the same level of skin protection as Level B, used when the concentration(s) and type(s) of airborne substances(s) are known and the criteria for using air-purifying respirators are met. ☐ Full-face or half-mask, air purifying respirators (National Institute for Occupational Safety and Health approved). ☐ Hooded chemical-resistant clothing (overalls; two-piece chemical-splash suit; disposable chemical-resistant overalls). ☐ Gloves, outer, chemical-resistant. ☐ Gloves, inner, chemical-resistant. ☐ Boots (outer), chemical-resistant steel toe and shank ☐ Boot-covers, outer, chemical-resistant ☐ Coveralls* ☐ Hard hat, face shield, personal cooling system* ☐ Escape mask* ☐ Face shield* * optional/as needed	☐ A work uniform affording minimal protection: used for nuisance contamination only ☐ Coveralls. ☐ Boots/shoes, chemical-resistant steel toe and shank. ☐ Boots, outer, chemical-resistant (disposable)* ☐ Gloves* ☐ Safety glasses or chemical splash goggles* ☐ Hard hat* ☐ Escape mask* ☐ Face shield* * optional/as needed

Hospitals should conduct training, including decontamination exercises, for personal protective equipment quarterly so appropriate staff will have demonstrable competency for Occupational Safety and Health Administration Level C. Hospitals should work with their local field representatives from their vendors and suppliers for formalized training.

Occupational Safety and Health Administration guidelines stress that emergency response planning should include selection of personal protective equipment based on worst-case employee exposure scenarios. Personal protective equipment selection should be based on the hospital's role in community emergency response evaluation. Potential exposures to hospital staff usually result from proximity to, or contact with a patient whose skin and/or clothing may be contaminated. The hospital staff's personal protective equipment must be sufficient for the type and exposure levels an employee can reasonably anticipate from such incidents. Anticipated exposures are likely to include airborne or absorption hazards from a patient whose skin or clothing has come in contact with hazardous liquids or has been contaminated with hazardous particles.

For greater detail on personal protective equipment and Occupational Safety and Health Administration guidelines, go the Occupational Safety and Health Administration website at: http://www.osha.gov/SLTC/personalprotectiveequipment/index.html.
In preparation for a healthcare surge, suppliers can provide guidance in determining the appropriate amount of supplies and equipment required, including chemical and radiological materials protection and personal protective equipment. It will be vital to work with suppliers to consider each healthcare facility's unique characteristics such as patient population, surge capacity and probability of the various types of catastrophic emergencies that may occur due to location (e.g., proximity to a nuclear power plant). Suppliers and manufacturers use tools designed to facilitate critical decisions, using specific inputs, about the type and quantity of supplies needed to set up care sites.

Various models have been developed to predict personal protective equipment needs, including models by the CDC and the World Health Organization. The CDC model can be found at http://www.cdc.gov/flu/tools/flusurge/ with supplemental guidance at http://www.cdc.gov/flu/pdf/FluSurge2.0_Manual_060705.pdf. The World Health Organization model can be found at http://whqlibdoc.who.int/hq/2006/WHO_CDS_NTD_DCE_2006.2_eng.pdf

10.5. Storage and Inventory Management for Supplies, Pharmaceuticals and Equipment

This section addresses storage and inventory management for supplies, pharmaceuticals, and equipment including environmental concerns, security, and access. These are considerations that hospitals must address during pre-surge planning and healthcare surge responses.

10.5.1. Pharmaceuticals

The pharmaceutical inventory must be managed so the pharmaceuticals will be effective when needed. Therefore, there must be a process to monitor expiration dates, storage dates and for

rotating stock from a cache into the general inventory to minimize pharmaceuticals that may expire. The Pharmaceutical Storage Checklist Tool below addresses the issues and processes that hospitals are strongly encouraged to consider in storing pharmaceuticals at a hospital or in a cache/warehouse.

The Pharmaceutical Storage Checklist is shown below. The complete tool can be found in the Hospital Operational Tools Manual on pages 85-87.

Pharmaceutical Storage Consideration Checklist

Whether in preparation for a healthcare surge or during a surge, there are many considerations that need to be addressed so that pharmaceuticals can be accessed and used immediately. The following checklist includes considerations for pharmaceutical storage across six major categories including:

- Inventory management
- Environmental management
- Security
- Caches External to a Facility
- Licensing
- Ease of access

Inventory Management

- ❑ A process for monitoring the expiration dates.
- ❑ A process for rotating stock from the cache into the general inventory to minimize outdates, if applicable.
- ❑ A process for returning unused stock to vendors for replacement or credit, if applicable.
- ❑ A process for local repackaging of pharmaceuticals if they come in bulk containers.
- ❑ A process for properly labeling repacked pharmaceuticals.

Environmental Management

- ❑ A process for monitoring the environment to meet United States Pharmacopeia (USP) standards, e.g., temperature, humidity, pests.
- ❑ A process for maintaining adequate room temperature ranges between 68° and 77° F, the range required for most medications, as specified in the Strategic National Stockpile guidelines.
- ❑ A process to ensure that the manufacturer's storage guidelines are met.

Security

Facility (assuming a heightened state of security)

- ❑ A process for ensuring the security of the pharmaceuticals (e.g., locks, security personnel).
- ❑ A process for controlling access into the building or area.
- ❑ A process for controlling access within the building.
- ❑ A process for identifying and tracking patients, staff and visitors.
- ❑ A process for monitoring facilities with security cameras.
- ❑ A process for ensuring security locks on pharmaceuticals are in place.
- ❑ A process for working with local authorities prior to a healthcare surge to address heightened security needs.
- ❑ A process for working with private security entities prior to a healthcare surge to address heightened security needs.

Caches External to a Facility

- ❑ A process for ensuring the security of the caches.
- ❑ A process for controlling access into the area.
- ❑ A process for controlling access within the area.
- ❑ A process for working with local authorities prior to a healthcare surge to address heightened security needs.
- ❑ A process for working with private security entities prior to a healthcare surge to address heightened security needs.

Licensing

- ❑ A process to consider any licensing needs, e.g., Board of Pharmacy, depending on the location of the cache.
- ❑ A process to consider the location of the cache and if it is licensed to receive a delivery of pharmaceuticals.

Ease of Access

- ❑ A process for staging the layout of pharmaceuticals to ensure ease of access, e.g., what is needed in the first 24 hours.

10.5.2. Supplies and Equipment

Hospitals should be aware of items that require ongoing maintenance, such as portable monitoring equipment, ventilators and ventilator seals, and other items that use batteries to ensure they continue to be in working order. Obsolescence is also essential to consider as supplies and equipment may become outdated due to technological advances or changes in ordering patterns.

Space is also a very important consideration. Many hospitals have inadequate space to house equipment and supplies and there needs to be a prioritization of what will be included in on-site storage space. Other options addressing space limitations include storing supplies and equipment at other facilities that may exist within their healthcare system or using warehouse space either on-or-off site. The Supplies and Equipment Storage Checklist Tool below addresses the vital areas that hospitals are strongly encouraged to consider when developing plans to store supplies and equipment on-site at a hospital or off-site in a warehouse.

The Supplies and Equipment Storage Checklist is shown below. The complete tool can be found in the Hospital Operational Tools Manual on pages 90-92.

Supplies and Equipment Storage Checklist

Whether in preparation for a healthcare surge or during a surge, there are many considerations that need to be addressed so that supplies and equipment can be accessed and used immediately. The following checklist includes considerations for supplies and equipment storage at an Alternate Care Site across six major categories including:

- Inventory management
- Environmental management
- Security
- Caches External to a Facility
- Transport
- Ease of access

Inventory Management

- ❑ A process for monitoring and maintaining preventive maintenance requirements:
  - ❑ Batteries
  - ❑ Ventilator seals
  - ❑ Electrical equipment
- ❑ A process for returning stock to the vendors for replacement or credit, if applicable
- ❑ A process for monitoring the obsolescence of equipment (out-of date), e.g., automated

external defibrillators (AEDs)

- ❑ Considerations for storing large amounts of supplies and equipment:
  - ❑ Is storage space limited on-site?
  - ❑ Can supplies and equipment be stored at other off-site locations (e.g., warehouses, other facilities in health system)?

Environmental Management

- ❑ A process for monitoring personal protective equipment (e.g., temperature)

Security

Existing Healthcare Facility (assuming a heightened state of security)

- ❑ A process for ensuring the security of the supply and equipment caches
- ❑ A process for controlling access into the building or area
- ❑ A process for controlling access within the building
- ❑ A process for identifying and tracking patients, staff and visitors
- ❑ A process for monitoring facilities with security cameras
- ❑ A process for working with local authorities prior to a healthcare surge to address heightened security needs
- ❑ A process for working with private security entities prior to a healthcare surge to address heightened security needs

Caches External to a Facility

- ❑ A process for ensuring the security of the supply and equipment caches
- ❑ A process for controlling access into the area
- ❑ A process for controlling access within the area
- ❑ A process for working with local authorities prior to a healthcare surge to address heightened security needs
- ❑ A process for working with private security entities prior to a healthcare surge to address heightened security needs

Transport

- ❑ A process for obtaining the caches and transporting them to the desired locations
- ❑ A process for loading supplies and equipment in an efficient manner (e.g., loading docks)

Ease of Access

- ❑ A process for staging the layout of supplies and equipment to ensure ease of access,(e.g., what is needed in the first 24 hours)

10.6. Use of Vendors and Suppliers for Supplies, Pharmaceutical and Equipment Procurement

Many organizations rely on vendors to store supplies and equipment until they are needed for a surge event. Below is a list of factors a hospital should consider when selecting a vendor to ensure proper storage and maintenance of supplies and equipment:

- "Disaster clauses" within the contract with the vendor to understand what they are responsible for during a healthcare surge situation
- Process for the rotation of stock and inventory (control management)
- Vendor lead time for critical supplies, pharmaceuticals and equipment
- Process for material delivery during a healthcare surge

10.6.1. Memoranda of Understanding with Vendors/Suppliers

Prior to a declared emergency and the establishment of a resource prioritization process through SEMS/NIMS, a memorandum of understanding with vendors and suppliers may be an effective method in sustaining operations in a hospital if resources are scarce. Areas in a memorandum of understanding that would be beneficial to include:

- The parties involved
- Description of supplies and equipment to be shared
- Scope and applicability of services
- Liability (professional, tort, expenses)
- Definition of Terms
- Date the memorandum of understanding is effective
- Date the memorandum of understanding terminates
- Points of contact
- Cost of services, equipment, and personnel involved
- If the agreement is subject to any governing body
- Safeguards in case the understanding/agreement collapses

The benefits of planning for and developing memoranda of understanding include an increased level of awareness and understanding of a community's needs and capabilities, and building an environment of trust and collaboration during a disaster. The process of developing a memorandum of understanding may be more beneficial than the resulting document.

10.6.2. Donations of Supplies and Equipment

Donations received from non-governmental organizations, manufacturers, wholesalers and retailers are another way of increasing the pool of supplies and equipment available during a healthcare surge. Potential sources of donations may include corporations and faith-based organizations that may have stockpiles of supplies and equipment. In recent disasters, hospitals have solicited these organizations directly for donations. This is recommended only if the hospital has adequate infrastructure, personnel and processes in place to manage the receipt, storage, maintenance, security and deployment of the donated supplies, pharmaceuticals and equipment. It is recommended that the donations be coordinated at the Operational Area Emergency Operations Center to enable the entry of additional resources at a level where it can be part of the overall system supply base and be made available for communities that may be in most need.

10.7. Acquiring Additional Supplies, Equipment and Pharmaceuticals through the Standardized Emergency Management System

Even with extensive planning, hospitals may require supplies, equipment and pharmaceuticals beyond local availability. Additional resources must be requested through the SEMS/NIMS process. Requests for resources will be made through the appropriate Hospital Incident Command staff to the Unified Command. Resource requests should be as specific as possible to ensure resource needs are met. See Foundational Knowledge, Section 3.9: Standardized Emergency Management System for additional information on SEMS/NIMS.

The following are examples of State and federal resources that will be utilized to fill resource requests received through the SEMS/NIMS process. Planners should be aware that during statewide events resources will be used to fill multiple requests and some requests will be delayed or unable to be filled.

10.7.1. State Resources

During a healthcare surge hospitals should use SEMS/NIMS to request the resources that CDPH has purchased, such as N-95 respirators and ventilators. Although CDPH has 50.9 million N-95 respirators and 2400 ventilators to help healthcare providers respond to an emergency in California, they may be insufficient to meet the needs of all emergencies. These resources will be distributed based on event specific priorities and may not be available to all hospitals in all events. Hospitals in their planning should consider these resources as one source but not the only source of necessary resources.

10.7.2. State/Federal Resources

Through State and federal partnerships, the following resources can be made available during a healthcare surge:

- *Antivirals*: Through a federal cost-sharing program, CDPH maintains a total of 3.8 million courses of antivirals, comprised of 90% Tamiflu and 10% Relenza. The federal government maintains an additional 5.3 million courses for California. Together these courses provide 9.1 million courses for treatment for approximately 25% of California's population.
- *Strategic National Stockpile:* The federal Strategic National Stockpile has large quantities of pharmaceuticals and medical supplies to protect the American public if there is a public health emergency severe enough to cause local supplies to run out. These caches are available to CDPH upon request and would be delivered to sites identified by local health departments.
- *CHEMPACK:* This program is operated by the CDC and provides state and local governments a sustainable nerve agent antidote cache that increases their capability to respond quickly to a nerve agent event such as a terrorist attack.

10.8. Staging Considerations

Most hospitals have limited storage capacity, and likely have insufficient disaster supply storage in close proximity to their designated treatment areas. Further, because disaster supplies are not routinely used, they are often stored in the least convenient available space, sometimes in offsite warehouses. This can result in delays in care as hospitals try to retrieve their supplies from various storage locations.

Hospitals often organize their disaster supplies similar to other hospital materials – each item is stored with like items in the same location. While this is an efficient means of monitoring and replenishing inventory under routine operating procedures, it may not be optimal in a disaster response.

One option hospitals may wish to consider is identifying a small storage area near their designated disaster triage and treatment site. This area can be used for the "first push" of the supplies likely needed in the first moments of a crisis. For example, a small collection of cots, linens, gowns and medical supplies could be gathered here. If space allows, a casualty shelter (tent), lights and generator could be added. If environmental conditions allow, pharmaceutical supplies might be included. As the catastrophic emergency evolves, and additional supplies are needed, the more remote storage areas can be tapped to replenish or supplement the first push of supplies. Plans to retrieve the additional supplies should be activated as their first set is deployed.

If space is sufficient, the "first push" supplies may be packaged in a cart or trailer to make deployment more rapid. Consideration should be given to the path of travel between the storage site and the destination so that the chosen cart or trailer will successfully clear all obstacles. Further, a detailed inventory should accompany the first push of supplies, indicating "what" and "how many" of each item is immediately available, and where additional supplies are located so that they can be acquired by staff who may not be knowledgeable of how the supplies are organized and stored.[46]

The Staging Recommendations Checklist below serves as a tool to identify considerations that organizations should assess when staging their resources. This tool can be utilized at hospitals that store items with the potential need for immediate use.

The Staging Recommendations Checklist is shown below. The complete tool can be found in the Hospital Operational Tools Manual on pages 88-89.

Staging Recommendations Checklist

- ❑ Develop a process for determining what items will be needed first. Use the concept of last in, first out.
- ❑ Develop a staging plan that does not place one type of material all in one place (e.g., cots all in one area).
- ❑ Develop a plan for how the materials will be moved (e.g., deployable cart).
- ❑ Develop a plan for how items will be set up once they are taken out of storage (e.g., tents, tables, carts and provisions for temperature control, such as ice, ice chests, etc.).
- ❑ Develop a plan that considers that space is often a limiting factor.
- ❑ Develop a plan that considers alternate sites to stage supplies, pharmaceuticals and equipment (e.g., offsite warehouses).
- ❑ Develop a plan that considers using pushcarts for moving materials efficiently and incorporate into staging plan.
- ❑ Label pushcarts with all materials and expiration dates.
- ❑ Incorporate components that account for property into staging plan.
- ❑ Identify ownership of staging areas (state vs. local) and who is responsible for identifying points of distribution.
- ❑ Store pharmaceutical caches in secure containers that can be easily transported (e.g., plastic totes with tear-away locks).
- ❑ Keep non-expired medical supplies separate from medical supplies that have expiration dates.
- ❑ Cover supplies, pharmaceuticals and equipment for protection from the elements for purposes of reducing spoilage and the need to repackage materials.

11. Administration

It is essential that hospitals plan for the administrative functions during a healthcare surge. This section discusses key administrative tasks including patient tracking, patient registration, patient valuables tracking, medical records, document storage, disease reporting, and workers' compensation benefits and how these tasks can be planned for and managed during a healthcare surge.

11.1. Patient Tracking

Although electronic tracking systems are preferred, in cases where electronic systems are unavailable, paper-based tracking is a viable alternative. This section provides recommendations to hospitals on a paper-based patient tracking mechanism to be used during a healthcare surge. The recommendations in this section are based on the following major concepts:

- *Collect minimum necessary data:* Given that an unanticipated disaster may severely limit the capability of the healthcare system to obtain and transfer information, a manual tracking system should be simple to use and focus on collecting minimum data elements.
- *Assign patients a unique identifier:* A fundamental component of an effective tracking system will be to establish a unique patient identifier or disaster incident number.
- *Patient tracking is a priority:* Tracking persons seeking treatment at healthcare system entry points (e.g. hospitals, alternate care sites, and emergency medical system) during a healthcare surge is a high priority for hospitals, alternate care sites and the community.
- *Paper-based tracking is an essential contingency:* Although significant efforts are under way to develop robust electronic patient tracking systems for disaster and emergency purposes, manual back-up processes should be maintained in case of system failures. Paper-based processes reduce compatibility issues when sharing data and total cost associated with purchasing new technology.

11.1.1. Disaster Incident Number

A disaster incident number is a unique identifier used to track patients during a healthcare surge. The policy and form listed below provide an example of how hospitals can use disaster incident numbers and the process and documentation that could be instituted at the county level for the purpose of tracking a patient during a healthcare surge.

A sample Disaster Incident Number Policy and Label are shown below. The complete material can be found in the Hospital Operational Tools Manual on pages 96-98.

A disaster incident number is a unique identifier used to track patients during a healthcare surge. Having a single entity responsible for creating disaster incident numbers is essential to avoiding duplication. Local government is responsible for determining who within the local jurisdiction is responsible for assigning disaster incident numbers. Hospitals should work with their local government to obtain their block of numbers in advance of an emergency. Once disaster incident numbers are obtained, hospitals should document these disaster incident numbers on adhesive labels to affix to patient records, triage tags (tags used by first responders and medical personnel to sort patients based on their medical need) or other unique patient identifier.

Policies and procedures for use are listed below:

1. A disaster incident number is a unique patient identifier that would follow the patient from the point of entry into the healthcare system through discharge for a surge/disaster period.
2. The disaster incident number is comprised of two specific elements of identification:
   a. The first two digits are reflective of the California county code where that patient entered the system. County codes are 1 to 58. Those counties that have a single digit county code are to place a 0 in front of the first digit.
   b. The second set of numbers is a numeric value between 1 and 9,999,999. This number specifically identifies a particular patient within a county.
   c. Example: 01-0000025
3. The disaster incident number will be assigned at any of the following entry points and/or locations:
   a. Hospital – To be assigned at registration
   b. Alternate Care Site/Field Treatment Centers/Shelters – To be assigned at registration
   c. Emergency Medical Services (Field Crew) – To be assigned upon pick up from disaster site
4. The disaster incident number label includes the following elements to be completed by the person performing the intake for that patient. At all entry points, the goal is to fill out as much information as possible at the time the disaster incident number is initiated. When the disaster incident number is initiated by emergency medical services, condition, gender and destination are key data elements.
   a. First Name - patient's first name
   b. Last Name - patient's last name
   c. Street Address - patient's home address
   d. City - patient's city of residence
   e. Social Security Number – the last four digits of a patient's social security number
   f. Telephone - patient's home phone

g. Cell - patient's cell phone
h. Destination - place the patient is being triaged to
i. Condition (Minor compromise, Major compromise, Not compromised, Shelter only)
j. Facility Name

5. The disaster incident number form may include a bar code that represents the number for that form.
6. Ideally, the disaster incident number should replace the triage number on the triage tag. Alternatively, the triage tags can be modified to include space for a disaster incident number label.

Sample disaster incident number label

First Name:	Multiple copies of these adhesive labels are provided to follow the patient as he / she moves
Last Name:	
Disaster Incident Number:	BAR CODE and Disaster Incident Number
Street Address:	
City:	BAR CODE and Disaster Incident Number
Social Security Number:	
Tel:	BAR CODE and Disaster Incident Number
Cell:	
Destination:	BAR CODE and Disaster Incident Number
Facility Name:	

Condition (indicate condition with check mark):	
Minor compromise: [ ]	Not compromised: [ ]
Major compromise: [ ]	Shelter only: [ ]

11.1.2. Patient Tracking Form[47]

The following form is an example of the type of tool that could be instituted at a hospital for the purpose of tracking patients as they are transferred to other hospitals. Additionally, this form could serve as a tool to report hospital census and bed capacity to the Operational Area Emergency Operations Center.

The Patient Tracking Form is shown below. The complete tool can be found in the Hospital Operational Tools Manual on pages 158-160.

PURPOSE: Track patients seeking medical attention within a hospital and disposition of those transferred to other hospitals during a healthcare surge

PATIENT TRACKING FORM

1. INCIDENT NAME: _____	2. DATE/TIME PREPARED: _____	3. OPERATIONAL PERIOD DATE/TIME: _____

4. TRIAGE AREAS IMMEDIATE, DELAYED, EXPECTANT, MINOR, MORGUE

MR # / Triage #	DIN	Last Name	First Name	Sex	DOB/Age	Time n	Area Triaged To or Ambulance Unit	Disposition	Time Out

5. AUTHORIZATION SIGN OFF: _____ 6. CLINICAL PROVIDER: _____

7. SUBMITTED BY: _____ 8. AREA ASSIGNED TO: _____ 9. DATE/TIME SUBMITTED: _____

10. FACILITY NAME: _____ 11. PHONE: _____ 12. FAX: _____

INSTRUCTIONS:

Print legibly and enter complete information.

1. **INCIDENT NAME** If the incident is internal to the hospital, the name may be given by the treating hospital's incident commander. If the incident affects the larger community, the name may be given by a local authority (e.g., fire department, local Emergency Operations Center, etc.).
2. **DATE/TIME PREPARED** Use the international standard date notation YYYY-MM-DD, where YYYY is the year, MM is the month of the year between 01 (January) and 12 (December), and DD is the day of the month between 01 and 31. For example, the fourteenth day of February in the year 2006 is written as 2006-02-14. Use the international standard notation hh:mm, where hh is the number of complete hours that have passed since midnight (00-24), and mm is the number of complete minutes that have passed since the start of the hour (00-59). For example, 5:04 pm is written as 17:04. Use local time.
3. **OPERATIONAL PERIOD DATE/TIME** Identify the operational period during which this information applies. This is the time period established by the treating hospital's incident commander, during which current objectives are to be accomplished and at the end of which they are evaluated. For example, a 12-hour operational period might be 2006-08-16 18:00 to 2006-08-17 06:00.

4. **TRIAGE AREAS** (IMMEDIATE, DELAYED, EXPECTANT, MINOR, MORGUE) For each patient, record as much identifying information as available: medical record number, triage tag number, name, sex, date of birth and age. Identify area to which patient was triaged. Record location and time of diagnostic procedures, time patient was sent to surgery, disposition of patient and time of disposition.
   a. **LAST NAME** Record patient's last name
   b. **FIRST NAME** Record patient's first name
   c. **DIN** Disaster identification number is the unique identifier assigned to that patient for the surge
   d. **MR #/Triage #** Medical record (MR) number and/or triage number assigned to that patient at the hospital
   e. **SEX** Record "M" for male and "F" for female
   f. **DOB/AGE** Date of birth for that patient. Should be recorded as YYYY-MM-DD. If available and/or time permits, age should be recorded as well.
   g. **TIME IN** Record the time the patient was received at the hospital. Use the international standard date notation YYYY-MM-DD. Use the international standard notation hh:mm. Use local time.
   h. **AREA TRIAGED TO** The area or zone a patient is triaged to
   i. **DISPOSITION** The specific area, hospital or location the patient is being transferred or discharged to
   j. **TIME OUT** Record the time of patient transfer or discharge. Use the international standard date notation YYYY-MM-DD. Use the international standard notation hh:mm. Use local time.
5. **AUTHORIZATION SIGN OFF**
6. **CLINICAL PROVIDER**
7. **SUBMITTED BY** Use proper name to identify who verified the information and submitted the form.
8. **AREA ASSIGNED TO** Indicate the triage area where these patients were first seen.
9. **DATE/TIME SUBMITTED** Indicate date and time that the form is submitted to the situation unit leader.
10. **HOSPITAL NAME** Record the hospital name. Use when transmitting the form outside of the treating hospital.
11. **PHONE** Record the hospital phone number.
12. **FAX** Record the hospital fax number.

WHEN TO COMPLETE Hourly and at end of each operational period, or the length of time scheduled for the execution for a given set of operational actions as specified in the incident action plan, upon arrival of the first patient and until the disposition of the last.

11.1.3. Paper-Based Intra-hospital Patient Tracking Process

This procedure is an example of the type of process that could be instituted at a hospital for the purpose of tracking patients as they move through a hospital when electronic systems are unavailable.

The Paper-Based Intra-Hospital Patient Tracking Process is shown below. The complete text including the accompanying policy can be found in the Hospital Operational Tools Manual on pages 156-157.

Policy:
A manual method for tracking patients as they move through the hospital may be required during a healthcare surge when computer systems are unavailable.

Procedure:

1. Prior to the healthcare surge, a hospital will maintain a supply of index cards and determine a method for housing those cards (e.g., “bed board,” index card box).
2. At the point of a healthcare surge, a designated person will be responsible for completing a card for each patient currently in-house. The following information will be recorded on the card:
    a. Patient Name
    b. Date of Birth/Age
    c. Attending Physician
    d. Diagnosis
    e. Level of Care (e.g., Intensive Care Unit, medical surgical, etc.)
    f. Physical Location of the Patient (e.g., east wing, Intensive Care Unit bed 5)
    g. Condition (e.g. critical, stable, etc.)
    h. Disaster Incident Number
3. A card will also be initiated at the point of registration for every patient that is treated, triaged, admitted or discharged once the healthcare surge begins.
4. At midnight each night, a designated staff person or person(s) will makes rounds in the patient care areas to collect newly created cards and ensure that the current location of the patient is documented on the card. At the same time, the location of each patient who already had a card will be verified. The cards will be utilized to document any changes to the patient.
5. The updated and newly collected cards will be filed back into the index card box or other collection device by the patient care area so updates can easily be made the following day.

11.2. Down-Time Procedures for Registration and Medical Records Number

During an emergency, methods for completing registration and obtaining medical records numbers within hospitals may be unavailable. Back-up procedures may be required to maintain these administrative functions that are critical to business continuity and sustaining operations during a healthcare surge.

11.2.1. Sample Registration Down-time Procedures

Most hospitals have existing procedures that can be used during daily system down-time situations. As additional guidance, the following sample registration downtime procedures can be used by hospitals to prepare for downtime during a healthcare surge. Registration staff should manually complete pre-numbered (if available) face sheets which will provide a source of information by which the backlog of manual admissions and registrations can be entered retroactively into the computer once the system becomes available. Sample registration logs, face sheets and insurance verification forms follow the procedures below.

Sample Registration Down-Time Procedures

PURPOSE: To provide admitting and registration services to patients in the event of a healthcare surge capacity. Also, to enable admitting and registration staff to complete registration processes during healthcare surge capacity down-times.

PROCEDURE: During healthcare surge capacity and computer down-time, the following guidelines for minimum data collection are recommended:

- Create a disaster packet that includes the following:
  - Paper Face Sheets
  - Emergency Room Record/Triage Sheets
  - Charge Ticket
  - Order Sheets
  - Wrist Band
  - Blank Labels
  - Consent to Treat Forms
- Include the disaster incident number on all disaster packet materials.
- Maintain a reasonable supply of disaster packets that could be used in the event of a healthcare surge (at least 100 packets at each hospital).
- Create the packets with pre-numbered documents, labels and wrist bands.
- Maintain a block of down-time specific medical record numbers and account numbers to be used in the event of a healthcare surge.
- Maintain a log of all patients registered with their medical record number and account number. This might require multiple logs at each registration/access point.

- All registration personnel may need to complete a paper face sheet (see sample face sheet for example).
- Although insurance verification and eligibility may be relaxed during a disaster, this information should be collected as soon as possible (see sample insurance verification form).
  - Verify Eligibility
  - Payer/Provider Care Notification
  - Authorization
- If multiple copies of the patient face sheet are required in the hospital, consider maintaining a supply of carbon paper with the disaster packet supply.
- Collect a minimum data set to facilitate the ability to complete the claim forms in the event of a disaster. This will depend upon governmental and private payer approval. Hospitals should initiate discussion with their payer representatives to discuss minimum data sets.
  - Name/Guardian
  - Sex
  - Date of birth
  - Social security number
  - Name of Payer
  - Primary Care Provider

Sample Registration Log

The Sample Registration Log is shown below. The complete tool along with the accompanying policy can be found in the Hospital Operational Tools Manual on pages 180-181.

#	Medical Record #	Disaster Incident #	Last Name	First Name
1				
2				
3				
4				
5				
6				
7				
8				

Sample Paper-Based Face Sheet[48]

The Sample Paper-Based Face Sheet is shown below. The complete tool along with the accompanying policy can be found in the Hospital Operational Tools Manual on pages 176-178.

Patient Information:
Name: _____DIN:_____DOB: _____SSN: _____Sex: __Male __Female
Mailing Address:_____Zip:_____City:_____County:_____
Home Phone: _____ Cell/Message Phone: _____
Marital Status: __Single __Married __Widow __Divorced __Separated
Name of Spouse: _____Maiden Name: _____
Race/Ethnicity: _____ Primary Language: _____Translator Required? __ Yes __ No
Employer Name: _____Employers Phone Number: _____
Employer Address if Work Comp related: _____Occupation: _____

Accident/Injury/Condition Information:
Type of accident: _____Date of Accident/Injury: _____Time: _____
Condition:_____
Location: _____
Is there legal action involved? _____Attorney or Insurance name: _____
Phone_____Address_____
Policy ID#: _____ Claim#: _____Adjuster: _____
Is there a police report? _____Was there another car involved? _____Who was at fault? _____
If other involved do you have there Insurance information? _____
_____

Guarantor information (Person responsible for bill, co-pay, deductible, SOC etc.)
Name: _____DOB: _____SSN: _____
Address: _____Zip: _____City:_____
Home Phone Number: _____Work Phone Number: _____
Employer Address: _____Occupation: _____

Emergency Contact:
Name: _____Relationship: _____Phone #: _____
(Last Name, First Name)

Insurance Information: (Copy of Insurance Card and Identification Required)
Name of insurance Coverage: _____Policy#: _____Group#_____
Is this a HMO plan? __Yes __NO. If yes name the Medical group: _____
Primary Care Physician _____Co-pay $_____

Subscriber Information:
Name_____Relation_____DOB_____SSN_____
Last Name, First Name

Employer _____Employer's Work Phone_____

Transferring Facility: _____Referring Physician: _____

FOR EMPLOYEE USE ONLY:
If the patient has "No" Insurance was the POE Letter Provided _Yes _No
Is the patient under 21 or over 65 years of age? _Yes _No
Is the patient legally disabled? _Yes _No
Is the patient pregnant? _Yes _No
Does the patient have children under the age of 21 residing in the home? _Yes _No
Forms Completed: _ T & C _NOPP _MCARE MRL & ADDENDUM _Insurance Letter _DFR _ EEAF _ITI
_____Eligibility Verified: _Active _Inactive Financial Counselor Referral: _Yes_ No
_____Runner_____Follow Up

The Sample Paper-Based Insurance Verification Form is shown below. The complete tool along with the accompanying policy can be found in the Hospital Operational Tools Manual on pages 178-179.

Sample Paper-Based Insurance Verification Form[49]

Medical Center
Insurance Verification/Pre-certification

Tax ID#	MJC#	M/CSNU#	MCD#	B/C#
Type of Service: ☐ Inpatient ☐ Day Surgery ☐ MRI ☐ Other _____				
Today's Date	Patient's Name	Disaster Incident #	Date of Adm/Service	
Insurance Carrier 1			Primary ☐ Secondary ☐ Tertiary ☐ Payor 2	
☐ HMO Plan ☐ POS Plan ☐ PPO Plan ☐ Indemnity (Commercial) Plan 3 ☐ Worker Comp Indemnity ☐Workers Comp Managed			☐ In-network ☐ Out of Network 4	
CWF/HDX/Medicheck Checked: ☐ Yes ☐ No Active Coverage ☐ Yes ☐ No 5			Card Copied ☐ Yes ☐ No 6	
Referral required for the Facility: ☐ Yes ☐ No Active Obtained ☐ Yes ☐ No Referral Number: 7				
Subscriber: 8			Relationship to patient 9	
ID/Policy Number: 10	Group Number: 11		Coverage Effective Date: 12	
WC/Auto Claim #: 13	Date of Accident/Injury: 14		Open Claim ☐ Yes ☐ No 15	
Verification Phone # 16	Contact Person/Adjuster 17			
Deductible/co-pays: 18	Frequency: 19		Major Medical Benefits 20	
Maximum $ Policy Limits 21	Maximum Benefit Days: 22			
Benefits: 23				
Claims: 24				
Attention:				
Verification Completed By: 25			Date:	
Pre-certification Required: ☐ Yes ☐ No 26	Pre-Cert Phone Number: 27		Contact Person: 28	
Pre-certification ☐ Initiated Only-UM Dept must call with clinical information ☐ Denied ☐ Approved ☐ Number of Days Approved 29				
Pre-certification Authorization/Reference Number: 30				
Pre-certification Initiated By: 31			Date & Time	
Pre-certification Completed by or confirmed by: 32			Date & Time	
Miscellaneous/Comment Section: 33				

11.2.2. Minimum Requirements for Medical Record Documentation

During a disaster, normal methods for collecting medical record information electronically may be unavailable. Therefore, paper-based methods for capturing medical record information may be required. Furthermore, it may be reasonable to expect that most healthcare resources will be devoted to patient care and administrative functions will need to be reduced to minimum requirements under healthcare surge conditions. This section recommends minimum requirements for medical record documentation during healthcare surge.

The sample short form included below and in the Hospital Operational Tools Manual is an example of the type of patient medical record that could be initiated during a healthcare surge when electronic systems for documenting the provision of care are unavailable. The short form medical record should be utilized to capture pertinent assessment, diagnosis and treatment information. This form is not expected to meet existing medical records documentation requirements, rather, it serves as a recommended set of elements that can be considered as accepted documentation during healthcare surge.

The Short Form Medical Record is shown below. The complete tool can be found in the Hospital Operational Tools Manual on pages 182-184.

Policy

This Short Form Medical Record should be completed by hospital personnel for individuals seeking medical care.

Instructions

This document should be completed for individuals seeking medical attention.

Demographic

Patient Demographic Information – include patient name, date of birth, parent/guardian, disaster incident number[50] and/or medical record number, known allergies and primary physician. A disaster incident number is a unique identifier used to track patients during a healthcare surge. If patient labels are used within an organization, and they are available, a label can be affixed in place of handwriting the information.

History

- Chief Compliant - enter patient's primary complaint upon presenting for care
- Significant Medical History - enter notes on patient's medical history
- Glasgow Coma Scale - enter score for each area
- Field Triage Category - enter category
- Site Triage Category - enter category
- Pupil Size - enter pupil size

- Reactive - circle yes/no
- Pain - circle patient's level of pain
- Temp - indicate patient's temperature
- Pulse - indicate patient's pulse
- Respiration - enter patient's rate of respiration
- Blood Pressure - enter patient's systolic and diastolic blood pressure
- Intake - enter patient fluid intake
- Output - enter patient fluid output
- Special Dietary Needs - enter patient's special dietary needs
- Medications - indicate medications the patient is currently taking including name, dose, route, and time
- Last Menstrual Period - indicate last period
- Pregnancy Status - indicate status

Physical Exam

- Physical Exam - This section should be utilized to capture comments relative to the assessment of the patient's cardiovascular, pulmonary and other body systems.

Re-Assessment

- This section is to be completed as a secondary assessment prior to a procedure. It includes a place for a set of vital signs and any lab results.

Procedure/Disposition

- This section of the form includes space to document the following:

• Pre- and post-procedure diagnosis • Procedure performed • Findings • Condition of the patient post procedure • A check box to indicate if discharge instructions were provided in printed form and/or verbally • Dietary restrictions • Activity restrictions	• Discharge medications • Follow-up visit information • Condition on discharge/transferred to • Date, time and physician's signature authorizing discharge • Time admitted • Physician order notes/other notes

Short Form Medical Record

Demographic

Patient Name:_____ DOB/Age:_____

Parent / Guardian:_____ Primary Physician:_____

DIN:_____ MRN:_____

Allergies:_____ ☐ NKA

History

Chief Complaint:_____

Significant Medical History:_____

Last Menstrual Period:_____ Pregnancy Status:_____

Glasgow Coma Scale	
Eye	
Motor	
Verbal	
Total	

Field Triage Category: _____ Site Triage Category:_____

Pupil Size L:_____ Reactive: ☐ Yes ☐ No

Pupil Size R:_____ Reactive: ☐ Yes ☐ No

Circle pain (Adult): 0 (no pain) 1 2 3 4 5 6 7 8 9 10 (worst pain)

Circle pain[1] (Child/Other

Time recorded:			
Temp:			
Pulse:			
Respiration:			
Blood Pressure:			

Notes:_____

Intake		Output	
Total		Total	

Special Dietary Needs:_____

Medications

Name	Route		Dose	Time Frequency

Physician initials: _____ Nurse initials:_____ Other initials:_____

Physical Exam

Cardiovascular:_____ Pulmonary:_____

Neurological:_____

Other Significant Findings:_____

Physician initials:_____

Re-Assessment

Date:_____ Time:_____

System Review: Temp:____ Pulse:____ Respiration:____ Blood Pressure:____

Lab Results:_____ X-ray Results:_____

Physician initials: _____ Nurse initials:_____ Other initials:_____

Procedure / Disposition

Pre-Procedure DX:_____ Post-Procedure DX:_____

Procedure:_____ Findings:_____

Condition of Patient Post Procedure: ☐ Critical ☐ Guarded ☐ Stable

Discharge Instructions (YES/NO): Written_____ Verbal_____

Diet: ☐ Regular ☐ Soft ☐ Liquid ☐ Other:_____

Activities: ☐ No Restrictions ☐ Restrictions as Follows:_____

Discharge Medications:_____

Follow-Up Visit: When_____ NA:_____

Condition at discharge: ___ Critical ___ Guarded ___ Stable ___ Fair ___Deceased

___ Temp ___Pulse ___Respiration ___Blood Pressure

Discharge: ☐ Home ☐ Shelter ☐ ACS ☐ SNF ☐ Deceased Date: _____

☐ Transfer:_____ ☐ Other:_____ Time: _____

Admitted: ☐ Time admitted:_____

Physician order:_____

_____

Notes: _____

_____

Physician initials: _____ Nurse initials:_____ Other initials:_____

Wong, DL, Hockenberry-Eaton M, Wilson D, Winkelstein ML, Schwartz P: *Wong's Essentials of Pediatric Nursing*, ed. 6, St. Louis, 2001, p.1301.

11.2.3. Hospital Reporting Requirements

During a declared healthcare surge, it may be difficult for hospitals to adhere to all the current reporting requirements. However, it is recommended that the following reporting categories remain in effect for purposes of managing resources and mitigating the adverse health effects on the population:

- Disease Reporting/Notification
- Birth and Death Reporting
- Reporting Transfers of Patients
- Inventories of Medical Supplies

For all remaining reporting requirements, a waiver of sanctions, penalties and/or time requirements during the declared healthcare surge period may be appropriate or become necessary. To the extent hospitals are able, they would be expected to make reasonable efforts to report information during the declared disaster time period or as soon as practical. In cases in which information is destroyed, the reporting of information is not practical and, therefore, no issue of penalty exists.

The table below provides a list of reporting requirements, corresponding time requirements and penalties for hospitals operating under normal conditions. Additionally, it identifies the entity responsible for receiving reporting information. Column titles are defined as follows:

Hospital Reporting Requirements: Lists hospital reporting requirements under normal conditions

Time Requirement: Defines time period by which reporting requirement must be met

Penalty: Describes the penalty associated with not meeting the corresponding reporting requirement

Receiving Entity: Organization/agency/governing body to receive required reporting information

Hospital Reporting Requirement	Time Requirement	Penalty	Receiving Entity
Health Response Reporting			
Disease Reporting/Notification			
a) 17 CCR 2500(b),(h),(j) b) Health and Safety Code Sections 120130, 120176, 120185, 120190, 120250 Anthrax, Botulism (Infant,	Immediate	Per Health and Safety Code Section 120275, failure to report a disease listed in statute or regulation is a misdemeanor, and for licensed facilities, is a condition of licensure under 22	Local health officer

Hospital Reporting Requirement	Time Requirement	Penalty	Receiving Entity
Food borne, Wound, Other), Brucellosis, Cholera, Ciguatera Fish Poisoning, Dengue, Diarrhea of the Newborn-Outbreaks, Diphtheria, Domoic Acid Poisoning (Amnesic Shellfish Poisoning), Escherichia coli O157:H7 Infection, Hantavirus Infections, Hemolytic Uremic Syndrome, Meningococcal Infections, Paralytic Shellfish Poisoning, Plague-Human or Animal, Rabies-Human or Animal, Scombroid Fish Poisoning, Severe Acute Respiratory Infection (SARS), Shiga toxin (detected in feces), Smallpox (Variola), Tularemia, Varicella (deaths only), Viral Hemorrhagic Fevers (e.g., Crimean-Congo, Ebola, Lassa and Margurg viruses), Yellow fever, Occurrence of any unusual disease, Outbreaks of any disease (including diseases not listed in 17 CCR 2500)		CCR 70737. New diseases may be added to the regulatory list, but a penalty does not attach until six months from the date the new disease was published in regulation. Failure to report may result in suspension or revocation of license. Note that local health officer may take whatever action required to control the spread of disease.	
Amebiasis, Anisakiasis, Babesiosis, Campylobacteriosis, Colorado Tick Fever, Conjunctivitis, Cryptosporidiosis, Encephalitis, Specify etiology: viral, bacterial, fungal, parasitic, foodborne disease, haemopilus influenzea, invasive disease, hepatitis A, Listeriosis, lymphocytic choriomeningitis, malaria, measles (rubeola), meningitis, specify etiology, viral, bacterial, fungal, parasitic, pertussis (whooping cough),	1 Day	Per Health and Safety Code Section 120275, failure to report a disease listed in statute or regulation is a misdemeanor, and for licensed facilities, is a condition of licensure under 22 CCR 70737. New diseases may be added to the regulatory list, but a penalty does not attach until six months from the date the new disease was published in regulation. Failure to report may result in suspension or revocation of license.	Local health officer

Hospital Reporting Requirement	Time Requirement	Penalty	Receiving Entity
piliomyelitis, paralytic, psittacosis, Q fever, relapsing fever, salmonellosis (other than typhoid fever), shigellosis, streptococcal infections (outbreaks and individual cases in food handlers and dairy workers), swimmer's itch, syphilis, trichinosis, tuberculosis, typhoid fever, typhus fever, vibrio infections, water associated disease, west nile virus infection, yersiniosis.		Note that local health officer may take whatever action required to control the spread of disease.	
Chancroid, Chlamydial Infections, Coccidioidomycosis, Cysticercosis, Echinococcosis (Hydatid Disease), Ehrlichiosis, Giardiasis, Gonococcal Infections, Hepatitis, Viral, Hepatitis B (specify acute or chronic), Hepatitis C (specify acute or chronic), Hepatitis D (Delta), Hepatitis (other, acute), Kawasaki Syndrome, Legionellosis, Leprosy (Hansen Disease), Leptospirosis, Lyme Disease, Mumps, Non-Gonococcal Urethritis (excluding lab confirmed Chlamydial infections), Pelvic Inflammatory Disease, Reye Syndrome, Rheumatic Fever, Acute, Rocky Mountain Spotted Fever, Rubella (German Measles) Rubella Syndrome, Congenital, Tetanus, Toxic Shock Syndrome, Toxoplasmosis, Typhus Fever.	7 Days	Per Health and Safety Code Section 120275, failure to report a disease listed in statute or regulation is a misdemeanor, and for licensed facilities, is a condition of licensure under 22 CCR 70737. New diseases may be added to the regulatory list, but a penalty does not attach until six months from the date the new disease was published in regulation. Failure to report may result in suspension or revocation of license. Note that local health officer may take whatever action required to control the spread of disease.	Local health officer

Hospital Reporting Requirement	Time Requirement	Penalty	Receiving Entity
Birth and Death Reporting			
a) Birth Reporting (Health and Safety Code Section102400 *et seq.*)	10 days from DOB	Misdemeanor (Health and Safety Code Section 103775)	Local registrar
b) Death Reporting (Health and Safety Code Section 102775 *et seq.)*	8 calendar days after death and prior to disposition of human remains	Misdemeanor (Health and Safety Code Section 103775)	Local registrar
c) Mass Fatalities (Health and Safety Code 103450)	None identified	Misdemeanor (Health and Safety Code Section 103775)	County Superior Court
Reporting Transfers of Patients			
a) Known violations (Health and Safety Code Section 1317.4)	1 week	The penalty provision is under Health and Safety Code Section 1317.6, and subjects the facility to civil penalties not to exceed $25,000 per violation and revocation of its emergency medical service permit. Physicians are subject to fines of up to $5,000 per violation. Facilities are also required to have transfer policies and protocols as a condition of licensure. Failure to have requisite policies and protocols subjects facilities to fines up to $1,000 per day after 60-days prior written notice from the department that the transfer policies and protocols are non-compliant.	CDPH
b) Transfer records (Health and Safety Code Section 1317.4)	Annually	Same as above	CDPH
Inventories of Medical Supplies (Health and Safety Code Section 120176)	Report upon request of the local health officer	It is a misdemeanor to violate an order of the local health officer related to or respecting quarantine or disinfection.	Local health officer

Hospital Reporting Requirement	Time Requirement	Penalty	Receiving Entity
Law Enforcement Reporting			
Suspicious Injury Reports (Penal Code Section 11160 *et seq.*)	Immediately or as soon as practicably possible.	A misdemeanor subject to up to six months jail and/or $1000 fine.	Local law enforcement
Crime Scene/Evidence Collection Requirements (45 CFR 164.512 (f)(3),(5),(6) (describing permitted disclosures under HIPAA, in accordance with certain requirements)	Covered entities *may* disclose certain protected health information, but no timeframe for making a permitted disclosure is required.	Permissible disclosures; no penalty identified for failure to report.	Local law enforcement
Crime Reporting/Law Enforcement			
a) Violence ag. hospital personnel (Health and Safety Code Section 1257.7 (d))	Within 72 hours	Misdemeanor if knowingly interfering with or obstructing the lawful reporting process.	Local law enforcement
b) Violence ag community healthcare worker (Labor Code Section 6332)	None identified	Subject to surprise inspection, complaint based investigation, and fines.	Division of Labor Statistics and Research in the form and detail and within the time limits prescribed by the Division of Labor Statistics and Research.
c) Child abuse and neglect (Penal Code Section 11164 et seq.)	Immediately or as soon as practicably possible. Written report filed within 36 hours.	Misdemeanor punishable by up to six months confinement in a county jail or by a fine of one thousand dollars ($1,000) or both.	Police department, sheriff's department, county designated probation department, or county welfare department.
d) Elder and dependent adult abuse (Welfare and Institutions Code Section 15600 et seq.)	By telephone immediately or as soon as practicably possible, and by written report sent within two working days.	Facility type based (e.g., if a Skilled Nursing Facility, to local ombudsman); or to the local law enforcement agency.	A misdemeanor, punishable by not more than six months in the county jail, by a fine of not more than one thousand dollars ($1,000), or both.

Hospital Reporting Requirement	Time Requirement	Penalty	Receiving Entity
e) Facility neglect or abuse (Penal Code Section11161.8)	Immediately or as soon as practicably possible.	Confinement in a county jail or a fine of $1,000 or both.	Local law enforcement
Administrative Reporting			
Reportable "Unusual Occurrences" (22 CCR 70737, 71535)	By telephone as soon as reasonably practical	Condition of licensure; subject to suspension or revocation of license.	Local health officer and California Department of Health Services District Office
Office of Statewide Health Planning and Development Reporting Requirements (Health and Safety Code Section 128675 *et seq.*)	Reasonable time	Civil penalty of $100 per day (Health and Safety Code Section 128770)	Office of Statewide Health Planning and Development
Cancer Registry (Health and Safety Code Section 103875 *et seq.*)	None identified	No penalty identified for failure to report; subject to recoupment of all costs expended by the California Department of Health Services to obtain the information if the hospital fails to report.	To the department or the authorized representative of the department
Reporting Adverse Reactions to Vaccinations (42 USC Section 300aa-14, 42 USC Section 300aa-25)	None identified	The National Vaccine Program including the National Vaccine Injury Compensation Program that addresses compensation for injuries or deaths related to vaccinations. No penalty was identified for failing to report but program funds are tied to reporting.	Director appointed by Secretary of Health and Human Services.
Reports Under the Safe Medical Device Act of 1990 (21 USC 360(i)(b), 21 CFR 803.10, 803.22, 803.19, 803.33	Report as soon as practicable but not later than 10 working days after known death, serious injury or other significant adverse device experiences identified by the Secretary	Civil money penalty based on the type of infraction, and ranging from $15,000 per infraction to $1,000,000 aggregate. (21 USC Section 333 (g).)	Secretary of Health and Human Services or his/her designee.

Hospital Reporting Requirement	Time Requirement	Penalty	Receiving Entity
Medication Errors (16 CCR 1711(a)(b); Business and Professions Code Section 4125	A pharmacy quality assurance program and record within 2 days of a medication error that is immediately retrievable by the Board of Pharmacy if requested.	Requirement of the pharmacy; subject to loss of permit or license to operate.	Maintained by the hospital for one year after discovery of error and subject to review by board, but protected as a deemed peer review document to promote quality.
Occupational Injuries and Illnesses (Labor Code Section 6409, 8 CCR 14003)	Within five days after the employer obtains knowledge of the injury or illness. In every case involving a serious injury or illness, or death, in addition to the report required by subdivision (a), a report shall be made immediately by the employer to the Division of Occupational Safety and Health by telephone or telegraph.	Penalties vary based on infraction, seriousness of injury and if a specific statute prescribes a penalty. For example, if failure to report a serious injury or death, a civil penalty of not less than five thousand dollars ($5,000) applies. Other penalties are codified at Labor Code Section 6423 *et seq*.	Department of Industrial Relations, through its Division of Labor Statistics and Research
Burns and Smoke Inhalation Injuries (Health and Safety Code Section13110.7)	Burn Centers: after treatment ends, discharge or death	None identified	State fire marshall
Joint Commission Sentinel Event Reporting (Joint Commission Manual, SE-2, IV - Reviewable Sentinel Events; SE-5 - Required Response to a Reviewable Sentinel Event, PI.1.10, PI.2.20, PI.2.30, PI.3.10)	45 days	Subject to loss of accreditation	Joint Commission

Hospital Reporting Requirement	Time Requirement	Penalty	Receiving Entity
Medicare Claims Processing Manual, Chapter 1 – General Billing Requirements, Exhibit 1 – Data Element Requirements Matrix (FI) (Rev. 145, 04-23-04) A3-3600, Addendum L	Within 1 year of the service date (Social Security Act Section 1848(g)(4))	Assigned claims submitted more than 1 year after the service date will be subject to a 10 percent payment reduction (Social Security Act Section 1848(g)(4))	Centers for Medicare and Medicaid Services
Medi-Cal Inpatient/Outpatient Provider Manual, Part 2 – Inpatient Services (IPS), UB-92 Completion: Inpatient Services, UB-92 Submission and Timeliness Instructions.	Original (or initial) Medi-Cal claims must be received by Electronic Data Systems (EDS) within six months following the month in which services were rendered	Reduced rate or denial of payment. However, delay reason codes may be entered in cases of late submission and to avoid penalty	Electronic Data Systems (EDS)
Reporting Work-Connected Fatalities and Serious Fatalities: 8 CCR 342. **Assessment of Civil Penalties: 8 CCR 337(a)(6).**	Immediately means as soon as practically possible but not longer than 8 hours after the employer knows or with diligent inquiry would have known of the death or serious injury or illness. If the employer can demonstrate that exigent circumstances exist, the time frame for the report may be made no longer than 24 hours after the incident.	Minimum penalty of $5,000	District Office of the Division of Occupational Safety and Health

11.3. HIPAA Compliance during Healthcare Surge

During a healthcare surge, hospitals may need to share patient information in a catastrophic event to provide urgent care to an increased number of patients. HIPAA rules were never

intended to prevent the delivery of healthcare during an emergency and as such the federal Department of Health and Human Services has indicated they will not be imposing HIPAA compliance fines on providers during a healthcare surge. This protection is in alignment with HIPAA regulations that indicate covered entities may use or disclose protected health information without facing HIPAA sanctions under the following instances:

- 45 CFR 164.510(b)(4) indicates that "a covered entity may use or disclose protected health information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating with such entities the uses or disclosures permitted by 45 CFR 164.510 (b)(1)(ii). [These are the uses or disclosures permitted to notify or assist in the notification of a family member or personal representative.]
- The requirements in 45 CFR 164.510 (b)(2) and (3) apply to such uses and disclosures to the extent that the covered entity, in the exercise of professional judgment, determines that the requirements do not interfere with the ability to respond to the emergency circumstances.

Additionally, the federal Department of Health and Human Services issued the following guidelines on HIPAA emergency provisions. This guidance can be found at http://www.hhs.gov/ocr/hipaa/EnforcementStatement.pdf and is excerpted below:

Providers and health plans covered by the HIPAA Privacy Rule can share patient information in all the following ways:

1. TREATMENT. Healthcare providers can share patient information as necessary to provide treatment. Treatment includes
   - sharing information with other providers (including hospitals and clinics),
   - referring patients for treatment (including linking patients with available providers in areas where the patients have relocated), and
   - coordinating patient care with others (such as emergency relief workers or others that can help in finding patients appropriate health services).
   - Providers can also share patient information to the extent necessary to seek payment for these healthcare services.
2. NOTIFICATION. Healthcare providers can share patient information as necessary to identify, locate and notify family members, guardians, or anyone else responsible for the individual's care of the individual's location, general condition, or death.
   - The healthcare provider should get verbal permission from individuals, when possible; but, if the individual is incapacitated or not available, providers may share information for these purposes if, in their professional judgment, doing so is in the patient's best interest.
   - Thus, when necessary, the hospital may notify the police, the press, or the public at large to the extent necessary to help locate, identify or otherwise notify family members and others as to the location and general condition of their loved ones.

- In addition, when a healthcare provider is sharing information with disaster relief organizations that, like the American Red Cross, are authorized by law or by their charters to assist in disaster relief efforts, it is unnecessary to obtain a patient's permission to share the information if doing so would interfere with the organization's ability to respond to the emergency.

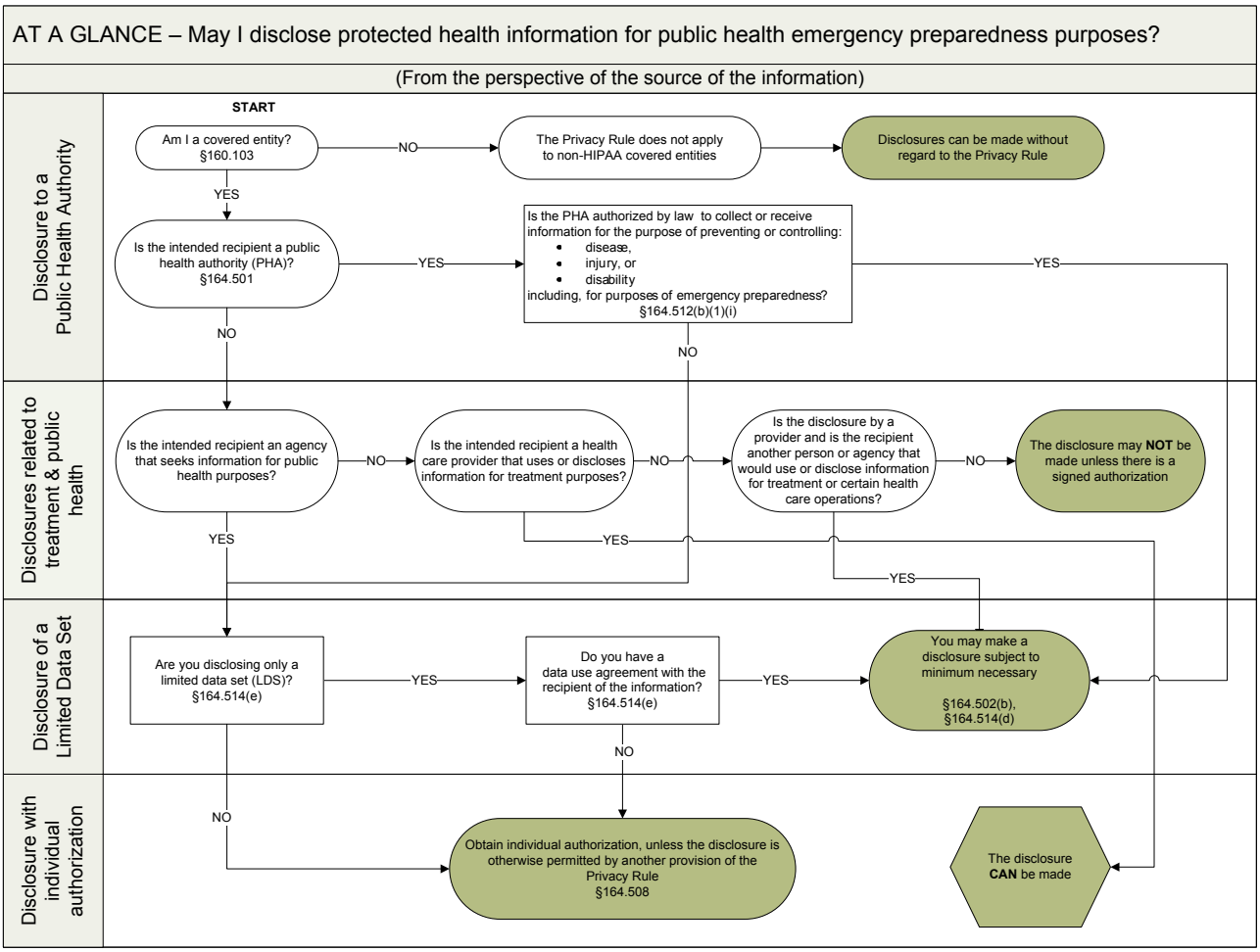
3. IMMINENT DANGER. Providers can share patient information with anyone as necessary to prevent or lessen a serious and imminent threat to the health and safety of a person or the public -- consistent with applicable law and the provider's standards of ethical conduct.
4. FACILITY DIRECTORY. Healthcare facilities maintaining a directory of patients can tell people who call or ask about individuals whether the individual is at the facility, their location in the facility, and general condition.

The U.S. Department of Health and Human Services has developed a flow chart depicting when protected health information can be disclosed during an emergency. This flow chart is displayed on the following page.

The Decision Making Tool for Disclosure of Protected Health Information (PHI) is shown on the following page. The complete tool can be found in the Hospital Operational Tools Manual on pages 94-95.

For additional guidance on using this tool, see the federal Health and Human Services website at: http://www.hhs.gov/ocr/hipaa/decisiontool/.

Decision Making Tool for Disclosure of Protected Health Information



11.4. Patient Valuables Tracking

Most hospitals currently have a procedure in place to track patient valuables upon admission. Planners should evaluate current procedures to determine how they can be streamlined for use in a surge event.

11.4.1. Sample Procedure for Patient Valuables Tracking[51]

This policy and sample tracking form are an example of the type of process and documentation that could be instituted at a hospital to track patient valuables during a healthcare surge.

PURPOSE	To establish a uniform and secure procedure for the collection, storage, safeguarding and release of patient valuables.
POLICY LIABILITY LIMITS	A. The hospital shall not assume responsibility for damage to or loss of a patient's personal valuables or property unless negligence or willful wrongdoing on the part of the facility or its employees can be shown. B. Patient or patient representative shall be advised to send personal valuables or property home or make independent arrangements for off-site storage. If this is not possible, patients will be advised as follows: 1) The facility accepts no responsibility for the loss or damage of any personal valuables and property retained by the patient except where a negligent act contributed to a loss or damage. 2) The facility maintains a reasonable secure space for keeping small-size valuables and will not assume responsibility for the loss or damage of these items.
DEFINITIONS	A. Personal valuables include but are not limited to cash, checks, wallet contents, coin purse, keys, pocket knifes, watches, hearing aids, miscellaneous papers, jewelry, personal electronic devices. B. Property includes dentures or other dental appliances, glasses and other optical aids, clothing, footwear, purses, suitcases, walkers, wheelchairs, canes and other articles of unusual value and small size.

11.4.2. Inventorying Valuables

Patients should be advised to not bring valuables with them to the hospital. During the admitting process, a designated staff member should advise the patient that valuables such as jewelry, credit cards and cash (more than $20) will not be properly secured in the hospital.

Patients should be strongly encouraged to arrange with family members or others to secure their valuables.

The Hospital Patient Valuables Deposit Form is shown below. The complete tool can be found in the Hospital Operational Tools Manual on pages 147-149.

Instructions

In the event a patient must store valuables with the hospital for safekeeping, a designated hospital staff member should inventory the valuables and complete a patient valuables deposit form in the presence of the patient. The disaster incident number should be included on the patient valuables deposit form. The hospital staff should:

1. Inventory and document valuables on the form.
2. Describe jewelry generically:

   "Yellow metal" is used to describe gold.

   "White metal" is used to describe silver.

   Precious and semi-precious stones should be described by color and not by the type of stone.

   Example: A man's gold Timex watch with five diamonds would be described as "Man's yellow metal watch with five clear stones, Timex."
3. Conduct the inventory in the presence of the patient. If the patient is not able to sign the form or observe the inventorying of valuables, a friend or family member may do so. If a friend or family member is not present, another hospital staff must witness the process.
4. List credit cards individually by account number.
5. Document personal blank checks, including the total number of blank checks.
6. Record currency by denomination and also the total amount. Large amounts of currency being held (more than $1,000) should be reported to hospital security for a determination on whether further security precautions should be taken.
7. Record "none" if no currency is deposited. The space for currency should not be left blank.
8. Visually assess the patient for valuables such as jewelry, rings, necklaces, earrings, etc., and encourage the patient to include all items in the inventory.
9. Have a witnessing hospital staff member verify the inventory and document its accuracy by signing the patient valuables deposit form. This should be performed prior to placing the valuables into a patient valuables envelope.
10. Write the control number from the patient valuables envelope on the patient valuables deposit form.
11. Have the patient, family member or friend sign the patient valuables deposit form. If they are not available or able to sign, note in the signature slot that the patient is unable to sign.
12. Place the valuables into the patient valuables envelope, along with the original copy of the patient valuables deposit form, and seal it in the presence of the patient and the witnessing

hospital staff member.

13. Provide a second copy of the patient valuables deposit form to the patient and include the third copy in the patient's chart.
14. Complete a patient valuables control log that is kept near the storage place for patient valuables (e.g., a safe) and have a witnessing hospital staff member initial the log.
15. Deposit the envelope in a secured container in the presence of a witnessing hospital staff member.

IMPORTANT! RECORD VALUABLES PAK NUMBER	
PATIENT NAME	
MEDICAL RECORD #	DISASTER INCIDENT #
RECEIVED BY	DELIVERED TO

RECEIVED FROM PATIENT OR REPRESENTATIVE

I leave the following items of personal property in the care, control and custody of the hospital and I acknowledge that the items shown here have been put in a container, sealed and marked with my name, and that this has been done in my presence.

SIGNATURE OF DEPOSITOR	
DATE DEPOSITED	WITNESSED BY

RETURNED TO PATIENT OR REPRESENTATIVE

I hereby acknowledge that all personal property deposited with the hospital on the above mentioned date has been returned to me.

SIGNATURE OF DEPOSITOR	
DATE RECEIVED	WITNESSED BY

HOSPITAL NAME
ADDRESS
CITY, ST ZIP CODE
PHONE NUMBER

PATIENT'S VALUABLES DEPOSIT

CURRENT COUNT		CREDIT CARDS/CHECKS
X	$100=	
X	50=	
X	20=	
X	10=	
X	5=	
X	2=	
X	1=	
Total Currency	$	
Total Coin	$	
Total Deposit	$	

OTHER VALUABLES	
COMPLETED BY	DATE

11.4.3. Patient Valuables Envelope

Valuables should be stored in an envelope, ideally, a plastic, tamper-proof envelope. If one is unavailable, consider using a large manila envelope.

- The envelopes should be consecutively numbered for auditing and control purposes, if possible.
- A designated manager should ensure that patient-valuables envelopes are available to the triage, emergency department and admitting areas. The amount should be consistent with operational needs.
- Surplus envelopes should be securely stored.

11.4.4. Patient-Valuables Control Log

The Patient-Valuables Control Log is used to document, track and audit valuables deposited or removed from the patient-valuables secured locations. This log should indicate the date and time the deposits or releases occurred, the staff person releasing the valuables, the patient's name, the witnessing hospital staff member's initials, and the control number of the patient-valuables envelope.

The Patient Valuables Control Log is shown below. The complete tool can be found in the Hospital Operational Tools Manual on pages 161-162.

PATIENT VALUABLES CONTROL LOG								
Date Received	Patient Name	Disaster Incident Number	Envelope Control Number	INITIALS		Date Released to Patient	INITIALS	
				Employee Witness	Employee Depositing Valuables		Employees Witness	Employee Releasing

11.5. Workers' Compensation for Hospital Employees and Volunteers

Workers' compensation covers injuries or illnesses that occur due to employment. Hospitals may have employees injured at work during a catastrophic emergency and workers' compensation is an important mechanism with which these organizations should be familiar. Human Resources departments have specific policies and procedures for reporting injuries sustained at work and should plan for injuries during a healthcare surge. Workers' compensation is also an important funding source because it covers "every person in the service of an employer under any appointment or contract of hire or apprenticeship, express or implied, oral or written, whether lawfully or unlawfully employed."[52] This includes aliens and minors, making it one of the only funding sources to cover the costs of healthcare for individuals not entitled to other programs because of their legal status.

While workers' compensation covers various types of catastrophic emergencies, injuries and illnesses including single events or injuries caused by repeated exposure, it does not cover first aid, which is defined in the California Labor Code 5401 as "any one-time treatment, and any follow-up visit for the purpose of observation of minor scratches, cuts, burns and splinters, or other minor industrial injury, which do not ordinarily require medical care. This one-time treatment, and follow-up visit for the purpose of observation, is considered first aid even though provided by a physician or registered professional personnel."

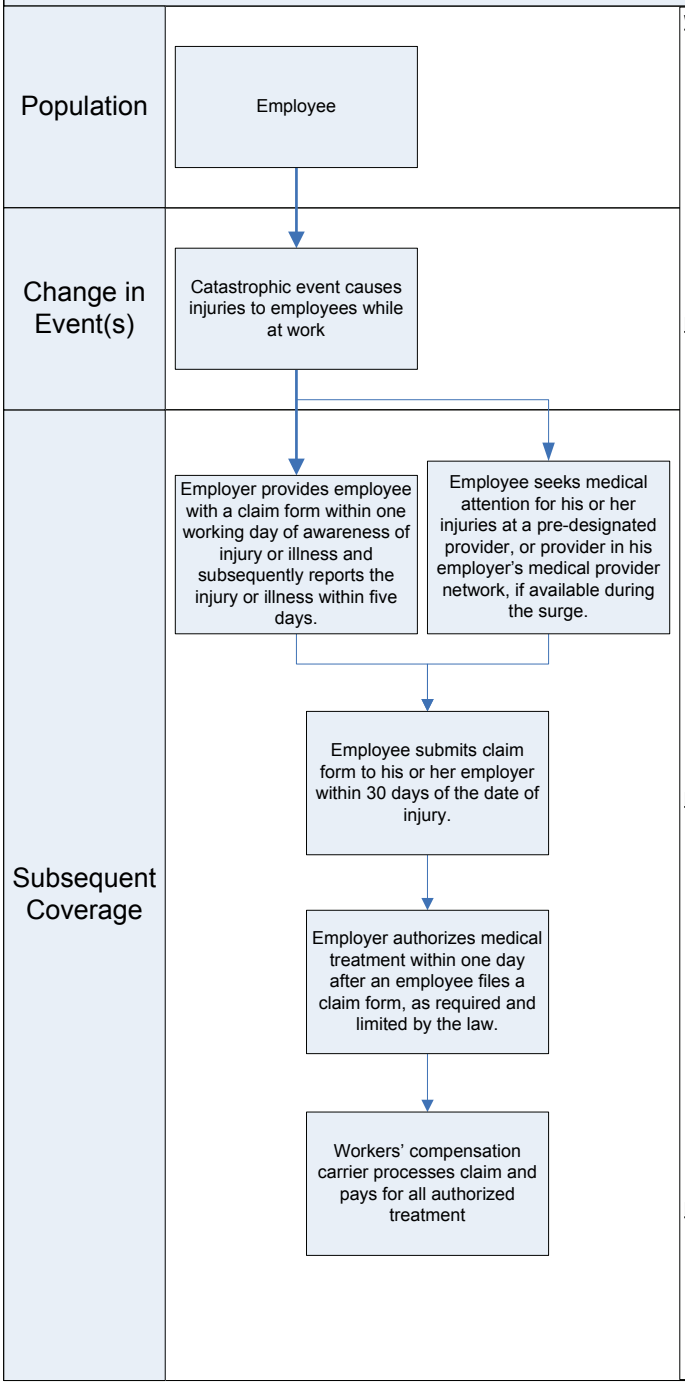
Labor Code Section 5402 requires an employer to authorize medical care within one day of receipt of a claim form and to reimburse for all medical treatment in accordance with the American College of Occupational and Environmental Medicine's guidelines or utilization schedules adopted by the Division of Workers' Compensation administrative director. Until the claim is accepted or denied, liability for medical treatment is limited to $10,000. This statute does not address an employer's recovery rights on denied claims.[53]

During a healthcare surge, medical provider networks and utilization schedules may pose challenges if the medical networks are unavailable or affected by the event. To facilitate prompt payment to providers, workers' compensation medical network requirements may need flexing during a healthcare surge.

The process flows that begin on the next page depict how Workers' Compensation may play a role during a healthcare surge for general employees and disaster service workers. The Workers' Compensation Claim Form (DWC1), and all other Division of Workers' Compensation forms, can be found at http://www.dir.ca.gov/dwc/forms.html. For additional information on how to file a workers' compensation claim, how to request a qualified medical evaluation and other information, refer to the State of California Division of Workers' Compensation website at http://www.dir.ca.gov/dwc/.

The Workers' Compensation Process Flow is shown below. The complete tool can also be found in the Hospital Operational Tools Manual on pages 189-190.

Workers' Compensation During Declared Disaster – General Population



Worker's Compensation Eligibility

- Workers' compensation covers injuries or illnesses that occur due to employment, including single events or injuries caused by repeated exposure (Labor Code Section 3208 and Section 3208.1)
- Workers' Compensation does not cover first aid (Labor Code Section 5401)
- Employees covered under Workers' Compensation are "every person in the service of an employer under any appointment or contract of hire or apprenticeship, express or implied, oral or written, whether lawfully or unlawfully employed, and includes (a) aliens and minors (Labor Code Section 3351)

Employee Responsibility

- Report any injury or illness to employer as soon as possible.
- Complete the Workers' Compensation Claim Form and submit to employer within 30 days of the date of injury (Labor Code Section 5400)
- Should the employee disagree with any of the actions of the workers' compensation policy, submit an Application for Adjudication of Claims with the Workers' Compensation Appeals Board within one year of the date of the injury, or one year from the "last furnishing of indemnity or medical treatment benefits" by the employer or workers' compensation insurance carrier (State Compensation Insurance Fund).
- Pre-designate a physician, if interested, following certain rules and requirements. Each employee who chooses to pre-designate a physician must provide the name and address of the physician to his or her employer prior to becoming injured.
- The law states that employees are not responsible for co-payments or balance-due after the workers' compensation insurance carrier has paid the provider.

Employer Responsibility

- Provide the employee with a Workers' Compensation Claim Form within one working day after the injury or illness has been identified. (Labor Code Section 5401(a))
- Submit the completed claim form to the appropriate workers' compensation insurance carrier.
- Authorize medical treatment as required and limited by the law within one day after an employee files a claim. This authorization pertains until the claim is accepted or rejected, up to $10,000 in total.
- Report "within five days of knowledge every occupational injury or illness which results in lost time beyond the date of the incident or requires medical treatment beyond first-aid" within one day after an employee files a claim (State Compensation Insurance Fund).
- Employer must pay for workers' compensation and must have insurance or be self-insured. (Labor Code Section 3600 and Section 3700)

Payer Responsibility

- Accept or deny new claim within a reasonable time (Labor Code Sections 5814 and 5814.6; 8 CCR Section 10109)
- New claim presumed to be covered by workers' compensation if not denied within 90 days (Labor Code Section 5402(b))
- The workers' compensation insurance carrier pays for all authorized treatment.

12. Reimbursement

12.1. Hospital Planning Considerations for Different Funding Sources

12.1.1. Healthcare Surge Response and Disaster Recovery

Maintaining existing revenue streams will be critical to hospitals during a healthcare surge. Hospital preparation should include advanced planning and collaboration with commercial health plan partners, a detailed knowledge of the resources that are available to hospitals during surge conditions and the methods to access additional resources from federal and Stated Funded Programs.

For those hospitals that have significant relationships with commercial health plans, collaborative discussions can have a significant impact on the ability of both the hospital and health plans to accommodate specific operational issues and reimbursement requirements during surge conditions. Hospitals and commercial health plans can take a proactive approach in working together to address disaster-related concerns through contract provisions. Sufficient planning and coordination between health plans and hospitals will be essential in maintaining business continuity and sustaining operations at facilities providing medical care during a healthcare surge. A hospital's ability to comply with administrative policies and procedures and maintain the exchange of information with health plans may be impacted and should be addressed during the planning phase.

Hospitals should also be aware of the administrative and reimbursement changes that may take place with Medicare, Medi-Cal and Workers' Compensation. Part of the planning process should include identifying the actions hospitals may need to take to ensure adequate reimbursement levels from these payers.

12.1.2. Hospitals and Health Plans

When working with health plan partners, hospitals will want to reach agreement on revised contract language which focuses on streamlined reimbursement, simplified policies and procedures and increased access and coverage for patients during a healthcare surge. Clear and concise documentation through formal contract changes that outline the obligations of both the hospital and the health plan during a surge may eliminate confusion and be beneficial to both parties.

Below are specific steps hospitals may want to consider when working with their health plan partners to prepare for a healthcare surge. These suggested guidelines are applicable to commercial, Medicare Advantage, Medi-Cal Managed Care and Workers' Compensation products.

Rates	Polices and Procedures	Access & Coverage
• Simplify hospital rate structure which may include negotiating a global acute care rate for inpatient care. • Consider negotiating lump sum advance payments to facilitate and maintain cash flow. • Consider negotiating contract language to obtain an automatic increase in capitation during a surge, when appropriate. • Move toward a common reimbursement system, such as a Medicare Diagnosis-Related Group based system, to simplify claims generation and plan payment process.	• Modify timely filing provisions to accommodate late or delayed claims which may be due to lack of correct benefit and eligibility information. • Create new or modify existing contracts to include disaster provisions that address rights and obligations outside the typical force majeure clauses. • Create policies to expedite cash flow from plan during a declared healthcare surge. • Consider developing minimum required data elements for reimbursement purposes during a healthcare surge and incorporate these elements into health plan contracts. • Consider developing contract provisions to include third-party vendors who may assist with billing on behalf of an existing facility during an extended healthcare surge.	• For closed network models, revise pre-authorization and referral requirements to allow access to care when needed and where available.

12.1.3. Hospitals and Public Payers

Public payers can play a significant role during a healthcare surge through the issuance of waivers which focus on streamlining reimbursement, reducing administrative complexities and removing barriers to accessing patient care. Hospitals that serve Medicare or Medi-Cal beneficiaries should be aware of the administrative and financial implications of these waivers and any applicable steps that need to be taken by hospital to fully benefit from these waivers and declarations.

Medicare and Medi-Cal Waivers

Since regulations governing emergency provisions do not fully address all funding and reimbursement issues that might arise during a healthcare surge, the potential exists for the

issuance of waivers and declarations to address barriers to funding or access to care. The following section outlines two applicable waivers and their areas of impact: Section 1135 which impacts programs managed by the Centers for Medicare and Medicaid Services and Section 1115 demonstration waivers which impact the Medi-Cal program.

These key waivers may be issued in response to a healthcare surge impacting the reimbursement process for hospitals. While hospitals benefit from the flexed rules and requirements that these waivers would afford, they have little influence over their issuance. Hospitals should note Section 1135 offers the greatest financial impact with the least amount of effort and time, while 1115 Demonstration Waivers are more cumbersome with less likelihood of significant and timely impact.

Section 1135 Waivers

The Section 1135 waiver is designed to address the existing rules and requirements that may limit access to healthcare and impose financial barriers for providers during a healthcare surge. Under 42 U.S.C. Section 1320b-5 (section 1135 of the Social Security Act), the Secretary of Health and Human Services has the authority to waive certain requirements of Centers for Medicare and Medicaid Services programs in an emergency area during an emergency period. [54] These waivers are known as Section 1135 waivers. As documented in the Federal Register, “the stated purpose of Section 1135 of the Social Security Act is to enable the Secretary to ensure, to the maximum extent feasible, in any emergency area and during an emergency period, that sufficient healthcare items and services are available to meet the needs of enrollees in Medicare, Medicaid and the State Children’s Health Insurance Program.”[55]

For purposes of Section 1135 waivers, “an ‘emergency area’ is a geographical area in which, and an ‘emergency period’ is the period during which there exists an emergency or disaster declared by the President pursuant to the National Emergencies Act or the Robert T. Stafford Disaster Relief and Emergency Assistance Act and a public health emergency declared by the Secretary pursuant to section 319 of the Public Health Service Act.”[56] “The term ‘healthcare provider means any entity that furnishes healthcare items or services, and includes a hospital or other provider of services, a physician or other healthcare practitioner or professional, a healthcare facility or a supplier of healthcare items or services.”[57]

Section 1135 waivers provide a key opportunity to facilitate hospital reimbursement by flexing some of the Centers for Medicare and Medicaid Services rules and requirements. However, hospitals have little control over when and where these waivers are issued. Hospitals may appeal to the Department of Health Care Services which can in turn submit a request to the Secretary of Health and Human Services, but ultimately the issuance of these waivers is up to the discretion of the Secretary.

A primary purpose of Section 1135 of the Social Security Act is to ensure “that healthcare providers that furnish such items and services in good faith, but that are unable to comply with

one or more requirements described in subsection (b), may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse."[58]

It is important to note that these waivers or modifications can "be made retroactive to the beginning of the emergency period or any subsequent date in such period" at the Secretary's discretion.[59] "They are issued in response to specific catastrophic emergencies and defined for a designated time and place. Some of the key rules and requirements that can be addressed by these waivers are:

- Conditions of participation
- Physician state licensure requirements
- Emergency Medical Treatment and Active Labor Act
- Physician referral limitations
- HIPAA
- Medicare Advantage payment limitations
- Deadlines and timetables[60]

For the complete Section 1135 waiver under 42 U.S.C. Section1320b-5 see the Reference Manual, Section 9: Full Text of Social Security Act, Section 1135 Waiver.

Section 1115 Demonstration Waivers

In addition to the Section 1135 waivers addressing Medicare, Medicaid and the State Children's Health Insurance Program, Section 1115 demonstration waivers provide another mechanism to modify rules and requirements related to the Medi-Cal program. Section 1115 waiver programs "serve as a precedent for federal and state officials who wish to make temporary changes to the Medicaid program in response to the unique circumstances resulting from catastrophic emergencies such as the devastation of Hurricane Katrina."[61] However, since the demonstration waivers have historically proven to be cumbersome to administer and time consuming to take effect, hospitals should not depend on them to provide primary relief during a healthcare surge.

Under current law, Section 1115 waivers allow states to:

- provide services to individuals not traditionally eligible for Medicaid
- cover non-Medicaid services
- limit benefit packages for certain groups
- adapt their programs to the special needs of particular geographic areas or groups of recipients
- accomplish a policy goal such as to temporarily provide Medicaid assistance in the aftermath of a disaster.[62]

According to a Congressional Research Service report, “Section 1115 of the Social Security Act … authorizes the Secretary [of Health and Human Services] to waive certain statutory requirements for conducting demonstration projects that further the goals of Titles XIX (Medicaid) and XXI (State Children’s Health Insurance Program). Under Section 1115, the Secretary may waive Medicaid requirements contained in Section 1902 (known as “freedom of choice” of provider, “comparability” and “statewideness”). States must submit proposals outlining terms and conditions for proposed waivers to Centers for Medicare and Medicaid Services for approval before implementing these programs.”[63]

Congressional Research Service report RL 33083 adds further clarification on the Section 1115 waiver, indicating that "while Section 1115 is explicit about provisions in Medicaid law that may be waived in conducting research and demonstration projects, a number of other provisions in Medicaid law and regulations specify limitations or restrictions on how a state may operate a waiver program." For example, one provision restricts states from establishing waivers that fail to provide all mandatory services to the required poverty-related groups of pregnant women and children; another provision specifies restrictions on cost-sharing imposed under demonstration waivers.

Other features of the Section 1115 waiver authority include:

- *Federal Reimbursement for Section 1115 Demonstrations.* Approved Section 1115 waivers are deemed to be part of a state’s Medicaid plan. Project costs associated with waiver programs are subject to that state’s Federal Medical Assistance Percentages. Changes to these financing arrangements, even under a Section 1115 waiver, would require Congressional action.

- *Financing and Budget Neutrality.* Unlike regular Medicaid, Centers for Medicare and Medicaid Services waiver guidance specifies that costs associated with waiver programs must be budget neutral to the federal government over the life of the waiver program. To meet the budget neutrality test, estimated spending under the waiver cannot exceed the estimated cost of the state’s existing Medicaid program under current program law requirements.

- *Relationship of Medicaid Demonstration Waivers to Other Statutes.* Section 1115 waiver projects may interact with other program rules outside of the Social Security Act; for example, employer-sponsored health insurance as described by the Employee Retirement Income Security Act or alien eligibility as contained in immigration law. In cases like these, the Secretary does not have the authority to waive provisions in these other statutes."[64]

Although health professionals will likely not be involved in initiating any Section 1115 waivers, it is useful for providers to understand the impact that these waivers might have on the delivery of healthcare during a healthcare surge.

12.2. Administrative and Procedural Guidelines - General Planning Considerations

One of the key challenges that hospitals will face during a healthcare surge will be sustaining operations and maintaining adequate cash flow while continuing to provide uninterrupted medical care to affected populations. Complex administrative procedures as well as routine payment cycles may contribute to these challenges. This section outlines some of the ways in which hospitals can maintain their current revenue stream through steps and planning measures taken in advance of a healthcare surge.

Given the unpredictable nature of a disaster and its potential to significantly impact the healthcare system, sufficient planning and coordination between hospitals and payers will be essential to maintaining business continuity as well as sustaining operations at facilities providing medical care. Such coordination and planning may include modifying specific contract provisions related to administrative requirements, negotiating minimum data sets for charge capture and billing purposes, selecting third-party vendors who may assist with billing on behalf of an existing facility during an extended healthcare surge or developing new policies to expedite cash flow during a declared surge.

The following information illustrates recommended changes to the documentation of patient information and medical services provided to support the registration and billing process. Hospitals may use this information as a guide during the surge planning process.

12.2.1. Minimum Required Data Elements and Templates for Charge Capture

During a healthcare surge, electronic systems regularly used for charge capture within existing facilities may be unavailable. As a result, paper-based processes for capturing charges may be the only method available. Furthermore, it may be reasonable to expect that most healthcare personnel will be devoted to patient care and may not be able to adhere to existing charge capture protocols.

Maintaining accurate charge capture information will allow facilities to properly bill for services, receive accurate and appropriate reimbursement, and maintain cash flow and support business continuity efforts during a healthcare surge. Because accurate billing and reimbursement is critically important to both hospitals and payers, administrative functions during healthcare surge conditions may need to be reduced to minimum requirements. The following includes a list of recommended minimum data elements required for charge capture during a healthcare surge. Sample templates are also included. The forms are not meant to replace existing forms at hospitals but rather to serve as samples to consider using during a healthcare surge. Acceptance of charge capture elements will ultimately depend on private/government payers agreeing to accept these recommended minimum data elements for billing purposes. It is thus recommended hospitals proactively discuss these and other disaster-related concerns with payers through contract provisions.

The following recommended list of minimum required data for charge capture was derived from current standard charge capture elements:

- Patient name
- Medical record number
- Date of service
- Capture units/dose/quantity
- Department services provided in
- Service description
- Disaster incident number
- Work related injury Y/N

Two sample charge capture forms are provided as templates for hospitals to consider using during healthcare surge and which focus on capturing only the most critical information for effective charge capture. The first form was developed from the suggested minimum data list above specifically for use during a healthcare surge. The second form was adapted from a current charge capture form and can be used by hospitals with more time and resources available to complete charge capture protocols during a healthcare surge.

The Sample Charge Capture Form 1 is shown below. The tool can also be found in the Hospital Operational Tools Manual on pages 211-212.

Instructions:

One form should be completed per patient.

Unique Patient Identifier: Enter patient disaster incident number or other identifier if available.[65]

Patient Name: Enter name of patient.

Provider Name: Enter name of provider or facility.

Service Description: Describe service provided to patient.

Department: Enter department where care provided.

Units of Service or Quantity: Enter number of units or total quantity supplied.

Date of Service: Enter date.

Code - Service/Revenue/Current Procedural Terminology/Healthcare Common Procedure Coding System: To be completed by billing personnel; enter appropriate code for service provided.

Service Price: To be completed by billing personnel; enter price for service provided.

Posted Charge: To be completed by billing personnel; enter total charge for service provided.

Disaster Incident Number: Enter disaster incident number.

Sample Charge Capture Form 1

The following template serves as an example for hospitals to consider using during healthcare surge and is based on the idea of capturing only minimum required data for charge capture. **Unique Patient Identifier (#):**				**Patient Name (Last, First):**		
Provider Name:				**Disaster Incident Number:**		
				To be completed by Billing		
Service Description	**Department**	**Units of Service or Quantity**	**Date of Service**	**Code:** **Service / Revenue/** **Current Procedural Terminology/Healthcare Common Procedure Coding System**	**Service Price**	**Posted Charge**
Total Charges						

The Sample Charge Capture Form 2 (Acuity Charge Sheet) is shown below. The tool can also be found in the Hospital Operational Tools Manual on pages 213-215.

A set of forms (acuity and procedure forms) are presented as options for capture charges for service, medication and supplies for individual patients.

Instructions:

One set of forms should be completed for each patient.

An “X” should be added to each box that corresponds to the service provided. Check marks serve as points in determining acuity level for billing purposes. Type A interventions count as one point. Type B interventions count as two points. Add all points and indicate the total in the corresponding acuity level row (ER 0, ER 1, ER 2, etc.).

ACUITY CHARGE SHEET

TYPE A INTERVENTIONS - COUNT AS ONE	X	TYPE B INTERVENTIONS - COUNT AS TWO	X
Dischg Instr. Intermed. (Prescriptions, All-scripts, Pre-packs)		Admission to Inpatient or Obs. (Includes Paperwork & Transport)	
Fetal Heart Tones (Obtain)		Assault Exam	
Orthostatic Vital Signs		Cardiac Monitoring (Therapeutic Purposes Only)	
Visual Acuity Test (Snellan Chart/wall chart)		Pulse Oximetry/Capnography (Therapeutic Purposes Only)	
MEDICATIONS		Discharge Instruct Complex (Lovenox/Wd Care/Dsg?Inj/Arrange testing)	
Med Administration (PO, SL, NG, Enternal), Contrast Admin		PT and RN Out of TX Room for Procedure (RN Monitoring)	
Med Administration (Topical, Suppository, Eye/Ear Drop)		Reassessments (After Meds, Change of Status, Neuro Checks)	
SPECIAL NEEDS		**SPECIAL NEEDS**	
Apply Buddy Tape, Ace Wrap, Cloth Arm Sling, Post-Op Shoe		2:1 or 1:1 Nursing Care (Any Age for more than 30 min)	
2+ Staff Assist with Procedure (older than 5 Years, over 10 min)		Coordination of Ancillary Supt (On-site presence necessary)	
Staff Assist w/ Pediatric Proc. (5 yrs or younger, over 10 min)		Ambulance Arrival-Accept Patient	
Breathalyzer		Assist Bathroom/Commode (Incontinent, Emesis, Ostomy, Bedpan)	
Telephone Consult (Call only, no onsite presence)		Behavioral Managemet (Combative/Confused)	
External Temperature Regulation (Cooling or Warming Blankets)		Chain of Custody Drug Scrn (Evid coll/Handling & Identification)	
Fall Risk Assessment (High risk patients only)		Critical Care Transfers (w/Ambulance to Facility/ ED Staff on Transfer)	
Feed Patient/Obtain Meals/PO Challenge		Death (Certificate or Fetal Demise Packet, Prep PT, Support Family)	
First Aid Procedure (Control Minor Bleed, Apply Ice)		EMTALA Forms, Transfer to & or Back to Another Facility/SNF	
Jewelry Removal/Secure Belongings (Cut Off Rings/Earrings)		Enema or Remove Fecal Impaction	
Pelvic/Breasat/Rectal Exam/Hernia Manip. (Assist Physician)		Helicopter Arrival/Departure Assistance	
Removal Nasal Packing		Isolatoin (Contract/Airborne/Full)	
Road Test Patient		Prep Patient for OR/Cath Lab/GI Lab? Interventional Procedure	
Seizure Precautions		Restraint Monitoring	
Special Form Reporting (e.g. Dog Bite)		Suicide or Security Watch	
TOTAL POINTS		**THERAPEUTIC**	
Total A & B Points		Care of Device (Foley/NG/PEC/gastro-, ileo-, colo-, nephro-, tracheo-stomy)	
LEVEL	**LVL**	PICC/Mid-Line/Central Line Care (Flushes/Removal/Dressings)	
ER 0 No CHG	0	Core Temperature Regulation	
ER 1 0 Points	1	Decontamination/Hazardous Materials/Lice	
ER 2 1 Point	2	Foreign Body Removal (Vagina/Rectum Only) (Assist Physician)	
ER 3 2-4 Points	3	Initiate Full Spinal Immobilization	
ER 4 5-7 Points	4	Irrigate Ears (RN Only)	
ER 5 8+ Points	5	IV/Lock Start (Only mark if NO injections or infusions given)	
Critical Care 30-74 minutes		Morgan Lens/Irrigate Eyes	
Critical Care Ea addl 30 after 74 min.		O2 Application/Setup/Adjustment from baseline (By RN)	
Special Charges	**LVL**	Specimen Collect (Sputum, Qk Cath/Void Urine, Stool, Cultures, Nasal Wsh)	
Left AMA/with no points (Medicall screened by MD/NP)	1	Suction (Tonsil Tip, Oral, Bulb, Sterile)	
Elopement/with no points (Medically screened by MD/NP)	1	Treat Miscarriage (Non-Surgical Intervention)	
AMA/Elopement W/Points choose appropriate level		Tube Placement (NG/Gastrostomy/Supra-Pubic Replacement	
Trauma Activation (Prior notification by DR or EMS)		Wd Care Cleanse, Dress, Steri-Strips (Only if not Asso w/ Proced)	

All marked items have supporting documentation

RN Signature:_____ **Patient Disaster Incident Number:**_____

12.2.2. Minimum Required Data Elements for Billing

In addition to charge capture, billing processes may pose a challenge for hospitals during a healthcare surge. Whenever possible, hospitals should follow normal billing processes and submit complete data. However, in the event that systems are impaired and/or staff are unavailable at provider sites, the use of minimum billing elements may become necessary. Implementing minimum data elements for billing requires coordination and approval between both health plans and hospitals. In a healthcare surge, hospitals may be unable to collect and transmit standard billing data and reducing required data elements may become necessary to facilitate payment. As such, it is recommended that hospitals work with their health plan or program representatives directly to discuss minimum data elements for registration and billing in the event of a healthcare surge. The minimum data elements in this section are included as recommendations only and ultimately it depends on health plans and government payers must agree to accept these recommended minimum data elements from hospitals for billing purposes.

Recommended Minimum Required Data Elements for Billing

The following lists were derived from existing Uniform Billing form 04 (Uniform Billing 04 or Centers for Medicare and Medicaid Services 1450) and Centers for Medicare and Medicaid Services 1500 forms. Under normal conditions, the Uniform Billing 04 form is used by institutional providers (e.g., hospitals, skilled nursing facilities, hospices) to submit Medicare paper claims and the Centers for Medicare and Medicaid Services 1500 form is used by noninstitutional providers (e.g., physicians) to submit Medicare paper claims. It is recommended that providers consider working with their payer partners on a similar list.

Institutional Providers Uniform Billing 04 Data Elements	Noninstitutional Providers Centers for Medicare and Medicaid Services 1500 Data Elements
• Subscriber Identification/policy number • Time in, time out • Work related injury Y/N 1: Provider name, address, phone number 4: Type of bill 8b: Patient name 42: Revenue codes 43: Revenue description 44: Healthcare Common Procedure Coding System rates/codes 46: Units of service 47: Total charges 50: Payer 56: National Provider Identifier 58: Insured's name	• Subscriber Identification/policy number • Time in, time out • Work related injury Y/N 1: Select which payer: Medicare / Medicaid / Champus / Champva / Group Health Plan/ Federal Employees Compensation Act Black Lung / Other 1a: Insured's Identification number 2: Patient name 3: Patient's birth date 5: Patient's address 21: Diagnosis or nature of illness or injury 24 A-G: date of service, place of service, type of service, procedures/services/supplies, diagnosis code, $ charges, days or units 24K: Use space to include condition code 25: Federal tax Identification number

Institutional Providers Uniform Billing 04 Data Elements	Noninstitutional Providers Centers for Medicare and Medicaid Services 1500 Data Elements
67: Principal diagnosis code 69: Admitting diagnosis 74: Principal procedure code 76: Attending 77: Operating	27: Accept assignment? (yes/no) 28: Total charge 33: Physician's/supplier's billing name, address, zip code & phone number

12.2.3. Additional Billing and Coding Guidance

Additional guidance regarding billing and coding during a disaster is included in this section and can be used by hospitals as a reference during the disaster planning process.

Administrative Simplification Compliance Act Waiver Application[66]

According to the Centers for Medicare and Medicaid Services' website, "The Administrative Simplification Compliance Act prohibits payment of services or supplies that a provider did not bill to Medicare electronically." The Administrative Simplification Compliance Act Waiver Application allows for flexibility in this rule and stipulates that "There are also some situations when this electronic billing requirement could be waived for some or all claims, however, a provider must obtain Medicare pre-approval to submit paper claims in these situations:

- Any situation where a provider can demonstrate that the applicable adopted HIPAA claim standard does not permit submission of a particular type of claim electronically
- Disability of all members of a provider's staff prevents use of a computer for electronic submission of claims
- Other rare situations that cannot be anticipated by the Centers for Medicare and Medicaid Services where a provider can establish that, due to conditions outside of their control, it would be against equity and good conscience for the Centers for Medicare and Medicaid Services to enforce this requirement

A request for this type of waiver must be sent by letter to the Medicare contractor to which a provider submits claims." This waiver can provide hospitals with flexibility in the way they bill Medicare should a healthcare surge create conditions that challenge electronic billing.

National Modifier and Condition Code To Be Used To Identify Disaster Related Claims[67]

In response to the emergency healthcare needs of beneficiaries and medical providers affected by Hurricane Katrina, the Centers for Medicare and Medicaid Services assured flexibility by modifying normal documentation requirements. Specifically, a new policy was issued establishing a national modifier for providers to use on claims in order to track and facilitate claims processing for individuals affected by the disaster. According to the new policy, "In order to facilitate claims processing and track services and items provided to individuals affected by Hurricane Katrina and any future disasters, a new modifier and condition code have been established for providers to use on disaster-related claims.

The new modifier and condition code are now effective nationwide and can be used by hospitals submitting disaster related claims. The new modifier is CR (Catastrophe/Disaster Related) and the new condition code is DR (Disaster Related). Hospitals can report either the modifier or condition code when submitting disaster related claims. The condition code would identify claims that are or may be impacted by specific payer policies related to a national or regional disaster, while the modifier would indicate a specific Part B service that may be impacted by policy related to the disaster."[68]

International Classification of Diseases, Ninth Revision, Clinical Modification Coding for External Causes of Injury

In the event of a disaster, coding professionals can use External Cause codes (E codes) to code healthcare encounters and identify the cause of injury(ies) for those affected by the disaster. "External causes of injury and poisoning codes are intended to provide data for injury research and evaluation of injury prevention strategies. E codes capture how the injury or poisoning happened (the cause), the intent (unintentional or accidental; or intentional, such as suicide or assault), and the place where the event occurred."[69] The use of E codes is supplemental to the application of International Classification of Diseases, Ninth Revision, Clinical Modification diagnosis codes. E codes are never recorded as principal diagnoses: the appropriate injury code should be sequenced before any E codes. E codes may be assigned in all healthcare settings. For the purpose of capturing complete and accurate International Classification of Diseases, Ninth Revision, Clinical Modification data in the aftermath of the natural disaster, a healthcare setting should be considered any location where medical care is provided by licensed healthcare professionals.

The use of E codes is limited to injuries, adverse effects and poisonings. They should not be assigned for encounters to treat the medical conditions of individuals affected by an emergency when no injury, adverse effect or poisoning is involved. E codes can be used in the following situations:

- Accidents due to natural and environmental factors
- Poisoning and adverse effects of drugs, medicinal substances and biologicals
- Transport accidents
- Accidental falls
- Accidents caused by fire and flames

- Late effects of accidents, assaults or self injury
- Assaults or purposely inflicted injury
- Suicide or self inflicted injury

Catastrophic emergencies, such as natural disasters, take priority over all other E codes except child and adult abuse and terrorism and should be sequenced before other E codes. As many E codes as necessary can be assigned to fully explain each cause. For example, if an injury occurs as a result of a building collapsing during a natural disaster, E codes for both the natural disaster and the building collapse should be assigned with the E code for disaster being sequenced as the first E code.[70]

12.2.4. Advancing and Expediting Payment

The following table outlines the possible opportunities for advancing and expediting payment from a range of payers. In many cases, payers do not have a formalized policy or procedure for advancing or expediting payments, but may have established a practice for doing so on an "as needed" basis. Hospitals in need of expedited or advanced payment options will likely need to contact their health plan or program representative directly to discuss advancing and expediting payments and establish memoranda of understanding and protocols in advance or at the time funds are needed.

The Advancing and Expediting Payment table is shown below. The table can also be found in the Hospital Operational Tools Manual on pages 192-194.

Payer	Option Available	Examples
Medicare Part A	Accelerated Payments	Cash-flow problems can be resolved through accelerated payments rather than through suspension of the mandatory payment floor which requires intermediaries to hold payment for electronic claims for thirteen days. In the past, intermediaries have been asked to immediately process any requests for accelerated payments or increases in periodic interim payment for providers. Intermediaries have also been authorized to increase the rate of the accelerated payment to 100 percent and extend the repayment period to 180 days on a case-by-case basis.[71]
Medicare Part B	Advance Payments	Cash flow problems can be resolved through advance payments rather than through suspension of the mandatory payment floor which requires intermediaries to hold payment for electronic claims for thirteen days. In the past, intermediaries have been asked to immediately process any requests for advance payments or increases in periodic interim payment for providers. Intermediaries have also been authorized to increase the rate of the advance payment to 100 percent and extend the repayment period to 180 days on a case-by-case basis[72]
Medi-Cal	Advance Payments	Medi-Cal has a process in place for advancing payment to participating hospitals. This interim payment process can be used in instances when hospitals are experiencing cash flow inadequacies, where Medi-Cal is experiencing payment delays or when a hospital's business operations are temporarily challenged. Medi-Cal will approve advances more readily if there is a problem with the State processing or payment system, not solely because the provider is experiencing billing issues. In the current process, if

Payer	Option Available	Examples
		the hospital has claims pending in the State system, the Department of Health Care Services (DHCS) can issue an interim payment and will reconcile it against future claim submissions and payments. The amount of the advance is usually about 75 percent of the claim value in the Medi-Cal system awaiting payment for that hospital. The hospital must be a Medi-Cal enrolled provider to receive these advance payments. This is a manual process at present and is highly labor intensive. In an emergency, this interim payment process can be invoked to advance a reasonable amount to keep a hospital's cash flow positive until business operations can resume to normal. Medi-Cal can issue this advance by either valuing the claims that are currently in the State processing system or running a report of a hospital's claim payment history and issuing an advance in lieu of receiving claims. If DHCS issues an advance without having evidence of claims in the payment system, it has not established its liability to pay and cannot claim the federal match for that payment. In circumstances where claims have not been received, DHCS would have to approve the advance because the funds would come from the State General Fund. This process could theoretically be set up easily, but in a healthcare surge it would take time to orchestrate given the number of hospitals that may be requesting it.[73]
Private Payer	Informal Agreements	Some private payers may have informal processes set up in order to advance payment to contracted providers in times of financial need. This advance payment process can be used when providers are experiencing cash flow inadequacies, where the payer is experiencing payment delays or when a hospital's business operations are temporarily challenged. The amount of the advance can vary depending on hospital need, hospital volume, previous payment history, contractual parameters and repayment factors. Upon hospital request, private payers will typically offer one of two options: 1) advance a lump-sum amount for a specified period of time to be repaid in full when the agreed period elapses or 2) advance an agreed amount based upon previous payment history and hospital need to be reconciled against future claim submissions. Contracted hospitals in good standing in need of expedited or advanced payment options will likely need to contact their plan or program representatives directly to discuss advancing and expediting payments and establish memoranda of understanding and protocols in advance or at the time funds are needed.[74]

12.3. Other Funding Considerations for Providers

12.3.1. Graduate Medical Education Reallocation Guidelines

Should hospital infrastructure changes occur as a result of a healthcare surge, causing medical students and residents to transfer midyear, the Graduate Medical Education (GME) funding attached to those students and residents should be reallocated to the host hospitals accepting those students and residents. In response to Hurricane Katrina, the Centers for Medicare and Medicaid Services developed an interim final rule titled "Payment for Graduate Medical Education (GME) in the Wake of a National Disaster or Public Health Emergency" to address this issue. This interim final rule provides a template which will allow for an immediate response and helps to minimize the impact of a national disaster on

hospital payment and resident training programs.[75]

The following policy developed as a result of Hurricane Katrina may provide guidance for host hospitals who accept displaced residents following a disaster. This information provides a framework for those healthcare providers involved in Graduate Medical Education of what might be expected during the period following a healthcare surge. The full text of the interim final rule, taken from the Centers for Medicare and Medicaid Services website, is included below, and can be found at http://www.cms.hhs.gov/AcuteInpatientPPS/Downloads/Katrina_Fact_Sheet.pdf.

Graduate Medical Education Reallocation Guidelines are shown below. The guidelines can also be found in the Hospital Operational Tools Manual on pages 200-203.

"Payment for Graduate Medical Education (GME) in the Wake of a National Disaster or Public Health Emergency"

Issue

Hurricane Katrina emphasized the need for the development of a policy which helps to mitigate any disruption of medical residency training programs caused by natural disasters. This interim final rule, with comment, provides a template for hospitals affected by national disaster or public health emergency, giving hospitals the flexibility to minimize the impact of the disaster on their medical residents and ensure continuity of resident training programs.

Background

Among other concerns, Hurricane Katrina caused major disruptions in the medical residency training programs in the affected New Orleans hospitals. The hospitals informed the Centers for Medicare and Medicaid Services that the training programs at many teaching hospitals in the affected areas were closing and that the displaced residents were being transferred to training programs at host hospitals throughout the country. The New Orleans hospitals asked [Centers for Medicare and Medicaid Services] to find a way in which host hospitals – those taking on the displaced residents – could continue to receive payment for the training they were now providing.

In response to these concerns, Centers for Medicare and Medicaid Services immediately issued a document discussing a provision in the existing regulations which allows hospitals that have closed programs to temporarily transfer their allotment of full time equivalent residents paid for under the Medicare program (referred to as the hospitals' full time equivalent cap) to the host hospitals so that host hospitals that were already training residents at or above their cap could receive payment for training additional residents displaced by the hurricane.

Further communications with teaching hospitals in New Orleans clarified that in most cases the programs did not close entirely. In addition, hospitals in the

hurricane-affected areas were in the process of reopening their residency training programs incrementally.

In order to provide relief where the programs have not or are no longer closed, the Department of Health and Human Services used the rulemaking process to allow host hospitals an adjustment to their full time equivalent caps. The new rule allows for the host hospitals to receive financial relief for the additional medical residents they have taken on in the wake of the disaster.

The New Regulation

Centers for Medicare and Medicaid Services has revised existing regulations to address new affiliations between hospitals and nationwide affiliations in situations where a special waiver has been implemented to ensure medical care for Medicare, Medicaid or State Children's Health Insurance Plan populations in an emergency area during an emergency period. This regulation change allows Katrina affected hospitals, as well as hospitals dealing with future national disasters or states of emergency, the flexibility to temporarily transfer residents while permitting payment for all affected hospitals.

Emergency Medicare Graduate Medical Education Affiliation

Under this interim final rule, hospitals will now be allowed to create Emergency Medicare Graduate Medical Education affiliation agreements retroactive to the date of the disaster (e.g., for Katrina, August 29, 2005) to incorporate new members host hospitals, even if the host hospital is outside of the affected area.

These “emergency affiliation agreements” allow for long distance affiliations. Under existing rules, affiliations are limited by geographical requirements or to hospitals under common ownership.

Emergency affiliations would be limited to no more than three years. During the effective period, the shared rotational arrangement requirement would also be relaxed so that residents will not be required to train in both hospitals that are members of the affiliated group.

Host Hospital Payment

Based on the provisions of the existing closed program regulations, and believing that the home hospital programs had actually closed, many host hospitals took in displaced residents in the belief that they would be paid in full for those residents.

Under the usual Graduate Medical Education payment rules, a hospital is paid in the current year based on a three-year “rolling average” count of residents; that is, the average of the number of residents in the current year, prior year, and penultimate year.

If a hospital increases its number of residents in the current year, as the

result of the existing affiliations provision, the hospital would only receive 1/3 of the payment for the additional residents in that year, 2/3 payment the next year, and finally, full payment in the third year.

Under the new affiliation option in the interim final rule, displaced residents from August 29, 2005 to June 30, 2006 (the end of the current academic year) will be excluded from the rolling average calculation with the effect that the payment will be made in full in one year rather than spread over three years.

As of July 1, 2006, the usual rolling average provision would apply to the host hospitals.

Conclusion

The process envisioned in this interim final rule will provide hospitals with greater flexibility to transfer residents within an emergency affiliated group while ensuring payment for all the hospitals involved.

The details of where the slots are transferred, determining how to deal with any excess residents the affected hospital was training in excess of its cap, and tracking those slots would be left to the hospitals to work out amongst themselves.

The documentation burden is less severe because the affiliated group decides how to share the caps. Each hospital and its fiscal intermediary would rely on the cap adjustment agreed upon in the emergency affiliation agreement for payment purposes.

Finally, in the first year of this emergency affiliation, displaced residents at host hospitals would be exempt from the three year rolling average and thus payment will be made in full in one year. In the first year not ***only will host hospitals receive payment in full for training displaced residents, but home hospitals will also receive 2/3 payment under the three-year rolling average mechanism, providing some much needed relief to the Katrina-affected hospitals.***

By making these changes, Centers for Medicare and Medicaid Services has taken action to address Katrina-related Graduate Medical Education payment issues. This updated regulation also helps the Agency to be prepared for future emergencies, establishing a template, which will allow for an immediate response to minimize the impact of a national disaster on hospital payment and resident training programs."

The Graduate Medical Education Transfer Checklist is shown below. The tool can also be found in the Hospital Operational Tools Manual on pages 204-207. Hospitals can use this checklist to implement the Graduate Medical Education Reallocation Guidelines above. This checklist was put together from reference material from the Centers for Medicare and Medicaid Services' website at http://www.cms.hhs.gov/Emergency/02_Hurricanes.asp#TopOfPage.

Graduate Medical Education Payment Transfer Overview and Checklist

If the host hospital has room under its full time equivalent caps:

- "No cap increase is necessary if the total number of residents the host hospital is receiving keeps the total number of residents under its caps. Indirect Medical Education and direct Graduate Medical Education payments will be made directly to the adopting hospital."[76]

- "The issue of who pays the residents' salaries is decided between the original hospital and the adopting hospital. This decision is to be incorporated in the emergency affiliation agreement between the two facilities." [77]

If the host hospital does not have room under its caps:

- The host hospital can count the displaced full time equivalent residents for Medicare payment purposes by virtue of a temporary full time equivalent cap adjustment as long as the original program in which the resident trained remains closed (whether because the hospital itself is permanently closed or because the specific residency training program is closed).[78]

- The displaced full time equivalent residents in excess of the caps are not included in the adopting hospital's rolling average count of full time equivalent residents for purposes of computing the adopting hospital's Indirect Medical Education and direct Graduate Medical Education payments, (nor is an adjustment made to the original hospital's prior and penultimate year full time equivalent counts for purposes of the rolling average). The displaced full time equivalents would be reported on the Medicare cost report for direct Graduate Medical Education on Worksheet E-3 Part IV of Centers for Medicare and Medicaid Services 2552-96, line 3.16 and/or line 3.22. For Indirect Medical Education payment, the displaced full time equivalents would be reported on line 3.17 of Worksheet E Part A. Furthermore, for Indirect Medical Education payment purposes on line 3.19 of Worksheet E Part A, the numerator of the adopting hospital's resident-to-bed ratio from the prior year may be adjusted to reflect the incremental increase in the current year full time equivalent count attributable to the displaced full time equivalents in excess of the caps.[79]

No later than 60 days after the hospital begins to train the displaced residents, the host hospital must submit to its fiscal intermediary:

- A request for a temporary adjustment to its full time equivalent caps

- Documentation that the hospital is eligible for the temporary adjustment by identifying the residents who have come from the closed program and have caused the hospital to exceed its cap
- Documentation that specifies (if possible, otherwise indicate an estimate of) the length of time the adjustment is needed
- A copy of the full time equivalent reduction statement by the hospital that closed its program (in the case where the adopting hospital is training residents displaced by the closure of another hospital's program but the original hospital is not permanently closed)
- In addition, the hospital that closed its program(s) must submit the full time equivalent reduction statement to its fiscal intermediary within the same 60-day timeframe.
  - The full time equivalent reduction statement is a statement signed and dated by the representative of the hospital that closed its program(s) specifying that the hospital agrees to the temporary reduction in its full time equivalent cap to allow the hospital training the displaced residents to obtain a temporary adjustment to its cap. After Hurricane Katrina, the 60-day timeframe for the reduction statements was extended.
- To include a resident in the full time equivalent count for a particular cost reporting period, the hospital must furnish the following information. The information must be certified by an official of the hospital and, if different, an official responsible for administering the residency program.
  - The name and social security number of the resident
  - The type of residency program in which the individual participates and the number of years the resident has completed in all types of residency programs
  - The dates the resident is assigned to the hospital and any hospital-based providers
  - The dates the resident is assigned to other hospitals, or other freestanding providers, and any nonprovider setting during the cost reporting period, if any
  - The name of the medical, osteopathic, dental or podiatric school from which the resident graduated and the date of graduation
  - If the resident is a foreign medical graduate, documentation concerning whether the resident has satisfied the requirements of this section
  - The name of the employer paying the resident's salary[80]
    - After Hurricane Katrina, the timely filing requirements for this documentation were extended.

Note: Only those caps for which the closing hospital originally had cap space are eligible for funding transfer. For example, if a hospital had 25 residents but cap space for 20, only 20 would be eligible for a cap transfer with funding. Host facilities must discuss and agree how to share the residents for whom no cap transfer is available.

12.3.2. Patient Transfer and Coverage Rules During a Healthcare Surge

During a healthcare surge, public health issues or specific medical needs may require patients be transferred between healthcare facilities. The following table outlines

commercial health plans and public payers' coverage rules and requirements for reimbursement related to patient transfers during a healthcare surge. This information provides guidance on specific payer requirements regarding patient transfers and should be used as a reference tool during disaster planning.

The Patient Transfer table is shown below. The complete tool can be found in the Hospital Operational Tools Manual on pages 208-210.

Payer	Scenario	Examples
Medicare	Evacuation to/from facility	Following a recent disaster, charges for ambulance transportation were paid according to the usual payment guidelines. The regulatory requirements must be met (for example, the vehicle must be an ambulance, the crew must be certified, the patient must need ambulance transport and the transport must be to an eligible destination). Ambulance transportation charges for patients who were evacuated from and returned to originating hospitals were included on the inpatient claims submitted by the originating hospitals. **Inpatient:** Payment is included in the diagnosis-related group payment amounts made to hospitals paid under the prospective payment system. **Outpatient:** Outpatient claims were submitted for ambulance charges incurred by patients who were transported from the originating hospitals and subsequently discharged by receiving hospitals. Medicare contractors made payment for ambulance transportations that evacuated patients from affected locations when the regulatory requirements were met. **Recommended Approach** From a claims perspective, in using the catastrophic/disaster related Healthcare Common Procedure Coding System modifier, an institutional provider should designate any service line item on the claim that is disaster related. If all of the services on the claim were disaster related, the institutional provider can use the disaster related (DR) condition code to indicate that the entire claim is disaster related.[81]

Payer	Scenario	Examples
Other	Patient Transfer	In times of declared disaster, a variety of resources are required for an appropriate response and recovery. It is expected that these resources will be compensated for. Resources should be requested through the appropriate SEMS/NIMS channels. A mission tracking number needs to be assigned which links the request to the event and, thus, to the reimbursement. Transportation resources can be broadly classified as traditional medical, ambulances, gurney vans, wheelchair cars, etc., and nonmedical, school and/or transit buses, vanpools, etc. Traditional medical resources can generally be funded through either direct fee-for-service billing or reimbursement from disaster relief funds. In order to be eligible for the latter, it is critical that resources be requested through the proper channels and in accordance with SEMS/NIMS. The request should come through the logistics branch of the appropriate emergency operations centers, either at the city, county or regional levels, generally progressing from city to region. The requests must be accompanied by a mission tasking number. Nonmedical transportation resources will generally only be reimbursed through available disaster relief funds. As is the case for medical resources, it is critical that resources be requested through the proper channels and in accordance with SEMS/NIMS.

12.4. Other Funding Sources Available

If a healthcare facility is located in a declared disaster area and has suffered any disaster-related damage, the facility may be eligible for federal disaster assistance. The two main entities offering disaster assistance to government, non-profit, and private businesses following a declared disaster are the Federal Emergency Management Agency and the United States Small Business Administration.

12.4.1. Federal Emergency Management Agency Public Assistance

The Federal Emergency Management Agency Public Assistance Grant Program provides supplemental federal disaster grant assistance to help State and local governments and certain private non-profit organizations recover after a disaster. The program provides assistance in two ways: 1) for the repair, replacement, or restoration of disaster-damaged,

publicly owned facilities and the facilities of certain private non-profit organizations that are considered a critical part of a community's infrastructure; and 2) for the reimbursement of the direct costs associated with stabilizing patients following a catastrophic emergency.

While these grants are aimed at governments and organizations, their final goal is to help a community and all its citizens recover from devastating natural disasters. Private non-profit facilities are eligible for the grant program if they are open to the public and perform essential services of a governmental nature. Emergency medical facilities and other healthcare facilities, such as hospitals, outpatient, and rehabilitation facilities, qualify to be considered as critical, private non-profit facilities. The Federal Emergency Management Agency does not compensate for disaster-related stabilization and care administered in a private, for-profit healthcare setting. Limited funding is available to not-for-profit agencies without government functions or agreements.

To be eligible for rebuilding assistance, the needed repair and recovery work must be as a direct result of the disaster, be for a location within the designated disaster area, and be for an entity that is the legal responsibility of an eligible applicant. Work that is eligible for supplemental federal disaster grant assistance is classified as either emergency work, which includes debris removal and emergency protective measures, or permanent work, which addresses buildings and equipment.

Costs associated with stabilizing patients following a catastrophic emergency that are eligible for reimbursement may include some personnel costs, equipment, supplies, and utilities. The Federal Emergency Management Agency does not provide ongoing payments for follow-up care or long-term care. The Federal Emergency Management Agency compensates medical costs only when a disaster victim has made a point-of-service contact with the provider for either the stabilization of injuries incurred as a direct result of the disaster or an illness that developed in a designated disaster area during the declared emergency time period.

Recommendations to Facilitate Payment From the Federal Emergency Management Agency

There are certain steps hospitals can take to facilitate payment from the Federal Emergency Management Agency. The following recommendations are not guarantees of eligibility or payment, but provide a basic understanding of the application process and emphasize key areas for hospitals to focus on to improve the likelihood that their application will be well received.

- Document all services provided to patients as clearly and thoroughly as possible. It is likely that all entities receiving funds from the Federal Emergency Management Agency will be audited to ensure that funds were used properly. Hospitals should note that these data elements are different from the recommended minimum required data elements for billing listed in Section 12.2.2: Minimum Required Data Elements for Billing. Hospitals expecting to be eligible for payment from the Federal Emergency Management Agency should be sure the following information is documented:

  - patient's name
  - permanent and temporary displacement addresses
  - telephone number
  - disaster-related medical conditions or pre-existing condition flare up
  - specific services rendered
  - cause of the injury or illness
  - date, time, and location of treatment
  - provider, provider license and Medicaid/Medicare ID number
  - provider's signature
  - whether treatment is for medical stabilization or regular medical care.

- Develop mutual aid agreements with neighboring hospitals and/or local government entities. Mutual aid agreements can be in place between governments and private, non-profit and public hospitals and providers. Mutual aid agreements between hospitals and local government should stipulate that emergency services are critical services performed on behalf of State/local government. These mutual aid agreements may increase the likelihood that Federal Emergency Management Agency funds will flow from one eligible entity to another.
- For-profit entities may explore public-private partnerships and contracts with local government. These service agreements can strengthen existing emergency resources for rural or isolated providers. Through these agreements, the Federal Emergency Management Agency will consider reimbursing direct costs to the public entity for services provided by the private entity if services are for stabilization care and no payment is collected from the patient in any form. Reimbursable costs must be reasonable and represent only the direct costs of providing care that result from the disaster and do not include costs of business interruption/lost revenue.
- Hospitals should review Federal Emergency Management Agency funding policies and procedures to become educated on the available resources and mechanisms that can be deployed for healthcare surge pre-planning, preparation and response. Hospitals can incorporate Federal Emergency Management Agency training into existing training curriculum and required annual training.
- Hospitals should review the Public Assistance Policy Digest - Federal Emergency Management Agency Report 321 and Applicant Handbook - Federal Emergency Management Agency Report 323. Both handbooks are available online at http://www.fema.gov/government/grant/pa/padocs.shtm and provide a comprehensive review of the applicant's role and responsibility for Public Assistance funding.[82, 83] Familiarity with these two handbooks will provide stakeholders, including providers, with an understanding of the process for applying for Federal Emergency Management Agency Public Assistance funds.

  To assist hospitals with the Federal Emergency Management Agency's application process, a process and checklist were developed. This checklist outlines the key steps that need to be taken by stakeholders during the application process. During the actual application process the Federal Emergency Management Agency provides a Public Assistance coordinator to work with applicants. However, understanding the key steps

of the process may facilitate the process. **For the complete process flow and checklist, see the Hospital Operational Tools Manual pages 195-199: Federal Emergency Management Agency Public Assistance Process and Checklist.**

12.4.2. United States Small Business Administration Disaster Loan Assistance

Any business or nonprofit organization, regardless of size, that is located in a declared disaster area can apply for Small Business Administration disaster assistance. The agency has two types of loans: 1) physical disaster loans; and 2) economic injury disaster loans. Physical disaster loans cover all types of physical loss, including uninsured or underinsured damage to structures, equipment, and inventory. Economic injury disaster loans typically cover unmet financial obligations and are only available to small businesses (small business size standards vary according to North American Industry Classification System code and are available at www.sba.gov). Small Business Administration may loan a maximum of $1.5 million to businesses with rates starting as low as 4 percent at terms of up to 30 years. If a healthcare facility qualifies as a major source of employment in a disaster struck zone, the Small Business Administration can waive this statutory lending limit.

Applications are available online, by calling the Small Business Administration, or at any Disaster Recovery Center or Business Recovery Center in the disaster impacted area. It is not necessary to wait for insurance settlements before applying for a Small Business Administration loan. However, any eventual insurance proceeds that duplicate Small Business Administration coverage must go toward repaying the loan.

12.5. California Authority Governing Commercial Health Plans During a Healthcare Surge and the Impact on Hospitals

During the normal course of business, laws and rules prescribe what health plans must make available to their members. Many of these laws and rules impact hospitals. During a healthcare surge, additional authority may become necessary to address the needs of health plans, their members and the community. While general and payer specific considerations were included in prior sections of this volume in an effort to aid hospitals in developing their own response to a healthcare surge, hospitals should also be aware of the authority governing health plans that may have a direct impact on hospitals in the event of a healthcare surge.

The State authority described here is included in order to make hospitals aware of the kinds of health plan responses that may be mandated. Awareness of these authorities can enable hospitals and health plans to more adequately prepare their staff and organizations for a healthcare surge response by providing the opportunity to incorporate these mandates into their own response plans.

The additional California authority that can be exercised during a healthcare surge includes

Government Code Sections 8550 and 8567 which permit the Governor to issue "orders and regulations necessary to carry out the provisions of" the Emergency Services Act in order "to protect the health and safety and preserve the lives and property of the people of the state."[84] Government Code Section 8571 also grants power to the California Governor "during a state of war emergency or a state of emergency, [to] suspend any regulatory statute, or statute prescribing the procedure for conduct of state business, or the orders, rules or regulations of any state agency…where the Governor determines and declares that strict compliance with any statute, order, rule or regulation would in any way prevent, hinder or delay the mitigation of the effects of the emergency."[85]

Under this authority, the Governor could address private payer administrative rules and requirements that may pose a barrier to financial viability and stability of the healthcare system and hospitals, and ultimately impact access to care. Specifically, the Governor could prevent cancellations of policies during an emergency for nonpayment of premiums or prescribe that minimum data fields be used by health plans and hospitals.

Within California, there are two agencies that regulate private health plans, the California Department of Insurance and the California Department of Managed Health Care. These two agencies have different scopes of authority and ways they may impact private health plans during a healthcare surge. The California Department of Insurance "licenses and regulates the rates and practices of insurance companies, agents and brokers in California."[86] This includes all insurance products governed under the California Insurance Code. Although the California Department of Insurance has broad authority to regulate health insurance companies, its role is in consumer protections and advocacy and would play a very limited role during a healthcare surge. A review of the Insurance Code indicates no authority for the Commissioner of Insurance to suspend statutes during an emergency. Action by the Governor would be required to mandate payer action. The Department of Managed Health Care plays a more significant role in a healthcare surge and is discussed in the next section.

12.5.1. The Department of Managed Health Care's Role in a Healthcare Surge

The Department of Managed Health Care licenses and regulates California health maintenance organizations, preferred provider organizations and discount plans governed under the Health and Safety Code and 28 CCR. These are the provisions that govern health maintenance organizations and grant the Department of Managed Health Care its enforcement authority.

Specifically, the Department of Managed Health Care and its Director:

- "Have charge of the execution of the laws of this state relating to healthcare service plans and the healthcare service plan business including, but not limited to, those laws directing the department to ensure that healthcare service plans provide enrollees with access to quality healthcare services and protect and promote the interests of enrollees."[87]

- "Are responsible for the performance of all duties, the exercise of all powers and jurisdiction, and the assumption and discharge of all responsibilities vested by law in the department. The director has and may exercise all powers necessary or convenient for the administration and enforcement of, among other laws, the laws … [relating to healthcare service plans and the healthcare service plan business…, primarily the Knox-Keene Health Care Service Plan Act of 1975]."[88]

- Have rule making and order making authority to "… adopt, amend, and rescind such rules, forms, and orders as are necessary to carry out the provisions of … [the Knox-Keene Act]."[89]

- "May waive any requirement of any rule or form in situations where in the director's discretion such requirement is not necessary in the public interest or for the protection of the public, subscribers, enrollees, or persons or plans subject to … [the Knox-Keene Act]."[90]

While the general powers described above may be exercised to address a large excess of demand over supply of healthcare services in a healthcare surge, additional authority may be necessary or appropriate to mitigate the effects of natural, manmade, or war-caused emergencies greatly impacting the healthcare delivery system operated by healthcare service plans. In order to cope proactively with a healthcare surge resulting from a disaster or a state of emergency, responsibility for protection of enrollees may necessitate:

- Keeping healthcare services available to enrollees.
- Keeping the revenue stream flowing to healthcare facilities and professionals in order to keep healthcare services available.
- Transferring enrollees from one plan to another in the event of diminished plan capacity to keep healthcare services available.
- Transferring provider capacity from one plan to another to mitigate a shortage of healthcare services in severely impaired geographic areas.

Depending upon the nature, breadth, and severity of the state of emergency, the statutory and order making powers of the Director of the Department of Managed Health Care may not be sufficient to protect enrollees adequately. Certain powers may have to be ordered or delegated by the Governor through, for example, Government Code Section 8572, which grants the Governor the authority to "commandeer or utilize any private property or personnel deemed by him necessary" during a state of war emergency or state of emergency.[91] Therefore, certain matters should be considered by the Governor for inclusion in executive orders to facilitate the protection of enrollees.

Such executive orders may include the Governor granting a limited transfer of authority to the Director of the Department of Managed Health Care to issue emergency rules and orders applying to healthcare service plans licensed by the Department of Managed Health Care. This limited transfer of authority would authorize the Director to suspend certain statutes, regulations and healthcare service plan contract provisions and take other actions in order to facilitate mitigation of the emergency and healthcare surge, as indicated by the

severity of the emergency. Such delegated authority may be exercised by the Director in whole or in part and from time-to-time, depending upon the severity and duration of the healthcare surge, the state of emergency, and the need to ensure that healthcare service plans provide enrollees with access to healthcare services and that enrollees' interests are protected.

It may be helpful for hospitals to understand in more detail the specific kinds of actions the Department of Managed Health Care may take under its delegated authority and the impact these actions will have on access to care and reimbursement. Awareness of these actions may enable hospitals to work with health plans to more fully prepare their staff and organizations for mandated healthcare surge responses by providing the opportunity to incorporate these mandates into their own response plans, if applicable.

Hospitals should be aware of the Department of Managed Health Care's delegated authority and the actions that might be taken:

- **To protect enrollees' access to healthcare services:** In the geographic areas of California affected by the state of emergency and healthcare surge and for specified time periods which cover the duration of the state of emergency and healthcare surge, ensuring that enrollees of healthcare service plans have access to healthcare services:
    - Directing the transfer of enrollees from an impaired health plan (due to impaired resources, financial capacity or administrative capacity) to a health plan with greater capacity.
    - Directing transfer of providers from a health plan with adequate provider capacity to a health plan with impaired provider capacity at the compensation rates of the transferee health plan or as otherwise specified to maintain enrollee access to care.
    - Ordering the suspension of requirements of healthcare service plan contracts, statutes and regulations that may prevent, hinder or delay the mitigation of the effects of the emergency, including but not limited to:
        - Prior authorization for referrals and use of out-of-network providers
        - All prior authorization requirements or preadmission certification requirements that could delay the provision of healthcare services
        - All restrictions relative to out-of-network provider access
        - Medical necessity reviews
        - Notification of hospital admissions (when used as a basis of denial of coverage or services)
        - Requirement that enrollees first seek care from their primary care physicians, thereby allowing enrollees to seek care from providers other than their designated primary care physicians
        - Use of participating network hospitals, expanded to require plans to treat all area hospitals as participating network hospitals under existing benefit provisions

  - Out-of-network charges to enrollees, suspended to allow enrollees to seek care from any available medical professional for which in-network benefits would apply
- Assuring timely access to prescription medications:
  - Directing that a 30-day supply cannot be rejected or pended regardless of date of last refill
  - Directing that maintenance medications may be dispensed in 90-day supplies
- Assuring continuity of coverage by:
  - Directing that group or individual contracts cannot be cancelled or terminated during the state of emergency even if premiums have not been paid
- Assuring collaboration in healthcare surge response and disaster recovery:
  - Directing that health plans rapidly assess the short-term impacts of the healthcare surge and disaster on their individual health plan operations and develop a disaster recovery plan according to a timeline specified by the Department of Managed Health Care
  - Directing that each health plan establish and publicize a 24-hour informational toll-free hotline for enrollees in the geographic area affected by the healthcare surge and disaster, as an information source to facilitate enrollees obtaining access to healthcare services

- **To manage financial risk**: In the geographic areas of California affected by the state of emergency and healthcare surge and for specified time periods which cover the duration of the state of emergency and healthcare surge, managing healthcare service plan financial risk during healthcare surge:
  - For pre-negotiated fee-for-service arrangements with providers, directing that when a provider claim (except Medi-Cal claims) is submitted but the premium is not received, the following rules shall apply to the healthcare service plan contract providing coverage for the enrollee:
    - The enrollee is responsible for co-payments, coinsurance and deductible amounts (collectable from the enrollee by the provider) according to the enrollee's coverage contract or evidence of coverage
    - The health plan pays 50% (or other percentage as directed) of either the contracted rate or the non-participating provider rate
    - The provider accepts 50% (or other percentage as directed) as payment in full and cannot bill the enrollee (except for co-payments, coinsurance and deductible amounts)
    - If the entire premium is subsequently received by the health plan, the provider claim is to be adjusted and paid according to the provider's contract with the health plan

- For capitated payment service arrangements with providers, directing that when a healthcare service is provided to an enrollee whose coverage eligibility verification identifies that the premium is not received for the healthcare service plan contract providing coverage for the enrollee who received the service from the provider, the Director of the Department of Managed Health Care may devise and order appropriate and necessary financial obligations and arrangements between and among health plans and providers in order to ensure continuity of provider operations for the benefit of enrollees.
- For any other circumstances in which the healthcare surge and state of emergency have greatly challenged the management of financial risk, the Director of the Department of Managed Health Care may assess the circumstances and devise and direct interim modifications of financial obligations and arrangements that ensure continuity of provider operations to enable health plans to provide healthcare services and continuity of access to healthcare services to enrollees.

- **To manage continuation of provider services:** In the geographic areas of California affected by the state of emergency and healthcare surge and for specified time periods which cover the duration of the state of emergency and healthcare surge, assuring continuation of provider services and protection of providers:
  - Authorizing the establishment of a California uncompensated care pool to pay a portion of the costs of care provided to coverage-impaired enrollees.
  - Directing that health plans pay claims as in-network, regardless of whether the healthcare provider was in network.
  - Directing that health plans establish advance payment to contracted providers for use when providers are experiencing cash flow inadequacies, where the health plan is experiencing provider payment delays, or when a provider's business operations are temporarily challenged.
  - Directing other necessary and appropriate actions identified by the Director of the Department of Managed Health Care as warranting urgent financial relief for hospitals and physicians to enable continuity of healthcare services essential for the protection of enrollees.

12.6. Hospital Reference Guide - Pertinent Regulations and Previous Responses to Healthcare Surge

One of the challenges in preparing for the operational and financial consequences of a surge in patient volume is the highly situational nature of any healthcare surge response. As such, it may be helpful to review the California and federal laws and regulations addressing the provider and health plan response focusing on patient care access and financing issues that might be challenged during a healthcare surge, as well as the specific responses that have occurred historically. In some cases, laws and regulations dictate how providers and health plans can respond to a catastrophic emergency, what benefits health plans are required to provide their members and what protections their members are

afforded. In other cases, past responses can provide a reference for providers with specific examples of the kinds of responses that might be appropriate in the future.

The tables that follow contain certain rules, requirements and other issues that may impact hospitals, payers and patients. They also contain pertinent regulations that impact payers as examples or applications from previous catastrophic events. The tables also cover pertinent regulations and previous responses related to Medicare, Medicare Advantage and Medi-Cal and can serve as a reference tool to assist hospitals during the planning phase of a healthcare surge by offering examples of past practices.

Please note that the regulations identified are not all inclusive but are those deemed most appropriate and applicable when working with health plans during a healthcare surge. These examples are not meant to prescribe any future response, but to serve as a guide during planning activities.

12.6.1. Previous Health Plan Response

The following tables address the following health plan rules/requirements/issues:

- Network requirements: Issues surrounding which hospital or licensed healthcare professional provides services to a member
- Pre-authorization: Issues surrounding providing services with or without prior-authorization
- Pharmaceutical coverage: Issues surrounding early refills and member co-payments for pharmaceutical prescriptions
- Co-pay requirements: Issues surrounding member responsibility for co-payments
- Claims management: Issues surrounding claim payments for members with late or non-current premium payments
- Insurance questions and coverage verification: Issues surrounding verifying insurance coverage and other insurance communication needs

Network Requirements : Issues surrounding which hospital or licensed healthcare professional provides services to a member	
Pertinent California Regulations Related to Accessing Standard Emergency Care	Per 28 CCR 1300.67, "the basic health care services required to be provided by a health care service plan to its enrollees shall include, where medically necessary, subject to any co-payment, deductible, or limitation of which the Director of Managed Health Care may approve: Emergency healthcare services which shall be available and accessible to enrollees on a twenty-four hour a day, seven days a week basis within the healthcare service plan area. Emergency healthcare services shall include ambulance services for the area served by the plan to transport the enrollee to the nearest twenty-four hour emergency facility with physician coverage, designated by the Health Care Service Plan. Coverage and payment for out-of-area emergencies or urgently needed services involving enrollees shall be provided on a reimbursement or fee-for-service basis

Network Requirements : Issues surrounding which hospital or licensed healthcare professional provides services to a member	
	and instructions to enrollees must be clear regarding procedures to be followed in securing such services or benefits. Emergency services defined in 28 CCR 1317.1 include active labor. 'Urgently needed services' are those services necessary to prevent serious deterioration of the health of an enrollee, resulting from an unforeseen illness, injury or complication of an existing condition, including pregnancy, for which treatment cannot be delayed until the enrollee returns to the plan's service area. 'Urgently needed services' include maternity services necessary to prevent serious deterioration of the health of the enrollee or the enrollee's fetus, based on the enrollee's reasonable belief that she has a pregnancy-related condition for which treatment cannot be delayed until the enrollee returns to the plan's service area."[92]
Pertinent California Regulations Relating to Coverage During Acts of War	Per 28 CCR 1300.67.05, "no healthcare service plan contract executed or amended on or after the effective date of this regulation shall limit or exclude healthcare services based on a determination that the need for the healthcare service arose as a result of an act of war. The term 'act of war' includes any act or conduct, or the prevention of an act or conduct, resulting from war, declared or undeclared, terrorism or warlike action by any individual, government, military, sovereign group, terrorist or other organization."[93]
Pertinent Federal Regulations Relating to Standard Emergency Care for Health Maintenance Organization Members	42 USC Section 300e indicates the "basic health services (and only such supplemental health services as members have contracted for) shall, within the area served by the health maintenance organization, be available and accessible to each of its members with reasonable promptness and in a manner which assures continuity, and when medically necessary be available and accessible twenty-four hours a day and seven days a week, except that a health maintenance organization which has a service area located wholly in a nonmetropolitan area may make a basic health service available outside its service area if that basic health service is not a primary care or emergency healthcare service and if there is an insufficient number of providers of that basic health service within the service area who will provide such service to members of the health maintenance organization. A member of a health maintenance organization shall be reimbursed by the organization for his expenses in securing basic and supplemental health services other than through the organization if the services were medically necessary and immediately required because of an unforeseen illness, injury or condition."[94]
Pertinent Federal Regulations Relating to Coverage During a Natural Disaster	42 USC Section 300e further indicates, "to the extent that a natural disaster, war, riot, civil insurrection or any other similar event not within the control of a health maintenance organization (as determined under regulations of the Secretary) results in the facilities, personnel or financial resources of a health maintenance organization not being available to provide or arrange for the provision of a basic or supplemental health service in accordance with the requirements of paragraphs (1) through (4) of this subsection, such requirements only require the organization to make a good-faith effort to provide or arrange for the provision of such service within such limitation on its facilities, personnel or resources.[95]
Pertinent California Regulations Pertaining to Utilizing Out-of-State Healthcare Practitioners	Per Business and Professions Code Section 900: a. "Nothing in this division applies to a healthcare practitioner licensed in another state or territory of the United States who offers or provides healthcare for which he or she is licensed, if the healthcare is provided only during a state of emergency as defined in Government Code Section 8558(b), which emergency overwhelms the response capabilities of California healthcare practitioners and

Network Requirements : Issues surrounding which hospital or licensed healthcare professional provides services to a member	
	only upon the request of the Director of the Emergency Medical Services Authority. b. The Director shall be the medical control and shall designate the licensure and specialty healthcare practitioners required for the specific emergency and shall designate the areas to which they may be deployed. c. Healthcare practitioners shall provide, upon request, a valid copy of a professional license and a photograph identification issued by the state in which the practitioner holds licensure before being deployed by the director. d. Healthcare practitioners deployed pursuant to this chapter shall provide the appropriate California licensing authority with verification of licensure upon request. e. Healthcare practitioners providing healthcare pursuant to this chapter shall have immunity from liability for services rendered as specified in Government Code Section 8659. f. For the purposes of this chapter, 'healthcare practitioner' means any person who engages in acts which are the subject of licensure or regulation under this division or under any initiative act referred to in this division. g. For purposes of this chapter, 'Director' means the Director of the Emergency Medical Services Authority who shall have the powers specified in Division 2.5 of the Health and Safety Code Section 1797."[96]
Pertinent California Regulations Relating to Utilizing Healthcare Practitioners with Lapsed or Inactive Licenses	Per Business and Professions Code Section 921 - 922, Health Care Professional Disaster Response Act: "This chapter shall be known and may be cited as the Health Care Professional Disaster Response Act. The Legislature finds and declares the following: 1. In times of national or state disasters, a shortage of qualified healthcare practitioners may exist in areas throughout the state where they are desperately required to respond to public health emergencies. 2. Healthcare practitioners with lapsed or inactive licenses could potentially serve in those areas where a shortage of qualified healthcare practitioners exists, if licensing requirements were streamlined and fees curtailed. a. It is, therefore, the intent of the Legislature to address these matters through the provisions of the Health Care Professional Disaster Response Act.[97] 1. A physician and surgeon who satisfies the requirements of Business and Professions Code Section 2439 but whose license has been expired for less than five years may be licensed under this chapter. 2. To be licensed under this chapter, a physician and surgeon shall complete an application, on a form prescribed by the Medical Board of California, and submit it to the board, along with the following: a. Documentation that the applicant has completed the continuing education requirements described in Business and Professions Code Section 2190, Chapter 5, Article 10 for each renewal period during which the applicant was not licensed. b. A complete set of fingerprints as required by Business and Professions Code Sections 144 and 2082, together with the fee required for processing those fingerprints.

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	3. An applicant shall not be required to pay any licensing, delinquency, or penalty fees for the issuance of a license under this chapter."[98]
Previous Response Example, Pertinent Waivers or other Application During a Healthcare Surge	Following Hurricane Katrina, under the authority of the Governor of Louisiana's numerous emergency declarations and executive orders, the Commissioner of Insurance for the State of Louisiana issued Emergency Rules 15, 17, 19 and 20. • These emergency rules suspended certain statutes and regulations regarding health insurance in Louisiana.[99] • These rules applied to primary and limited secondary parishes in Louisiana affected by the hurricanes over specific time periods.[100,101] • These rules applied only to products regulated by the Louisiana Department of Insurance. • These rules waived all restrictions relative to out-of-network access. Along with the Governor's emergency rules: • Aetna implemented policies for its members in the affected area to receive in-network benefits for care out of their network in any state, and seek care from providers, including dentists, other than their designated primary care physicians.[102] • United Healthcare provided emergency transportation and treated all area hospitals as participating network hospitals under existing emergency benefit provisions.[103] • Members from the affected disaster areas who could not access CIGNA participating physicians, hospitals or other providers for the dates of service from August 27, 2005, to September 30, 2005, were able to seek care as needed, for which in-network benefits applied. If members were unable to see their primary care physician, they sought care as needed from any available medical professional.[104] • Blue Cross of California made revisions that applied to members who were living in Alabama, Louisiana and Mississippi at the time of the disaster that allowed the affected members to see any physician necessary to provide access to care • Blue Cross of California paid all claims as in-network, regardless of whether or not the healthcare provider was in network.[105]

Pre-Authorization: Issues surrounding providing services with or without prior-authorization	
Pertinent California Regulations Relating to Authorization for Medically Necessary Services	Per 28 CCR Section 1300.71.4, "the following rules set forth emergency medical condition and post-stabilization responsibilities for medically necessary healthcare services after stabilization of an emergency medical condition and until an enrollee can be discharged or transferred. These rules do not apply to a specialized healthcare service plan contract that does not provide for medically necessary healthcare services following stabilization of an emergency condition. a. Prior to stabilization of an enrollee's emergency medical condition or during periods of destabilization (after stabilization of an enrollee's emergency medical condition) when an enrollee requires immediate medically necessary healthcare services, a healthcare service plan shall pay for all medically necessary healthcare services rendered to an enrollee.

Pre-Authorization: Issues surrounding providing services with or without prior-authorization	
	b. In the case when an enrollee is stabilized but the healthcare provider believes that the enrollee requires additional medically necessary healthcare services and may not be discharged safely, the following applies: 1. A healthcare service plan shall approve or disapprove a healthcare provider's request for authorization to provide necessary post-stabilization medical care within one half hour of the request. 2. If a healthcare service plan fails to approve or disapprove a healthcare provider's request for authorization to provide necessary post-stabilization medical care within one half-hour of the request, the necessary post-stabilization medical care shall be deemed authorized. Notwithstanding the foregoing sentence, the healthcare service plan shall have the authority to disapprove payment for (A) the delivery of such necessary post-stabilization medical care or (B) the continuation of the delivery of such care; provided that the healthcare service plan notifies the provider prior to the commencement of the delivery of such care or during the continuation of the delivery of such care (in which case, the plan shall not be obligated to pay for the continuation of such care from and after the time it provides such notice to the provider, subject to the remaining provisions of this paragraph) and in both cases the disruption of such care (taking into account the time necessary to effect the enrollee's transfer or discharge) does not have an adverse impact upon the efficacy of such care or the enrollee's medical condition. 3. Notwithstanding the provisions of subsection (b) of this rule, a healthcare service plan shall pay for all medically necessary healthcare services provided to an enrollee which are necessary to maintain the enrollee's stabilized condition up to the time that the healthcare service plan effectuates the enrollee's transfer or the enrollee is discharged. c. In the case where a plan denies the request for authorization of post-stabilization medical care and elects to transfer an enrollee to another healthcare provider, the following applies: 1. When a healthcare service plan responds to a healthcare provider's request for post-stabilization medical care authorization by informing the provider of the plan's decision to transfer the enrollee to another healthcare provider, the plan shall effectuate the transfer of the enrollee as soon as possible. 2. A healthcare service plan shall pay for all medically necessary healthcare services provided to an enrollee to maintain the enrollee's stabilized condition up to the time that the healthcare service plan effectuates the enrollee's transfer. d. All requests for authorizations, and all responses to such requests for authorizations, of post-stabilization medically necessary healthcare services shall be fully documented. All provision of medically necessary healthcare services shall be fully documented. Documentation shall include, but not be limited to, the date and time of the request, the name of the healthcare provider making the request and the name of the plan representative responding to the request."[106]
Previous Response Example, Pertinent Waivers or other Application During a Healthcare	Following Hurricane Katrina, under the authority of the Governor of Louisiana's numerous emergency declarations and executive orders, the Commissioner of Insurance for the State of Louisiana issued Emergency Rules 15, 17, 19 and 20. • These rules suspended: – Medical certifications

Pre-Authorization: Issues surrounding providing services with or without prior-authorization	
Surge	– Referrals – Medical necessity reviews – Notification of hospital admissions – Right to conduct medical necessity reviews (for nonelective services)[107] Some private payers in California updated their force majeure clauses to excuse parties from some of the terms and conditions of the contract if a major disaster occurs. Along with the Governor of Louisiana's emergency rules: • Aetna implemented policies for its members in the affected area to receive treatment covered under their plan without medical pre-certification, referrals or notification of hospital admissions.[108] • CIGNA temporarily modified certain standard claim approval requirements including requirements for pre-certification, referrals, medical necessity determinations and hospital admission procedures. Essentially, this entailed suspending the need for members and their providers to get pre-certifications or referrals for procedures and treatments that usually require it. Similarly, they were not reviewing claims for medical necessity.[109] • WellPoint Health Networks, the parent company of Blue Cross of California, made revisions that applied to members who were living in Alabama, Louisiana and Mississippi at the time of Hurricane Katrina that: – Suspended requirements for prior authorization and pre-certification – Suspended requirements for authorization or referral from a primary care physician[110]

Pharmaceutical Coverage: Issues surrounding early refills and member co-payments for pharmaceutical prescriptions	
Previous Response Example, Pertinent Waivers or Other Application during a Healthcare Surge	Following Hurricane Katrina, under the authority of the Governor of Louisiana's numerous emergency declarations and executive orders, the Commissioner of Insurance for the State of Louisiana issued Emergency Rules 15, 17, 19 and 20. • These rules stipulated that claims for an initial 30-day supply of prescription medication could not be rejected or pended regardless of date of last refill.[111] Along with the Governor of Louisiana's emergency rules: • Aetna implemented policies for its members in the affected area to refill prescriptions even if they were not due to be filled and, for those who use Aetna's mail-order pharmacy, receive replacement for any lost or damaged prescriptions for no additional costs.[112] • WellPoint Health Networks, parent company of Blue Cross of California, made revisions that applied to members who were living in Alabama, Louisiana and Mississippi at the time of the disaster that: – Suspended early refill limits and shipping prescriptions to members at alternative addresses – Waived co-payments for prescriptions[113] • United Healthcare allowed members who needed prescription refills to replace them quickly at local pharmacies or via mail service. Even before the hurricane hit, United Healthcare began allowing members to obtain early refills and extra

Pharmaceutical Coverage: Issues surrounding early refills and member co-payments for pharmaceutical prescriptions	
	prescription levels in Alabama, Louisiana and Mississippi. • For United Healthcare, local pharmacies in the affected areas were notified of the following changes: Members were given a toll-free number to call with any questions on how to replace lost prescriptions. Members who normally used mail pharmacy services and who were in short supply were eligible to obtain medications through their local retail pharmacy. Mail pharmacy orders were expedited by key zip codes to crisis areas. All mail orders for temperature-sensitive prescriptions were assessed on a daily basis to determine appropriate and safe handling for fulfillment.[114] • CIGNA Pharmacy Management allowed members to order refills of their prescription medications early to replace medicines lost or destroyed, and waived medical necessity reviews. • Members who normally received their prescriptions in the mail through CIGNA Tel-Drug were allowed to have medications shipped overnight at no additional cost. If shipping to the member was not feasible, the member could request that the prescription be transferred to a local retail pharmacy. CIGNA Tel-Drug replaced lost or damaged medication at no charge to members. [115]

Co-Pay Requirements: Issues surrounding member responsibility for co-payments	
Previous Response Example, Pertinent Waivers or Other Application during a Healthcare Surge	Following Hurricane Katrina, under the authority of the Governor of Louisiana's numerous emergency declarations and executive orders, the Commissioner of Insurance for the State of Louisiana issued Emergency Rules 15, 17, 19 and 20. • These rules stipulated that when a claim is submitted but the premium has not been received: the insured was responsible for co-payments, deductibles and coinsurance.[116] Along with the Governor's emergency rules: • WellPoint Health Networks made revisions that applied to members who were living in Alabama, Louisiana and Mississippi at the time of the disaster that waived co-payments for prescriptions.[117]

Claims Management: Issues surrounding claim payments for members with late or non-current premium payments	
Previous Response Example, Pertinent Waivers or Other Application during a Healthcare Surge	Following Hurricane Katrina, under the authority of the Governor of Louisiana's numerous emergency declarations and executive orders, the Commissioner of Insurance for the State of Louisiana issued Emergency Rules 15, 17, 19 and 20. • These rules stipulated that when a claim is submitted but the premium has not been received: – The insured was responsible for co-payments, deductibles and coinsurance. – The insurer paid 50 percent of either the contracted rate or the non-participating rate. – The provider accepted 50 percent as payment in full and could not bill the patient. – If the entire premium was subsequently received, the claim was readjusted and paid according to the contract.[118]

Insurance Questions and Coverage Verification: Issues surrounding verifying insurance coverage and other insurance communication needs	
Previous Response Example, Pertinent Waivers or Other Application during a Healthcare Surge	• America's Health Insurance Plans published a 1-800 number where anyone could call to find their coverage/doctors. America's Health Insurance Plans connected them with their appropriate health plan. Most health plans had a 1-800 number as well. This process remains enabled for future emergency or disaster situations.[119] • United Healthcare established a 24-hour crisis toll-free hotline for anyone in the Gulf Coast.[120]

12.6.2. Medicare and Medicare Advantage Products: Previous Response

The tables below address the following rules/requirements/issues related to Medicare and Medicare Advantage members:

- Physician/network requirements: Issues surrounding which licensed healthcare professional provides services to a member
- Pre-authorization: Issues surrounding providing services with or without prior-authorization
- Pharmaceutical coverage: Issues surrounding early refills and member co-payments for pharmaceutical prescriptions
- Nonpayment of premiums and coverage continuity: Issues surrounding non-payment of premiums and termination of coverage

Physician / Network Requirements: Issues surrounding which licensed healthcare professional provides services to a member	
Pertinent Regulations Related to Accessing Standard Emergency Care	According to the Centers for Medicare and Medicaid Services' website, “for Medicare enrollees of a Medicare Advantage plan, there exists no ‘good faith’ provision similar to the Public Health Service Act provision. Therefore, Medicare Advantage plans are required to continue directly providing all Part A and Part B services, or otherwise arranging for such services to be provided, so that statutory and regulatory requirements for accessibility and availability of services continue to be met. For Medicare enrollees, Medicare Advantage plans have financial responsibility for emergency services and 'urgently needed' services. The term ‘urgently needed services’ are covered services medically necessary and immediately required when the Medicare beneficiary is temporarily outside of the plan’s service area. Medicare Advantage plans are also required to cover urgently needed services within the service area when, due to unusual and extraordinary circumstances, the organization’s provider network is temporarily unavailable or inaccessible, for example, because of a natural disaster or electrical power outage. Urgently needed services are medically necessary and immediately required (1) as a result of an unforeseen illness, injury or condition; and (2) it was not reasonable, given the circumstances, to obtain the services through the plan’s provider network.”[121]
	Physician Requirements for Medicare Eligibility

Physician / Network Requirements: Issues surrounding which licensed healthcare professional provides services to a member	
Pertinent California Regulations Relating to Physician Requirements for Medicare Eligibility	Physician means doctor of medicine, doctor of osteopathy (including osteopathic practitioner), doctor of dental surgery or dental medicine (within the limitations in subsection 70.2), doctor of podiatric medicine (within the limitations in subsection 70.3), or doctor of optometry (within the limitations of subsection 70.5) and, with respect to certain specified treatment, a doctor of chiropractic legally authorized to practice by a state in which he/she performs this function. The services performed by a physician within these definitions are subject to any limitations imposed by the state on the scope of practice.[122] "The issuance by a state of a license to practice medicine constitutes legal authorization. Temporary state licenses also constitute legal authorization to practice medicine. If state law authorizes local political subdivisions to establish higher standards for medical practitioners than those set by the state licensing board, the local standards determine whether a particular physician has legal authorization. If state licensing law limits the scope of practice of a particular type of medical practitioner, only the services within the limitations are covered."[123] **Facility Eligibility** Eligible provider must enroll by completing a Centers for Medicare and Medicaid Services Form 855A, and upon approval, enter into a Provider Agreement per 42 USC Section 1395cc; 42 CFR 489.10, .12, .53. To be eligible, facility must be licensed or approved by State licensing agency and meet applicable Conditions of Participation (CoP). 42 CFR 409.3. **Application Procedure** Medicare physicians and nonphysician providers use the form Centers for Medicare and Medicaid Services 855B.
Pertinent California Regulations Related to Facility Reimbursement for Emergency Services	**Emergency Services** 42 CFR 424.103 – Medicare pays for emergency services in nonparticipating hospital. Emergency defined at 42 CFR 424.101 as inpatient or outpatient hospital services necessary to prevent death or serious impairment of health and, because of the danger to life or health, require use of the most accessible hospital available and equipped to furnish those services. **Retroactivity** 42 CFR 489.13(2) – Retro effective date if a provider or supplier meets the requirements of 42 CFR 489.13 (d)(1) [accreditation] and (d)(1)(i) [compliance with additional requirements, then effective on date of compliance] or (d)(1)(ii) [if no additional requirements, then effective date is date of initial request for participation], the effective date may be retro for up to 1 year.
Pertinent California Regulations Related to Out-of-State Facility Reimbursement	**Out-of-State Facilities** Since Medicare is a federal program, Medicare beneficiaries who are not enrolled in Medicare +Choice programs should be able receive services in any state and same rules as for in-state facilities should apply. **Foreign Facilities** 42 CFR 413.74 and section 1814(f) of the Act – payment for the reasonable cost of emergency and nonemergency inpatient hospital services – may only be paid to

Physician / Network Requirements: Issues surrounding which licensed healthcare professional provides services to a member	
	hospitals in Canada and Mexico.
Previous Response Example, Pertinent Waivers or Other Application during a Healthcare Surge	**Applicable Waivers** Waivers of federal Centers for Medicare and Medicaid Services requirements (Section 1135 Waivers) - Under 42 U.S.C. Section 1320b-5 (Section 1135 of the Social Security Act), the Secretary of Health and Human Services has authority to waive certain requirements of Centers for Medicare and Medicaid Services programs in an emergency area during a federal emergency period. An "emergency area" is a geographical area in which, and an "emergency period" is the period during which, there exist two types of declared emergencies: an emergency or disaster declared by the President under the National Emergencies Act or the Stafford Act, and a public health emergency declared by the Secretary of Health and Human Services. 42 U.S.C. Section 1320b-5(g)(1). At the Secretary's discretion, waivers that are authorized after the emergency has occurred may be made retroactive to the beginning of the emergency period. 42 U.S.C. Section 1320b-5(c). With two exceptions (Emergency Medical Treatment and Active Labor Act and HIPAA), the waivers generally last for the duration of the emergency period or until Centers for Medicare and Medicaid Services determines that the waiver is no longer necessary. However, if a hospital regains its ability to comply with a waived requirement before the end of the declared emergency period, the waiver of that requirement no longer applies to that hospital.[124] The Secretary of Health and Human Services may waive: a. Conditions of participation or other certification requirements for an individual healthcare provider or types of providers b. Program participation and similar requirements for an individual healthcare provider or types of providers c. Pre-approval requirements[125] The Secretary of Health and Human Services may waive sanctions under 42 U.S.C. Section 1395nn(g), relating to limitations on physician referrals.[126] The Secretary of Health and Human Services may waive "requirements that physicians and other healthcare professionals be licensed in the state in which they provide services, if they have equivalent licensing in another state and are not affirmatively excluded from practice in that state or in any state a part of which is included in the emergency area." [127] Following Hurricane Katrina, Health and Human Services issued a waiver permitting Medicare Advantage enrollees to use out-of-network providers in an emergency situation. This waiver was applied retroactively.[128]

Pre-Authorization: Issues surrounding providing services with or without prior-authorization	
Previous Response Example, Pertinent Waivers or Other Application during a Healthcare Surge	• Following Hurricane Katrina, the Centers for Medicare and Medicaid Services deemed it acceptable for Medicare Advantage plans to implement a liberal service authorization policy. In the past, Medicare Advantage plans have approved all urgent requests for authorizations for participating/nonparticipating providers, including facility transfers to participating/nonparticipating hospitals. In addition, most plans approve urgent referral requests. • In the case of Hurricane Andrew in South Florida and also the hurricanes in Florida during 2004, Medicare Advantage plans in affected states advised the Centers for Medicare and Medicaid Services of their intention to be liberal in the

Pre-Authorization: Issues surrounding providing services with or without prior-authorization	
	interpretation of emergent and urgent care during the worst days of the effects of the hurricane. One health plan publicly announced that, for beneficiaries residing in a certain geographic area, the plan would pay all claims from all providers for medically necessary care during a specified number of days.[129]

Pharmaceutical Coverage: Issues surrounding early refills and member co-payments for pharmaceutical prescriptions	
Previous Response Example, Pertinent Waivers or Other Application during a Healthcare Surge	• With past emergency situations, Medicare Advantage plans have stipulated that for areas sustaining major damage, all pharmacy requests should be filled at participating level benefits for either participating or nonparticipating pharmacies. • Following Hurricane Katrina, managed care plans in the affected areas made special arrangements to ensure that members had access to needed medications. The plans permitted early refills, lifted other restrictions and arranged with a number of major pharmacy chains across the country to fill the prescriptions. These pharmacies, in turn, contacted the managed care organization or physician if the member did not know the name of the drug. The managed care organization reimbursed the member for any out-of-pocket costs associated with the prescription drug. Further information about access to pharmacies could be received through the plans individual toll-free member hot lines.[130]

Non-Payment of Premiums and Coverage Continuity: Issues surrounding non-payment of premiums and termination of coverage	
Previous Response Example, Pertinent Waivers or Other Application during a Healthcare Surge	• Following Hurricane Katrina, Medicare Advantage enrollees who could not pay the premiums they owed their managed care plan had up to 60 days to submit premium payment. They were not terminated from their plan for nonpayment of the premium during the post-evacuation time. • Following Hurricane Katrina, Medicare Advantage members were not disenrolled from their plan unless they wanted to be, even if their plan was affected by the hurricane. They remained enrolled in their Medicare managed care plan even while they were temporarily unable to use it. While they were unable to use their Medicare health plan they got healthcare from healthcare providers that were not part of their managed care plan's network.[131]

12.6.3. Medi-Cal: Previous Response

The tables below address issues surrounding which hospital or licensed healthcare professional provides services to a Medi-Cal beneficiary.

Network Requirements: Issues surrounding which hospital or licensed healthcare professional provides services to a member	
Pertinent California Regulations Related to Accessing Standard Emergency Care	For Medi-Cal, under 22 CCR 51056, "emergency services" mean services required for alleviation of severe pain, or immediate diagnosis and treatment of unforeseen medical conditions, which, if not immediately diagnosed and treated, would lead to disability or death. For purposes of treating eligible aliens, "emergency medical condition" means a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could

Network Requirements: Issues surrounding which hospital or licensed healthcare professional provides services to a member	
	reasonably be expected to result in any of the following: • placing the patient's health in serious jeopardy • serious impairment to bodily functions • serious dysfunction of any bodily organ or part
Pertinent California Regulations Related to Hospital Reimbursement for Emergency Services	Per 22 CCR 51207, "a hospital not meeting all the requirements may be paid for services furnished to eligible beneficiaries on an emergency basis per 22 CCR 51056 – only until such time as the patient may be moved safely to an institution that meets the requirements." Per 22 CCR 51056: a. "Emergency services mean services required for alleviation of severe pain or immediate diagnosis and treatment of unforeseen medical conditions, which, if not immediately diagnosed and treated, would lead to disability or death. b. For purposes of treating eligible aliens, it means a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following: 1. Placing the patient's health in serious jeopardy 2. Serious impairment to bodily functions 3. Serious dysfunction of any bodily organ or part"
Pertinent California Regulations Related to Noncontracted Hospital Reimbursement	Per 22 CCR 51541(c)(6), "noncontracted hospitals are not eligible to service Medi-cal beneficiaries, except under one of the following: a. They provide stabilizing services as required to program beneficiaries located in a closed health facility planning area who are in a life-threatening or emergency situation before the beneficiary may be transported to a contracting hospital. b. A beneficiary is located in a closed health facility planning area and experiencing a life-threatening or emergency situation but cannot be stabilized sufficiently to facilitate a transfer to a contracting facility, those health services medically necessary for alleviation of severe pain or immediate diagnosis and treatment of unforeseen medical conditions which, if not immediately diagnosed and treated, could lead to significant disability or death. c. They provide services to beneficiaries who are also eligible for benefits under the federal program of hospital insurance for the aged and disabled. d. They provide services to beneficiaries who live or reside farther than the community travel time standard from a contract hospital, as defined by the department, if the hospital providing services is closer than a contract hospital. 1. Provision of services to beneficiary where travel time from home to contract hospital exceeds the normal practice for the community or 30 minutes (whichever is greater) and the noncontracting hospital is closer 2. Provision of services to a Medicare cross-over patient, subsequent to exhaustion of Medicare benefits and patients in a life-threatening or emergency situation which could result in permanent impairment."
Pertinent California Regulations Related to	**Per 22 CCR 51006, Out-of-State Coverage:** (a) "Necessary out-of-state medical care, within the limits of the program, is

Network Requirements: Issues surrounding which hospital or licensed healthcare professional provides services to a member	
Out-of-State Facility Reimbursement	covered only under the following conditions: (1) When an emergency arises from accident, injury or illness; or (2) Where the health of the individual would be endangered if care and services are postponed until it is feasible that he return to California; or (3) Where the health of the individual would be endangered if he undertook travel to return to California; or (4) When it is customary practice in border communities for residents to use medical resources in adjacent areas outside the State; or (5) When an out-of-state treatment plan has been proposed by the beneficiary's attending physician and the proposed plan has been received, reviewed and authorized by the Department before the services are provided. The Department may authorize such out-of-state treatment plans only when the proposed treatment is not available from resources and facilities within the State. (6) Prior authorization is required for all out-of-state services, except: • Emergency services as defined in 22 CCR Section 51056. • Services provided in border areas adjacent to California where it is customary practice for California residents to avail themselves of such services. Under these circumstances, program controls and limitations are the same as for services from providers within the State."[132] **Per 22 CCR 51543, Out-of-State Hospital Inpatient Services Reimbursement:** a. "Out-of-state inpatient hospital services which have been certified for payment at the acute level and which are either of an emergency nature or for which prior Medi-Cal authorization has been obtained shall be reimbursed at an amount not to exceed the current statewide average of contract rates for acute inpatient hospital services negotiated by the California Medical Assistance Commission or the actual billed charges, whichever is less. **b.** Hospitals may request an administrative adjustment to the rate within 60 days of notice of payment. The request, which must be in writing, should be mailed to the California Department of Health Care Services, Hospital Reimbursement Unit, 714 P Street, P.O. Box 942732, Sacramento, CA 94234-7320. The decision on the administrative adjustment shall be final and is not subject to further appeal."[133] **Per 22 CCR 51006, Foreign Facilities:** "No services are covered outside the United States, except for emergency services requiring hospitalization in Canada or Mexico."[134]
Previous Response Example, Pertinent Waivers or Other Application during a Surge	**Section 1135 Waivers** Under 42 USC Section 1320b-5, the Secretary of Health and Human Services has authority to waive certain requirements of the Centers for Medicare and Medicaid Services programs in an emergency area during a federal emergency period (Section 1135 Waivers). An “emergency area” is a geographical area in which, and an “emergency period” is the period during which, there exist two types of declared emergencies: an emergency or disaster declared by the President under the National Emergencies Act or the Stafford Act, and a public health emergency declared by the Secretary of Health and Human Services. 42 USC Section 1320b-5(g)(1). At the Secretary’s discretion, waivers that are authorized after the

Network Requirements: Issues surrounding which hospital or licensed healthcare professional provides services to a member	
	emergency has occurred may be made retroactive to the beginning of the emergency period. 42 USC Section 1320b-5(c). With two exceptions (Emergency Medical Treatment and Active Labor Act and HIPAA), the waivers generally last for the duration of the emergency period or until the Centers for Medicare and Medicaid Services determines that the waiver is no longer necessary. However, if a hospital regains its ability to comply with a waived requirement before the end of the declared emergency period, the waiver of that requirement no longer applies to that hospital.[135] The Secretary of Health and Human Services may waive: a. Conditions of participation or other certification requirements for an individual healthcare provider or types of providers b. Program participation and similar requirements for an individual healthcare provider or types of providers c. Pre-approval requirements[136] The Secretary of Health and Human Services may waive sanctions under 42 USC Section 1395 (g), relating to limitations on physician referrals.[137] The Secretary of Health and Human Services may waive "requirements that physicians and other healthcare professionals be licensed in the state in which they provide services, if they have equivalent licensing in another state and are not affirmatively excluded from practice in that state or in any state a part of which is included in the emergency area." [138] Following Hurricane Katrina, the Louisiana Medicaid program developed an expedited process to enroll providers on an emergency basis and made modifications to its billing system to allow for overrides to issue payments to providers not previously enrolled in the Louisiana Medicaid program. This process was developed quickly in response to the devastation of Hurricane Katrina and included a shortened version of its normal process. This emergency provider enrollment process required a license number or Medicaid number from the provider's home state. Initially, providers were allowed to apply irrespective of whether they had seen displaced Louisiana Medicaid patients. As a result, Louisiana Medicaid received duplicate applications and submissions from . In response, Louisiana Medicaid began requiring a copy of a claim form with all applications. Retrospective enrollments were allowed, and, in all, Louisiana Medicaid enrolled approximately 19,000 out-of-state providers. One recommendation that came out of Louisiana's emergency provider enrollment was to require a copy of the provider's license, not simply the license number.[139]

13. Facility Operations Recovery[140]

The recovery phase of an emergency management program for hospitals focuses upon returning the hospital to baseline levels of functioning. Well-executed recovery activities can significantly improve the function of the recovering hospital compared with its pre-surge condition. In some cases, recovery must accomplish new building construction, geographic re-location, radical change in methods for conducting business, more stringent security arrangements or other drastic measures. Aspects of the Recovery Phase include:

- Identifying a starting point for recovery: The planning for incident recovery begins early in response, as soon as the response management is organized. Recovery activities begin well before most response objectives are accomplished.
- Determining the endpoint to recovery: The point when the recovery phase is complete can be difficult to recognize and may extend for very prolonged periods of time, even years in some cases. As an example, a community impacted by a large earthquake may require years to recover to its pre-event status.
- Return to readiness: For organizations with emergency response roles like hospitals, the completion of "return to readiness" tasks must be expeditiously completed during recovery.
- Recovery as part of a larger effort: Recovery for an organization is rarely conducted in isolation. Frequently, recovery is impacted by the larger community at the local, State, and Federal levels. Organizational recovery should be coordinated with this larger system, and the community authorities should be notified when the healthcare system is recovered. This may be simple (e.g. an organization officially notifying the jurisdiction that it has achieved baseline status) or complex (e.g. extensive interaction required for allocation of Federal resources in a post-event environment).

13.1. A Checklist of Recovery Planning Activities[141]

Activities that recovery planning should address include:

- Personnel recovery:
  - Completion of activities initiated during demobilization such as out-processing of personnel:
    - Accountability of personnel
    - Debriefings as necessary
    - Ensuring adequate rehabilitation time and actions for those participating in the response
    - Rescheduling as necessary for shift workers
    - Documentation of potential exposures (as appropriate)
  - Attending to acute and long-term physical and psychological health effects incurred by healthcare system personnel during response (e.g., conducting long-term health surveillance for exposed staff, or providing counseling services).

- Non-personnel resources: Recovery of mission critical systems and return to readiness of response resources.
  - Physical structure recovery:
    - Evaluating, cleaning, repairing damage to the facilities or rebuilding.
    - Rehabilitation of incident facilities, such as cleaning the decontamination areas, or returning to normal function the area used to support the Healthcare System Command Post.
    - Recertification of facilities that have received hazard impact (e.g. professional evaluation of a facility in a post-earthquake environment to certify structural integrity for occupation and use, certification that a contaminated area is clean, and others).
  - Equipment and Supply Cache recovery:
    - Replacing or servicing equipment used during response
    - Inventory of supplies and replacement of expended materials
  - Financial recovery:
    - Accounting accurately for all costs incurred as a result of a hazard impact and incident response and recovery. For healthcare systems, this may include:
      - Loss of normal business revenue due to the voluntary suspension of certain services in order to provide incident services (e.g. cancellation of elective procedures or surgeries)
      - Overtime staff costs
      - Loss of durable equipment
      - Structural impact
      - Loss of business due to patients avoiding an 'impacted facility'
      - Others.
    - Application for reimbursement of costs from appropriate resources.
    - Tracking of costs and reimbursements and impact on regularly budgeted operations.
  - Business systems recovery:
    - Re-establishing normal operations
      - Recovery of infrastructure necessary to resume normal operations
      - Notification to community authorities and the public that normal healthcare e system operations are resuming, and any changes (location, contact information for rescheduling, security procedures, and others) that are pertinent
      - Rescheduling of canceled or postponed activities
      - Addressing the backlog of urgent and elective cases in an expedited manner

- Evaluation of the public's perception of the system's response, with public information interventions as indicated.

- Coordination with external systems: Recovery activities should be coordinated with other healthcare facilities and the community response system. This might include:
  - Notification when baseline operations have been achieved.
  - Sharing particular hazard or vulnerability information that was developed during response and recovery and that may impact other healthcare facilities or the community.
  - Coordinating the application for and for allocation of financial resources in an objective and fair manner, as well as other resources (e.g. re-supply of medications from an arriving shipment, or resumption of the normal blood supply for the region).
- Organizational learning/Systems improvement: The Recovery plan should address the critical activities that initiate the organizational learning process.
  - Recovery efforts should include a thorough evaluation of how the response system performed under stress.
  - Specific strengths, weaknesses, and strategies to both lessen vulnerability and improve the system's ability to respond to future emergencies and disasters should be captured and tracked.
  - This information is analyzed, formatted and entered into the emergency management program process for organizational learning and should also be noted and considered during the Hazard Vulnerability Assessment revision process.

- After Action Reports/Corrective Action Plans: An After Action Report is used to provide feedback to a hospital after an event. The After Action Report summarizes response activities and analyzes performance so corrective actions for improvement can be identified, along with timelines for their implementation and assignment to responsible parties. Additional information on After Action Reports and templates can be found at: https://hseep.dhs.gov/pages/HSEEP_Home.aspx

- Community recovery activities: Active participation in planning and implementing initiatives that return the community itself to normal or to the defined 'new normal.' Some of this may be done urgently through the community-wide Incident Command System structure, and some may be accomplished through more normal business routes of administration as the community undertakes reconstruction. Hospitals should take an active role in recovery activities to help communities rebuild and redefine themselves following a healthcare surge.

14. Endnotes

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