

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

Hospital Training Presentation



Hospitals Training Overview and Learning Objectives

- This training course is intended to serve as an overview of the content in the Hospitals Volume of the Surge Standards and Guidelines Manual. It is designed to be used as tool for organizations developing training programs on their surge plans. Organizations should use this training course as a starting point and customize it to include organization specific surge planning objectives.

Upon completion of this course, you will be able to:

- Define basic terminology, such as surge, surge capacity, and standards of care (among others), as used in the context of the Standards and Guidelines for Healthcare Surge During Emergencies project.
- Introduce existing waivers and provisions to regulations as they pertain to a health emergency situation, and be able to locate those provisions.
- Describe the ethical and behavioral principles and practice guidelines required to be in place during a healthcare surge event.
- Identify regulatory information and other resources for planning and implementing a response to healthcare surge.

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.
- The overwhelming increase in demands for medical care arising out of such an event is called healthcare surge.
- 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:

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| <ul style="list-style-type: none">• Local response is primary• Medical response is complex• Coordinated response is essential• Bridging the "public-private divide"• Public health as an essential partner | <ul style="list-style-type: none">• The need for robust information processing• The need for effective overall management• Medical system resiliency |
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- 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.

¹ *Emergency Management Principles and Practices for Healthcare Systems*. The Institute for Crisis, Disaster, and Risk Management (ICDRM) at the George Washington University; for the Veteran's Health Administration, United States Department of Veteran's Affairs. Washington, D.C., June 2006. Available at <http://www1.va.gov/emshg/>

Key Healthcare Surge Planning Concepts for California

- The following concepts serve as the foundation for understanding the context and perspective for 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 outcomes challenges the professional, regulatory, and ethical paradigms of the healthcare delivery system. The standard of care will focus on saving the most amounts of lives as possible.
 - There is a great deal of flexibility in current state statute and regulations to enable a move to population based healthcare response.
 - In California, a healthcare surge is proclaimed in a local jurisdiction when an authorized local official, 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.
 - Local government will be responsible for determining the state of healthcare surge and the identification of and planning for the operations of Government-Authorized Alternate Care Sites.

Key Healthcare Surge Planning Concepts for California (continued)

- The intent of the Standards and Guidelines Manual is not to solve the challenges of the current healthcare delivery system but to operate within it.
- While the current healthcare delivery system is complex, much can be done in the event of a surge response to simplify it.
- Preserving overall financial liquidity in the healthcare delivery system during a catastrophe is an issue that is larger than any single stakeholder.
- 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.

Overview of Hospitals Volume

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 maintaining business continuity and sustaining operations at facilities providing medical care.

“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.

Overview of Hospitals Volume (*continued*)

- 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.
 - 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 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.

Transitioning From Individual Care to Population-Based Care Hospitals Volume, Section 2.1

- 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*¹, 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.

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

¹Ethical Considerations in the Allocation of Organs and Other Scarce Medical Resources Among Patients. (*Arch Intern Med.* 1995; 155: 29-40). © 1993 American Medical Association.

Standard of Care Defined

Hospitals Volume, Section 2.2

- The "standard of care" in California is based on what a reasonably prudent person with similar knowledge and experience would do under similar circumstances.

- 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.

- Standard of care is a legal concept that requires licensed healthcare personnel, when caring for patients, adhere to the customary skill and care that is consistent with good medical (or other healthcare) practice.
- Diligence implies compliance with laws and regulations (for example licensing requirements).
- Standard of care applies to all aspects of care and treatment - from initial assessment, to administering of proper medications and performing open-heart surgery.

National Incident Management System Implementation Activities for Hospitals and Healthcare Systems Hospitals Volume, Section 3.1

- 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.
- 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.
- Major categories for implementation activities for hospitals and healthcare systems include¹:

<ul style="list-style-type: none">• Organizational Adoption• Command and Management• Preparedness Planning	<ul style="list-style-type: none">• Preparedness Training• Preparedness Exercises• Resource Management• Communications and Information Management
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¹Federal Emergency Management Administration, Fact Sheet, NIMS Implementation for Hospitals and Healthcare Systems, September 12, 2006.
http://www.fema.gov/pdf/emergency/nims/imp_hos_fs.pdf

Standardized Emergency Management System (SEMS)

Hospitals Volume, Section 3.2

- SEMS is a system for managing the response to multi-agency and multi-jurisdictional emergencies in California.¹ The system integrates NIMS, the Incident Command System, and the support and coordination system developed under SEMS.
- 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.²
- 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.
- The Operational Area, defined in the Emergency Services Act, is a required concept of SEMS.³
- 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.⁴

¹In a letter dated September 28, 2006, the director of OES certified to the federal Department of Homeland Security the compliance of SEMS/NIMS with the National Incident Management System (NIMS) for fiscal year 2006.

²Government Code Section 8607(e).

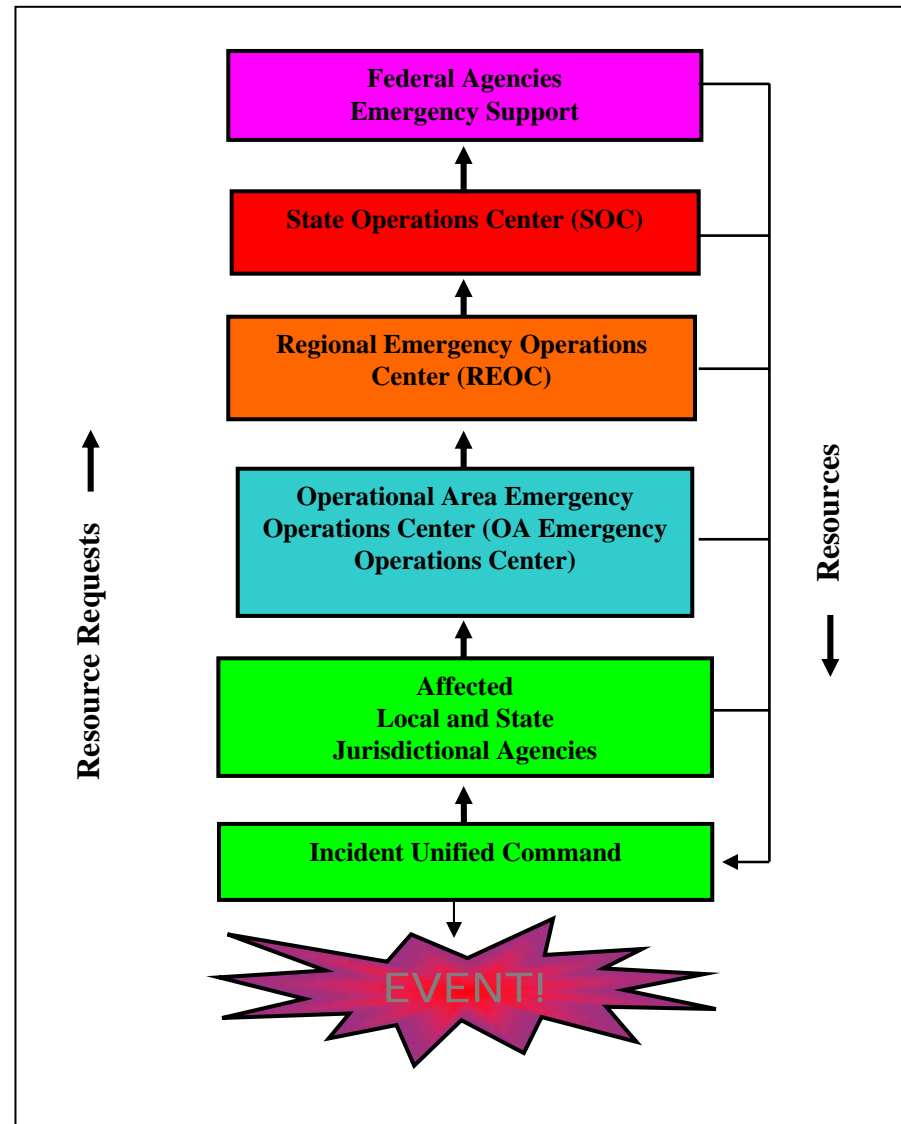
³Government Code Section 8559(b), 8605, and 8607(a)(4)

⁴Government Code Section 8605.

Standardized Emergency Management System (continued)

Hospitals Volume, Section 3.2

- SEMS is designed to foster the coordination of public and private sector resources at all levels of its structure.
- Requests for resources flow upward from the local level to the federal level and assistance to meet these requests 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.



Planning for the Incident Command System

Hospitals Volume, Section 3.3

- 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:
 - **Operations Section Chief**
 - **Planning Section Chief**
 - **Logistics Section Chief**
 - **Finance / Administration Chief**
- 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.

The Hospital Incident Command System

Hospitals Volume, Section 3.4

- 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 Guidebook¹ 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

¹ The Hospital Incident Command System Guidebook (August 2006) can be found at www.emsa.ca.gov/hics

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

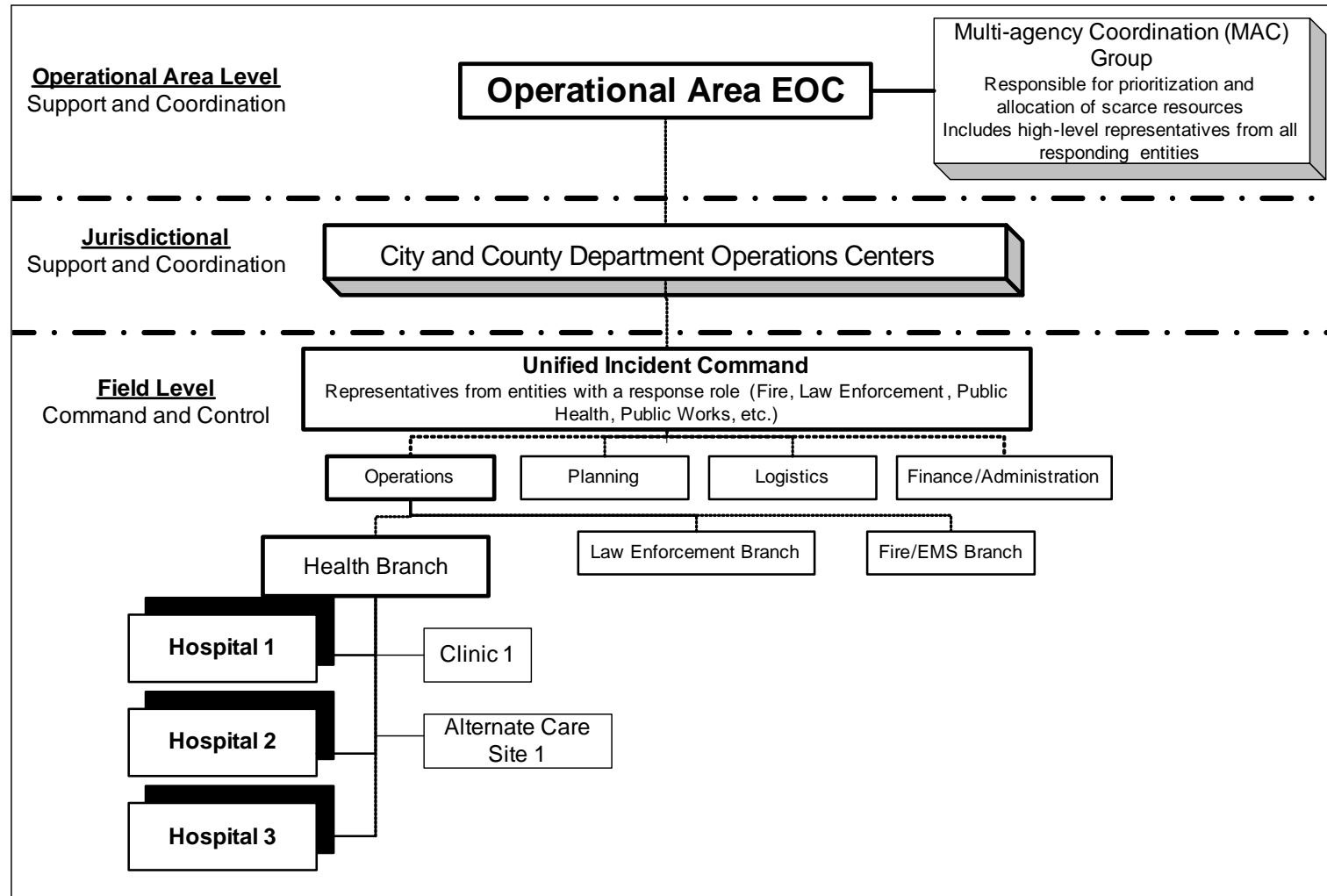
Hospitals Volume, Section 3.5

- 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.

How Hospitals Connect to the Emergency Response Structure

Hospitals Volume, Section 3.6

All healthcare providers must be integrated into this Unified Command. An authorized local official, or designee, will notify healthcare facilities that the Unified Command has been established and provide a contact for coordination of patient movement and requests for resources, services and supplies.



Hospital Expansion versus Alternate Care Sites

Hospitals Volume, Section 3.6.1

- There are two ways to address the increased demand for healthcare:
 - Expand existing healthcare facilities to increase capacity for patient care
 - Establish temporary healthcare facilities to provide care in non-healthcare locations.
- 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.

Community Surge Planning

Hospitals Volume, Section 3.7

- 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.
- 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.
- Contact information for the following organizations should be maintained in the hospital's emergency operations plan:
 - **The Local Health Department and officer**
 - **The Medical Health Operations Area Coordinator, or other appropriate designee**
 - **The Local Emergency Medical Services agency administrator and medical director**
 - **The Operational Area emergency operations center staff**

Developing a Hazard Vulnerability Analysis

Hospitals Volume, Section 3.8

- The Hazard Vulnerability Analysis is the needs assessment for an organization's emergency preparedness program.
- In *Emergency Management Principles and Practices for Healthcare Systems*¹, 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.
 - Healthcare facilities are very complex buildings combining the functions of a hotel, office, laboratory, and warehouse.
 - Many healthcare facility supplies (pharmaceuticals, splints, bandages, etc.) are essential for patient survival and crucial for treatment of victims.
 - Healthcare facility function is dependent upon utilities such as power, water supply, waste disposal, and communication.
 - 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.

¹*Emergency Management Principles and Practices for Healthcare Systems*. The Institute for Crisis, Disaster, and Risk Management (ICDRM) at the George Washington University (GWU); for the Veterans Health Administration (VHA)/US Department of Veterans Affairs (VA). Washington, D.C., June 2006. Available at <http://www1.va.gov/emshg/>.

Hospital Emergency Management Program

Hospitals Volume, Section 4

- 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.”¹
- The **Joint Commission’s Environment of Care** standard provides guidance and criteria for community-based surge capacity.
- **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.
- **California Code of Regulations Title 22** 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 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.

¹Adapted from National Fire Protection Association 1600, 2004, and the Veterans Health Administration Guidebook, 2004.

Increasing Surge Capacity in Hospitals

Hospitals Volume, Section 5.1

- During a healthcare surge, hospitals will face facility and operational challenges as they try and meet the demands of the healthcare surge.
- This will mean that facilities may be unable to comply with certain regulatory requirements and standards.
- Healthcare facilities need to identify wings, areas and spaces that could be opened and/or converted for use as patient/inpatient treatment areas.
- 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.

Patient Management

Hospitals Volume, Section 5.2

- Patient Transfer

- A hospital may also need to transfer patients to other facilities to meet the demand for patient care.
- Hospital emergency operations plans should consider patient transfer and the point at which patient transfers are coordinated through the Unified Command structure to ensure coordination of response efforts.

- Emergency Medical Treatment and Labor Act

- In 1986, Congress enacted the Emergency Medical Treatment and Labor Act to ensure public access to emergency services, regardless of ability to pay.
- Hospitals are 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.
- In the event of a declared emergency or crisis, State or local governments may develop community response plans that designate specific entities with the responsibility to handle certain categories of patients during these catastrophic events. 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.

Hospital Compliance Requirements and Existing Flexibility

Hospitals Volume, Section 5.3

- **Licensed Capacity**
 - Permission to temporarily exceed licensed bed capacity may be granted upon the facility's submission and CDPH Licensing and Certification District Office approval of an application for increased patient accommodations.
- **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.
 - 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.
- **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.

Structural Safety

Hospitals Volume, Section 5.4

- 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 Office of Statewide Health Planning and Development proposed proper building standards for earthquake resistance.
- 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.
- **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.

Infection Control

Hospitals Volume, Section 5.5

- During and following a catastrophic event the risk of infection may be exacerbated due to operational changes in patient care that hospitals are required to implement to accommodate disaster relief efforts.
- **22 CCR 70739** references standards set by the **Healthcare Infection Control Practices Advisory Committee** and places the following requirements on general acute care hospitals:
 1. 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.
 2. Prepare written reports on existing resources and evaluation measures (once every three years and updated annually).
 3. Develop a pandemic influenza component in the hospital's disaster plan.

Decontamination

Hospitals Volume, Section 5.6

- 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.
- Hospitals are encouraged to establish relationships and notification procedures with appropriate local agencies.
- The primary role of a hospital in a hazardous materials catastrophic emergency is to triage, treat, decontaminate and medically screen patients as necessary.
- Additional planning considerations may include establishing a “fast track” decontamination line for patients, establishing a separate decontamination area for patients that require secondary and/or technical decontamination, establishing a separate “lane” for patients arriving by Emergency Medical Services transport.

Hazardous Waste Management and Medical Waste Management Hospitals Volume, Sections 5.7 and 5.8

- 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.
 - 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).
 - 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.**
- Medical Waste Management
 - 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.

Mass Fatality Management Hospitals Volume, Section 5.9

- State and County Fatality Response
 - 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.
 - 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.
- Hospital Fatality Management
 - 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 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.
 - Hospitals should be in contact with the Operational Area Emergency Operations Center to learn where temporary morgue sites have been established in their community.

Security Planning

Hospitals Volume, Section 5.10

- 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.
- **Supplemental Security Staffing**
 - 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.
 - Consideration should be given to having a contingency contract(s) with local or national private security firms to provide trained personnel during an emergency.
- **Lock-Down vs. Restricted Access/Visitation**
 - 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.
 - 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.
 - Each hospital should outline the triggers for deciding to lock-down or restrict access in its Emergency Operations Plan with supporting incident-specific hospital plans, policies and procedures.

Security Planning (continued)

Hospitals Volume, Section 5.10

- Chain-of-Custody Considerations
 - "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.

Hospital Traffic Control during a Surge

Hospitals Volume, Section 5.11

- 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.

Business Continuity Planning

Hospitals Volume, Section 5.12

- 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 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.
 - **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.
- **Standard operating procedures** for key activities of equipment, plant and utilities should be developed as part of a hospital's business continuity planning.

Spontaneous Blood Donor Volunteers

Hospitals Volume, Section 5.13

- 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.

Expanding the Workforce Hospitals Volume, Section 6

- Increasing staff during a disaster will be one of the greatest challenges that a healthcare facility must address.
- 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.
- Once these sources are exhausted, additional staffing resources will be requested through the SEMS/NIMS structure.
- 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.

Expanding the Workforce (continued)

Hospitals Volume, Section 6

- 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.
- 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.
- 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.
- Once a staff member has been assigned a role during a healthcare surge, a process must be established to track that person providing services in the hospital.

Scope of Practice and Liability Protections

Hospitals Volume, Sections 7.1

- 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.
- The following **California Healing Boards** have provided guidance on current statutory flexibility in scope of practices and liability protections:

<ul style="list-style-type: none">• Licensed Vocational Nurses• Pharmacy• Physician Assistant	<ul style="list-style-type: none">• Podiatric Medicine• Respiratory Care
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- The **Emergency Services Act** authorizes the Governor to make, amend, and rescind orders and regulations necessary to carry out the provisions of the Emergency Services Act.
- **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. Standby orders can address the likely need for increasing the number of paid healthcare professionals during a state of emergency.
- Some liability protections already exist for hospitals, clinical staff and volunteers in State and federal laws.

Augmenting Registered Nurse Staffing Hospitals Volume, Section 7.2

- It is essential that hospitals plan for nursing shortages and augmentation of nursing staff.
- 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, the maximum number of caregivers available to provide care and the stresses that will challenge nurse-to-patient ratios.
- In developing nursing staffing strategies during extraordinary circumstances, hospitals should consider the following issues:
 - Patient and caregiver safety
 - Nursing fatigue
 - Nursing support and nurses' facility support
 - Nursing availability and training
 - The transition back to normal nurse-to-patient ratios as recovery from the emergency occurs.

Special Considerations for Pharmacists

Hospitals Volume, Section 7.3

- In the event of a declared disaster or emergency, the board expects to use its authority 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.¹
- 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.
- 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.

¹California Emergency Services Act [California Government Code Section 8550-8668] and the California Disaster Assistance Act.

Special Considerations for Pharmacists (continued)

Hospitals Volume, Section 7.3

- 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.
- The California State Board of Pharmacy encourages persons outside of California to assist California residents during declared states of emergency.
- 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.¹

¹California Business and Professions Code, Section 4062, subdivision (a).

Credential Verification

Hospitals Volume, Section 7.4

- 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 to the hospital for service, 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.
- 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 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).

Augmenting Non-Clinical Staff Hospitals Volume, Section 8

- 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.

Maintaining the Workforce Hospitals Volume, Section 9

- Workforce Health and Safety and Workers' Rights
 - Occupational safety and health requirements are 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.
 - 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**.
 - Another workforce health and safety issue that may arise is the requirement that vaccinations be provided to all employees and volunteers. Facilities will be responsible for providing vaccinations to staff unless such requirements are waived by appropriate authority during a state of disaster.
 - Employers not only have an obligation to safeguard the health and safety of their workforce, they also have responsibility to honor employees' rights.
- Occupational Safety and Health Planning
 - Hospitals are required to have a health and safety plan that includes, but is not limited to, the following:

<ul style="list-style-type: none">• Infection control• Life safety• Emergency action plan• Control of hazardous substances	<ul style="list-style-type: none">• Fatigue• Heat stress• Provision of sanitary hospitals• Personal protective equipment
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Maintaining the Workforce (continued)

Hospitals Volume, Section 9

- 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)**
- Hospital Staff Family Disaster Plan
 - Healthcare facilities should encourage staff to plan with their families for what could happen in a disaster. 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.
 - Arranging pet care.
 - Making an emergency supply kit.

Maximizing Sustainability

Hospitals Volume, Section 10.1

- The first step in preparing for a healthcare surge is ensuring the hospital can function independently for 72-96 hours at surge levels.
- Connecting to the Unified Command will be critical as during a healthcare surge the emergency response structure may 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.
- In order to **maximize sustainability**:
 - 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.

Pharmaceuticals

Hospitals Volume, Section 10.2

- One of the most challenging aspects of acquiring pharmaceuticals is determining which pharmaceuticals are needed and in what quantity.
- 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.
- 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.

Supplies and Equipment

Hospitals Volume, Section 10.3

- 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.
- When resources allow, or are available within the hospital, strong consideration should be given to involving key stakeholders in the planning process for supplies and equipment.
- Hospitals should consider resources used every day that may be needed in larger supplies during a healthcare surge.
- Planning should consider the potential volume of patients that may require hydration for a 72-hour period.
- 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.
- 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.

Acquisition of Personal Protective Equipment Hospitals Volume, Section 10.4

- Under California Labor Code Section 6401, every employer must furnish protective equipment, use safety devices and safeguards and provide training.
- 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.
- Natural disaster/biological situations are infection control/ epidemiological issues. They require universal precautions and respiratory precautions may be required depending on the situation.
- **Guidance on Selecting and Acquiring Personal Protective Equipment**
 - 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.
 - 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).
 - Hospitals should consider using equipment similar to that used by local emergency responders to standardize personal protective equipment within a community/region for interoperability.
 - Equipment selection should be hospital-specific.

Storage and Inventory Management for Supplies, Pharmaceuticals and Equipment Hospitals Volume, Section 10.5

- 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.
- 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.
- 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.
- These are considerations that hospitals must address during pre-surge planning and healthcare surge responses.

Use of Vendors and Suppliers for Supplies, Pharmaceuticals and Equipment Procurement

Hospitals Volume, Section 10.6

- 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.
- Memoranda of Understanding
 - A memorandum of understanding with vendors and suppliers may be an effective method in sustaining operations in a hospital if resources are scarce.
 - 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.
- Donations of Supplies and Equipment
 - 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.
 - It is recommended that the donations be coordinated at the Operational Area Emergency Operations Center.

Acquiring Additional Supplies, Equipment and Pharmaceuticals through the Standardized Emergency Management System Hospitals Volume, Section 10.7

- Even with extensive planning, hospitals may require supplies, equipment and pharmaceuticals beyond local availability. Additional resources must be requested through the SEMS/NIMS process.
- The **State has the following resources** that can be distributed during a healthcare surge based on event specific priorities through SEMS/NIMS:
 - *N-95 respirators*: CDPH purchased 50.9 million N-95 respirators for use by and protection of healthcare workers at healthcare facilities and government-authorized Alternate Care Sites.
 - *Ventilators*: CDPH has 2400 ventilators maintained for deployment by the vendor.
- Through **State and federal partnerships**, the following resources can be made available during a healthcare surge:
 - *Antivirals*: CDPH and federal government Tamiflu and Relenza courses provide for treatment of 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.
 - *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.

Staging Considerations

Hospitals Volume, Section 10.8

- Because disaster supplies are not routinely used, they are often stored in the least convenient available space, sometimes in offsite warehouses.
- 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.
- 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.¹

¹James Lenthall. Director, Safety/Security & Emergency Management, Saddleback Memorial Medical Centers.

Patient Tracking

Hospitals Volume, Section 11.1

- Although electronic tracking systems are preferred, in cases where electronic systems are unavailable, paper-based tracking is a viable alternative.
- 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 higher priority than tracking all persons within an affected area.
 - **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.

Patient Tracking (continued)

Hospitals Volume, Section 11.1

- A **disaster incident number** is a unique identifier used to track patients during a healthcare surge.
- Hospitals should track patients seeking medical attention within a hospital and disposition of those transferred to other hospitals during a healthcare surge using standardized **paper-based tracking forms** such as those provided in the Operational Tools Manual.
- Additionally, a manual method for tracking patients as they move through the hospital may be required during a healthcare surge when computer systems are unavailable.

Down-Time Procedures for Registration and Medical Records Number

Hospitals Volume, Section 11.2

- **Registration Down-Time Procedures**
 - Back-up procedures may be required to maintain administrative functions that are critical to business continuity and sustaining operations during a healthcare surge.
 - Registration staff will 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.
- **Minimum Requirements for Medical Record Documentation**
 - 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.
 - A short form medical record should be utilized to capture pertinent assessment, diagnosis and treatment information.
- **Hospital Reporting Requirements**
 - 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.

HIPAA Compliance during Healthcare Surge

Hospitals Volume, Section 11.3

- Emergency planners need to share patient information in a catastrophic event to provide urgent care to an increased number of patients.
- The federal **Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule** protects individually identifiable health information held by "covered entities" which include health plans, healthcare clearinghouses, and healthcare providers who transmit any health information in electronic form in connection with a transaction as defined under the act.
- However, 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.
- Additionally, 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.]

Patient Valuables Tracking

Hospitals Volume, Section 11.4

- Most hospitals currently have a procedure in place to track patient valuables upon admission.
- Hospitals may establish a uniform and secure procedure for the collection, storage, safeguarding and release of patient valuables.
- 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.
- 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.
- A **patient-valuables control log** should be used to document, track and audit valuables deposited or removed from the patient-valuables secured locations.

Workers' Compensation for Hospital Employees and Volunteers Hospitals Volume, Section 11.5

- 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.
- 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.
- 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.

Hospital Planning Considerations for Different Funding Sources

Hospitals Volume, Section 12.1

- 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 State Funded Programs.
- 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.
- 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.

Hospital Planning Considerations for Different Funding Sources (continued)

Hospitals Volume, Section 12.1

- 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**
 - 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.

Hospital Planning Considerations for Different Funding Sources (continued)

Hospitals Volume, Section 12.1

- **Policies and Procedures**

- 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.

- **Access & Coverage**

- For closed network models, revise pre-authorization and referral requirements to allow access to care when needed and where available.

Administrative and Procedural Guidelines – General Planning Considerations

Hospitals Volume, Section 12.2

- Coordination and planning between hospitals and payers may include modifying specific contract provisions related to administrative requirements, the selection of third-party vendors who may assist with billing on behalf of an existing facility during an extended healthcare surge or the development of new policies to expedite cash flow during a declared surge.
- **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.
 - The following includes a list of recommended minimum data elements required for charge capture during a healthcare surge.
 - 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

Administrative and Procedural Guidelines – General Planning Considerations (continued)

Hospitals Volume, Section 12.2

- **Minimum Required Data Elements for Billing**
 - In addition to charge capture, registration and 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.
 - 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.
- **Additional Billing and Coding Guidance**
 - 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 .

Administrative and Procedural Guidelines – General Planning Considerations (continued)

Hospitals Volume, Section 12.2

- National Modifier and Condition Code To Be Used To Identify 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.”¹
- ICD-9-CM Coding for External Causes of Injury
 - External Cause codes may be assigned to identify the cause of an injury(ies) incurred as a result of the disaster.
 - The use of E codes is limited to injuries, adverse effects and poisonings.
 - 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.
- Advancing and Expediting Payment
 - 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.

¹<http://www.nubc.org/R1810TN.pdf>

Other Funding Considerations for Providers

Hospitals Volume, Section 12.3

- 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.
 - The 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.¹
- Patient Transfer and Coverage Rules During a Healthcare Surge
 - During a healthcare surge, public health issues or specific medical needs may require transfer of patients between healthcare facilities.
 - The Operational Tools Manual contains an outline of commercial health plans and public payers' coverage rules and requirements for reimbursement related to patient transfers during a healthcare surge.

¹Centers for Medicare and Medicaid Services, "Fact Sheet - Payment for Graduate Medical Education (GME) in the Wake of a National Disaster or Public Health Emergency." http://www.cms.hhs.gov/AcuteInpatientPPS/Downloads/Katrina_Fact_Sheet.pdf

Other Funding Sources Available

Hospitals Volume, Section 12.4

- 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 Federal Emergency Management Agency does not compensate for disaster-related stabilization and care administered in a private, for-profit healthcare setting.
 - To be eligible for rebuilding assistance, the repair and recovery work to be done must be a direct result of the disaster, be located within the designated disaster area, and be the legal responsibility of an eligible applicant.
 - Federal Emergency Management Agency compensates medical costs only when a disaster victim has made a point-of-service contact with the provider for stabilization of injuries as a direct result of the disaster or an illness that presents in a designated disaster area during the declared emergency time period.

Other Funding Sources Available (continued)

Hospitals Volume, Section 12.4

- **Recommendations to Facilitate Payment**
 - Document all services provided to patients as clearly and thoroughly as possible.
 - Develop mutual aid agreements with neighboring hospitals and/or local government entities.
 - For-profit entities may explore public-private partnerships and contracts with local government.
 - Healthcare facilities 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.
 - Healthcare facilities should review the Public Assistance Policy Digest - Federal Emergency Management Agency Report 321 and Applicant Handbook - Federal Emergency Management Agency Report 323.
- **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.
 - 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.

California Authority Governing Commercial Health Plans During a Healthcare Surge and the Impact on Hospitals

Hospitals Volume, Section 12.5

- 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.”
- 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.
- Within California, there are two agencies that regulate private health plans, the **California Department of Insurance** and the **California Department of Managed Health Care**.
- 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.

California Authority Governing Commercial Health Plans During a Healthcare Surge and the Impact on Hospitals (continued)

Hospitals Volume, Section 12.5

- 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.
 - While general powers of the Department 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.
 - Depending upon the nature, breadth, and severity of the state of emergency certain powers may have to be ordered or delegated by the Governor.
 - Additionally, the Governor could grant 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.

Hospital Reference Guide – Pertinent Regulations and Previous Responses to Healthcare Surge Hospitals Volume, Section 12.6

- 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.
- Major health plan rules/requirements/issues to consider include:
 - 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.

Facility Operations Recovery

Hospitals Volume, Section 13

- The recovery phase of an emergency management program for hospitals focuses upon returning the hospital to baseline levels of functioning.
- Aspects of the **Recovery Phase** include:
 - Identifying a starting point for recovery
 - Determining the endpoint to recovery
 - Return to readiness
 - Recovery as part of a larger effort
- Activities that recovery planning should address include:
 - Personnel recovery
 - Physical structure recovery
 - Equipment and Supply Cache recovery
 - Financial recovery
 - Business systems recovery
 - Coordination with external systems
 - Organizational learning/Systems improvement
 - After Action Reports/Corrective Action Plans
 - Community recovery activities

Hospitals Wrap Up

Now that you have completed this training course, you should:

- Be able to define basic terminology, such as surge, surge capacity, and standards of care (among others), as used in the context of the **Standards and Guidelines for Healthcare Surge During Emergencies** project
- Be familiar with current, existing waivers and provisions to regulations as they pertain to a health emergency situation, and be able to locate those provisions
- Be able to articulate the ethical and behavioral principles and practice guidelines required to be in place during a healthcare surge event
- Be able to locate and utilize regulatory information and other resources for planning and implementing a response to healthcare surge