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

## Hospital Operational Tools Manual



California Department of PublicHealth

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

## Table of Contents

The Hospital Operational Tools Manual contains tools that enable hospitals in healthcare surge planning, management, delivery of care and administrative functions. The manual was designed to provide single-source direct access to the hospital specific tools included within the Hospitals Volume of the Standards and Guidelines Manual.

## The audience for these tools includes:

- Administrators and executives
- Legal counsel
- Compliance officers
- Risk management personnel
- Department managers and supervisors
- Physicians
- Nurses
- Allied health staff

## Using the Operational Tools Manual:

A. **Standards and Guidelines Manual:** The tools are referenced throughout the Hospitals Volume of the Standards and Guidelines Manual by tool name.

B. **Operational Tools Manual:** The tools in the Hospital Operational Tools Manual are organized alphabetically by tool name and by the following major sections:
   1. Workforce/Staff
   2. Supplies, Pharmaceuticals and Equipment
   3. Operations/Structure
   4. Sources of Funds

C. Each tool within the Operational Tools Manual includes a cover page which contains:
   1. Tool name
   2. Description
   3. Instructions

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

## Hospital Operational Tools Manual: Workforce/Staff

California Department of
PublicHealth

## Description

The tool is designed to assist planners and staffing coordinators at existing facilities in understanding the process by which augmented staff are accepted and deployed. Although the acquisition process for various types of augmented staff may differ depending on the volunteer organization, the acceptance and deployment process would essentially be consistent.

This tool can also be found in Volume I: Hospitals, Section 6.1: Process Flow for Acceptance and Assignment of Additional Staff During Healthcare Surge.

## Instructions

Review the tool to determine the appropriate method of accepting and deploying augmented staff during a healthcare surge.

# Acceptance and Assignment of Augmented Staff During Healthcare Surge



- Volunteer Point of Arrival
  - Unaffiliated and pre-registered volunteers arrive
- Registration
  - Registration Information (contact, competencies, avails) obtained or confirmed if pre-registered
- Credential Verification
  - Individual credentials verified as necessary
  - If false credentials → Released
  - If credentials verified →
- Staging Area for Resources
- Orientation
  - Orientation and briefing provided
- Search for Assignment
  - If no assignment → Released for possible future callback
  - If accepted assignment → Assignment

- Assignment
  - Update Available assignments
- Available Assignments
  - If immediate match → Assignment Briefing
  - If match for future shift → Temporary Release or Return to Staging Area
- Assignment Briefing
- Deployment
  - Incident Badging
- Task
  - Incident transportation, training, supervision

California Department of Public Health

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# Basic Plan for Augmenting Registered Nurse Staffing During Healthcare Surge

## Description

Hospitals can use this strategy to addresses nurse staffing issues during a healthcare surge.

This tool can also be found in Volume I: Hospitals, Section 7.2: Augmenting Registered Nurse Staffing.

## Instructions

Review the Registered Nurses staffing strategy.

# Basic Plan for Augmenting Nurse Staffing During Healthcare Surge[1]

## 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 staff with administrative roles (i.e., nursing supervisors, Risk Managers, Quality Managers) to care for patients.

- 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.

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[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.

## Description

The Considerations for Staff Support Provisions section is intended to lay out issues that a healthcare facility should consider for its staffing plans and strategies, and it is designed to serve as a starting point for healthcare surge planners to outline necessary policies and provisions to support staff during a healthcare surge.

This tool can also be found in Volume I: Hospitals, Section 9.3: Support Provisions for Staff.

## Instructions

Facilities should review the list as considerations for its staffing plans and strategies. Facilities should consider the formation of a Staff Disaster Support Committee or charge its Human Resources Department with pre-planning.

## Considerations for Staff Support Provisions[2]

**Purpose:** The following information provides an outline for healthcare surge planners on policies and provisions that might be needed to support staff during a healthcare surge.

## Staff Support Considerations

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

- 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.

- 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.

- 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.

- Hospitals should consider the provision of rooms for staff to 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.

- Hospitals should have areas for staff to eat and have refreshments.

- 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.

- 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.

- 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.

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[2] 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.

- Hospitals should consider back-up provisions for essential services such as food services, laundry, housekeeping and other services, 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

# Credentialing Log for Licensed Healthcare Professionals

## Description

This table is meant to provide existing facilities with a template to verify that health professionals who have been granted temporary disaster privileges have provided the appropriate, and required, documentation.

This tool can also be found in Volume I: Hospitals, Section 7.4.5: Credentialing Log for Licensed Healthcare Professionals.

## Instructions

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 Log for Licensed Healthcare Professionals | | | | | Declared Competencies |
| | 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 | |
| --- | --- | --- | --- | --- | --- | --- |
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# Family Emergency Health Information Sheet

## Description

A key component of healthcare surge planning is to ensure the health and safety of a facility's workforce.  Facilities should encourage staff to develop a family emergency plan. The following sheet is provided for staff and their family members to collect health and personal contact information.  These sheets were adapted from materials developed by the federal Department of Health and Human Services available at www.pandemicflu.gov.

Additional information for this tool can be found in Volume I: Hospitals, Section 9.4: Hospital Staff Family Disaster Plan.

## Instructions

Distribute the sheets to staff and encourage them to complete as part of a family emergency plan.

## Family Emergency Health Information Sheet

1. Family Member Information:

| Family Member | Blood Type | Allergies | Past/Current Medical Conditions | Current Medications / Dosages |
|---|---|---|---|---|
| | | | | |
| | | | | |
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2. Emergency Contacts:

| Contacts | Name/Phone Number |
|---|---|
| Local personal emergency contact | |
| Out-of-town personal emergency contact | |

California Department of Public Health

| Contacts | Name/Phone Number |
|---|---|
| Hospitals near:        Work: | |
| School: | |
| Home: | |
| Family physician(s) | |
| State public health department (See list on www.pandemicflu.gov/state/statecontacts.html) | |
| Pharmacy | |
| Employer contact and emergency information | |
| School contact and emergency information | |
| Religious/spiritual organization | |
| Veterinarian | |

## Description

The tool provides healthcare surge planners and other appropriate facility representatives with a list of organizations that could be considered as potential sources for augmented staff. For each potential source, the tool provides:

1. The organization's name along with a brief background and history of the organization
2. The website address for the organization

This table can also be used as a reference when determining organizations with which to develop personnel sharing Memoranda of Understanding.

This tool can also be found in Volume I: Hospitals, Section 6.4: Requesting Staff through the Standardized Emergency Management System.

## Instructions

Review the table to become familiar with the various sources to obtain additional staff during a healthcare surge.

| Organization<br>Brief Background & History | Additional Information May Be Found at: |
|---|---|
| **American Red Cross (ARC)**<br><br>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.<br><br>The most visible and well-known of Red Cross disaster relief activities are sheltering and feeding. | http://www.redcross.org<br><br>Information is available for both the national chapter as well as links to local chapters. |
| **California Medical Assistance Team (CalMAT)**<br><br>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.<br><br>The California Medical Assistance Teams will maintain caches that contain medical supplies, medical equipment, tents, pharmaceuticals and interoperable (compatible) communications.<br><br>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. | http://www.emsa.ca.gov/def_comm/viii092706_d.asp |
| **Community Emergency Response Teams (CERT)/Neighborhood Emergency Response Teams (NERT)**<br><br>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.<br><br>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<br><br>Information is available for the local chapter as well as links to the national chapter. |

| Organization<br>Brief Background & History | Additional Information May Be Found at: |
|---|---|
| **Disaster Medical Assistance Team (DMAT)**<br><br>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.<br><br>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.<br><br>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.<br><br>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. | http://www.ndms.dhhs.gov/teams/dmat.html |
| **Disaster Service Worker (DSW)**<br><br>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)**<br><br>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<br><br>California Medical Volunteer<br><br>https://medicalvolunteer.ca.gov/<br>(currently serves as a volunteer registration site) |

| Organization<br>Brief Background & History | Additional Information May Be Found at: |
|---|---|
| **Los Angeles County Emergency System for the Advance Registration of Volunteer Health Professionals (ESAR VHP)**<br><br>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.<br><br>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.<br><br>All other medical and mental health professionals do not require additional credentialing.<br><br>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 |
| **Medical Reserve Corps (MRC)**<br>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.<br><br>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 |

# Non-Clinical Support Matrix

## Description

The following sample staff utilization matrix provides existing facilities with a template and guidelines for inpatient non-clinical staffing needs for a facility operating in healthcare surge. This document provides recommendations for maintenance of non-clinical staff during a healthcare surge to maintain day-to-day operations as well as to meet the expanded needs. Sample matrices are provided. The staff utilization matrix was adapted from the Wisconsin State Expert Panel[3] in its guidance on healthcare surge capacity.

This tool can also be found in Volume I: Hospitals, Section 8.2: Non-Clinical Support Matrix.

## Instructions

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:

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

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[3] 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.

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

| 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 | | | |

## Description

A key component of healthcare surge planning is to ensure the health and safety of a facility's workforce.  Facilities should encourage staff to have a family emergency plan. The following checklist provides staff and their family members with a list of items to consider to help plan for pandemic flu. This checklist was adapted from materials developed by the federal Department of Health and Human Services available at www.pandemicflu.gov

Additional information for this tool can be found in Volume I: Hospitals, Section 9.4: Hospital Staff Family Disaster Plan.

## Instructions

Distribute the checklist to staff and encourage them to complete as part of a family emergency plan.

# Pandemic Flu Planning Checklist for Individuals & Families

## 1. To plan for a pandemic

❑ Store a two week supply of water and food. During a pandemic, if you cannot get to a store, or if stores are out of supplies, it will be important for you to have extra supplies on hand. This can be useful in other types of emergencies, such as power outages and disasters.

❑ Periodically check your regular prescription drugs to ensure a continuous supply in your home.

❑ Have nonprescription drugs and other health supplies on hand, including pain relievers, stomach remedies, cough and cold medicines, fluids with electrolytes, and vitamins.

❑ Talk with family members and loved ones about how they would be cared for if they got sick, or what will be needed to care for them in your home.

❑ Volunteer with local groups to prepare and assist with emergency response.

❑ Get involved in your community as it works to prepare for an influenza pandemic.

## 2. To limit the spread of germs and prevent infection

❑ Teach your children to wash hands frequently with soap and water, and model the current behavior.

❑ Teach your children to cover coughs and sneezes with tissues, and be sure to model that behavior.

❑ Teach your children to stay away from others as much as possible if they are sick. Stay home from work and school if sick.

| 3. Items to have on hand for an extended stay at home | |
|---|---|
| Examples of food and non-perishables | Examples of medical, health, and emergency supplies |
| ❑ Ready-to-eat canned meats, fish, fruits, vegetables, beans and soups<br><br>❑ Protein or fruit bars<br><br>❑ Dry cereal or granola<br><br>❑ Peanut butter or nuts<br><br>❑ Dried Fruit<br><br>❑ Crackers<br><br>❑ Canned juices<br><br>❑ Bottled water<br><br>❑ Canned or jarred baby food and formula<br><br>❑ Pet food<br><br>❑ Other nonperishable foods | ❑ Prescribed medical supplies such as glucose and blood-pressure monitoring equipment<br><br>❑ Soap and water, or alcohol-based (60-95%) hand wash<br><br>❑ Medicines for fever, such as acetaminophen or ibuprofen<br><br>❑ Thermometer<br><br>❑ Anti-diarrheal medication<br><br>❑ Vitamins<br><br>❑ Fluids with electrolytes<br><br>❑ Cleansing agent/soap<br><br>❑ Flashlight<br><br>❑ Batteries<br><br>❑ Portable radio<br><br>❑ Manual can opener<br><br>❑ Garbage bags<br><br>❑ Tissues, toilet paper, disposable diapers |

## Description

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 facilities to incorporate into current workforce resiliency policies. The term "worker" is used to refer to facility personnel during a time of healthcare surge, which could consist of paid employees or volunteers.

This tool can also be found in Volume I: Hospitals, Section 9.3: Support Provisions for Staff.

## Instructions

Review and understand policy for guidance on how to prepare for maximizing employee personal resilience and professional performance during a healthcare surge.

# Policy for Workforce Resilience during Disaster[4]

## 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 employee is too ill work)

Personal:
- Telephones for personal calls are located __(include rules)___.
- Televisions, radios, and internet access for keeping apprised of events are located _(include rules)__.

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[4] Sutter Health System.

- 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 areas:

   - 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

# Sample Family Emergency Plan

## Description

A key component of healthcare surge planning is to ensure the health and safety of a facility's workforce.  Facilities should encourage staff to have a family emergency plan.  The following form can be used by staff and their family members to collect information to be used in an emergency or disaster. This form was taken from the federal Department of Homeland Security website at www.ready.gov.

Additional information for this tool can be found in Volume I: Hospitals, Section 9.4: Hospital Staff Family Disaster Plan.

## Instructions

Distribute the sheets to staff and encourage them to complete as part of a family emergency plan. Staff should keep a copy of this plan in their emergency supply kit or another safe place where they can access it in the event of a disaster.

# Ready

**Prepare. Plan. Stay Informed.**

# Family Emergency Plan

Make sure your family has a plan in case of an emergency. Before an emergency happens, sit down together and decide how you will get in contact with each other, where you will go and what you will do in an emergency. Keep a copy of this plan in your emergency supply kit or another safe place where you can access it in the event of a disaster.

Out-of-Town Contact Name: _____     Telephone Number: _____

Email: _____

Neighborhood Meeting Place: _____     Telephone Number: _____

Regional Meeting Place: _____     Telephone Number: _____

Evacuation Location: _____     Telephone Number: _____

**Fill out the following information for each family member and keep it up to date.**

| | |
|---|---|
| Name: | Social Security Number: |
| Date of Birth: | Important Medical Information: |
| Name: | Social Security Number: |
| Date of Birth: | Important Medical Information: |
| Name: | Social Security Number: |
| Date of Birth: | Important Medical Information: |
| Name: | Social Security Number: |
| Date of Birth: | Important Medical Information: |
| Name: | Social Security Number: |
| Date of Birth: | Important Medical Information: |
| Name: | Social Security Number: |
| Date of Birth: | Important Medical Information: |

Write down where your family spends the most time: work, school and other places you frequent. Schools, daycare providers, workplaces and apartment buildings should all have site-specific emergency plans that you and your family need to know about.

**Work Location One**
Address:
Phone Number:
Evacuation Location:

**School Location One**
Address:
Phone Number:
Evacuation Location:

**Work Location Two**
Address:
Phone Number:
Evacuation Location:

**School Location Two**
Address:
Phone Number:
Evacuation Location:

**Work Location Three**
Address:
Phone Number:
Evacuation Location:

**School Location Three**
Address:
Phone Number:
Evacuation Location:

**Other place you frequent**
Address:
Phone Number:
Evacuation Location:

**Other place you frequent**
Address:
Phone Number:
Evacuation Location:

| Important Information | Name | Telephone Number | Policy Number |
|---|---|---|---|
| Doctor(s): | | | |
| Other: | | | |
| Pharmacist: | | | |
| Medical Insurance: | | | |
| Homeowners/Rental Insurance: | | | |
| Veterinarian/Kennel (for pets): | | | |

**Dial 911 for Emergencies**

California Department of Public Health

32

# Ready
Prepare. Plan. Stay Informed.

# Family Emergency Plan

Make sure your family has a plan in case of an emergency. Fill out these cards and give one to each member of your family to make sure they know who to call and where to meet in case of an emergency.

< FOLD HERE >

ADDITIONAL IMPORTANT PHONE NUMBERS & INFORMATION:

## Family Emergency Plan

EMERGENCY CONTACT NAME:
TELEPHONE:

OUT-OF-TOWN CONTACT NAME:
TELEPHONE:

NEIGHBORHOOD MEETING PLACE:
TELEPHONE:

OTHER IMPORTANT INFORMATION:

**Ready**

DIAL 911 FOR EMERGENCIES

ADDITIONAL IMPORTANT PHONE NUMBERS & INFORMATION:

## Family Emergency Plan

EMERGENCY CONTACT NAME:
TELEPHONE:

OUT-OF-TOWN CONTACT NAME:
TELEPHONE:

NEIGHBORHOOD MEETING PLACE:
TELEPHONE:

OTHER IMPORTANT INFORMATION:

**Ready**

DIAL 911 FOR EMERGENCIES

< FOLD HERE >

ADDITIONAL IMPORTANT PHONE NUMBERS & INFORMATION:

## Family Emergency Plan

EMERGENCY CONTACT NAME:
TELEPHONE:

OUT-OF-TOWN CONTACT NAME:
TELEPHONE:

NEIGHBORHOOD MEETING PLACE:
TELEPHONE:

OTHER IMPORTANT INFORMATION:

**Ready**

DIAL 911 FOR EMERGENCIES

ADDITIONAL IMPORTANT PHONE NUMBERS & INFORMATION:

## Family Emergency Plan

EMERGENCY CONTACT NAME:
TELEPHONE:

OUT-OF-TOWN CONTACT NAME:
TELEPHONE:

NEIGHBORHOOD MEETING PLACE:
TELEPHONE:

OTHER IMPORTANT INFORMATION:

**Ready**

DIAL 911 FOR EMERGENCIES

# Sample Family Emergency Supply List

## Description

A key component of healthcare surge planning is to ensure the health and safety of a facility's workforce. Facilities should encourage staff to have a family emergency supply kit. The following checklist provides staff and their family members with a list of items to consider when developing an emergency supply kit. This checklist was taken from the federal Department of Homeland Security website at www.ready.gov.

Additional information for this tool can be found in Volume I: Hospitals, Section 9.4: Hospital Staff Family Disaster Plan.

## Instructions

Distribute the sheets to staff and encourage them to complete as part of a family emergency plan.

# Recommended Items to Include in a Basic Emergency Supply Kit:

- ☐ Water, one gallon of water per person per day for at least three days, for drinking and sanitation

- ☐ Food, at least a three-day supply of non-perishable food

- ☐ Battery-powered or hand crank radio and a NOAA Weather Radio with tone alert and extra batteries for both

- ☐ Flashlight and extra batteries

- ☐ First aid kit

- ☐ Whistle to signal for help

- ☐ Dust mask, to help filter contaminated air and plastic sheeting and duct tape to shelter-in-place

- ☐ Moist towelettes, garbage bags and plastic ties for personal sanitation

- ☐ Wrench or pliers to turn off utilities

- ☐ Can opener for food (if kit contains canned food)

- ☐ Local maps

**✓ Additional Items to Consider Adding to an Emergency Supply Kit:**

❑ Prescription medications and glasses

❑ Infant formula and diapers

❑ Pet food and extra water for your pet

❑ Important family documents such as copies of insurance policies, identification and bank account records in a waterproof, portable container

❑ Cash or traveler's checks and change

❑ Emergency reference material such as a first aid book or information from www.ready.gov

❑ Sleeping bag or warm blanket for each person. Consider additional bedding if you live in a cold-weather climate.

❑ Complete change of clothing including a long sleeved shirt, long pants and sturdy shoes. Consider additional clothing if you live in a cold-weather climate.

❑ Household chlorine bleach and medicine dropper – When diluted nine parts water to one part bleach, bleach can be used as a disinfectant. Or in an emergency, you can use it to treat water by using 16 drops of regular household liquid bleach per gallon of water. Do not use scented, color safe or bleaches with added cleaners.

❑ Fire Extinguisher

❑ Matches in a waterproof container

❑ Feminine supplies and personal hygiene items

❑ Mess kits, paper cups, plates and plastic utensils, paper towels

❑ Paper and pencil

❑ Books, games, puzzles or other activities for children

# Sample Policy for Dependent Care

## Description

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, which will be located in a designated area within the facility. If no responsible person is available at home to provide care, these dependents will be housed in the dependent care area for the duration of the disturbance or until other arrangements are made.

Major procedure activities include:

- Mobilization
- Safety requirements
- Staff
- Supplies
- Food
- Registration
- Medications
- Psychological support
- Documentation
- Checking out of dependent care area

This tool can also be found in Volume I: Hospitals, Section 9.3: Support Provisions for Staff.

## Instructions

Review the policy and use in conjunction with the Sample Tracking Form for Dependent Care to track the individuals for whom the facility provides dependent care during a healthcare surge.

## Sample Policy for Dependent Care[5]

## Purpose

This procedure outlines the process by which a Hospital can provide shelter and food for staff and volunteer dependents 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.

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[5] Scripps Health, San Diego. July 2006.

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.

## Description

Provide guidelines for staffing during healthcare surge in the patient census and/or for critical needs in staffing.[6] The following major categories are covered:

- Incident commander – mission
- Planning/communication chief – mission
- Finance chief – mission
- Logistics/materials management – mission
- Medical staff – mission
- Patient care areas are to be designated under the direction of the incident commander and response team in collaboration with nursing leaders
- Department emergency staffing plan
- During event actions
- Post-event/recovery

This tool can also be found in Volume I: Hospitals, Section 6.3: Sample Policy for Surge Capacity Staffing Emergency Plan.

## Instructions

Use the policy guidelines to develop staffing plans that can be used during a healthcare surge.

---

[6] Scripps Health, San Diego.  July 2006.

# Sample Policy for Surge Capacity Staffing Emergency Plan[7]

## 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.

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[7] Scripps Health, San Diego. July 2006.

     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.

D. 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.

E. 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.

F. 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, Radiology, etc.) to assure patient care needs can be met.

G. 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.

H. 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.

# Sample Tracking Form for Dependent Care

## Description

The Sample Tracking Form for Dependent Care allows hospitals to track the individuals for whom they provide dependent care during a healthcare surge and to monitor the healthcare services provided to individuals while they are under dependent care.

This tool can also be found in Volume I: Hospitals, Section 9.3: Support Provisions for Staff.

## Instructions

Use the Sample Tracking Form for Dependent Care to track the individuals for whom the hospital provides dependent care during a healthcare surge and to monitor the healthcare services provided to individuals while they are under dependent care. Complete all applicable fields in the form.

# Sample Tracking Form for Dependent Care

| 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<br>Allergies<br><br>Food<br><br>Toileting<br><br>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:<br>• Apply armband with name and registration number on each dependent.<br>• Tag all medications, bottles, food and other belongings and store appropriately.<br>• Photograph dependent with person responsible and attach photo to this form.<br>• Use reverse side of this form to document care provided to this dependent.<br>• 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** | | | |

# Skills and Abilities Assessment Tool

## Description

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.

This tool can also be found in Volume I: Hospitals, Section 7.1.3: Flexed Scope of Practice.

## Instructions

Facility staffing coordinators or medical staff representatives should identify existing staff and pre-registered volunteers who may 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* |
| | | |
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# Staff Assignment Tracking Sheet

## Description

The Staff Assignment Tracking Sheet provides staff coordinators at facilities with the ability to assign roles and responsibilities prior to and during healthcare surge. For facilities that have pre-defined agreements (Memoranda of Understanding) with neighboring healthcare facilities or volunteer organizations, this sheet will also allow augmented staff to be assigned roles prior to a healthcare surge. In the event that augmented staff do not arrive from predetermined sources or additional staff should arrive as walk-in volunteers, this sheet, in conjunction with the healthcare surge staffing plan and job action sheets, will allow staff coordinators to assign and track responsibilities for all such augmented staff.

This tool can also be found in Volume I: Hospitals, Section 6.5.1: Staff Assignment Tracking Sheet.

## Instructions

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
- Name of the individual to whom the person reports (Supervisor)
- The time the staff member reported in to work
- The time the staff member concluded work
- The location within the facility the staff member is assigned

## Staff Assignment Tracking Sheet

| Name (Last, First) | Staff ID # (If Applicable) | Surge Roles & Responsibilities | Supervisor/Oversight | Time In | Time Out | Location |
|---|---|---|---|---|---|---|
| | | | | | | |
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# Staffing Component Considerations for Development of Mutual Aid Memoranda of Understanding

## Description

In the event of catastrophic emergency, local and state health and medical infrastructure and associated resources will be quickly committed to providing the necessary treatment and/or prophylaxis to effectively respond. Available resources from the state, federal and private sector will be mobilized and deployed to augment local medical and health resources as requested. In order to support the delivery of care at the onset of a healthcare surge, it may be necessary to invoke pre-established Memoranda of Understanding with neighboring healthcare facilities. Memoranda of Understanding between facilities and other organizations will contain sections including, but not limited to: patient transfer; supplies, equipment and pharmaceuticals; and personnel.

This tool presents areas of consideration when drafting Memoranda of Understanding.

This tool can also be found in Volume I: Hospitals, Section 6.2: Staffing Component Considerations for Development of Mutual Aid Memoranda of Understanding with Neighboring Healthcare Facilities.

## Instructions

Review the personnel sharing components presented in this tool and consider incorporating them into a Memoranda of Understanding. Modify the language as appropriate for your particular situation or organization.

# Staffing Component Considerations for Development of Mutual Aid Memoranda of Understanding

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. 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.

## Description

The following process flow diagram depicts the process by which hospitals conduct the emergency credentialing process so that a healthcare professional may be granted temporary disaster privileges.  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.

This tool can also be found in Volume I: Hospitals, Section 7.4.4: Temporary Disaster Privileging Process Flow Diagram.

## Instructions

Begin at "Has emergency management plan been activated?" and continue through process flow to reach resolution on granting of temporary disaster privileges.

# Temporary Disaster Privileging Process Flow Diagram

**Has emergency management plan been activated?**

— No → **Return to normal privileging process.**

— Yes ↓

**Is the organization unable to meet immediate patient needs?**

— No → **Return to normal privileging process.**

— Yes ↓

**Hospital Administration informs Medical Staff that disaster credentialing & privileging will be required.**

↓

**Volunteer Application will be given to any licensed independent practitioner requesting privileges.**

↓

**Application must be complete and include required forms of identification.**

↓ (two branches)

**Primary source verification is initiated and completed within 72 hours from the time the practitioner presents to the organization.**

**Medical Staff Director (or designated individual) determines the practitioner's duties and area of assignment.**

↓

**Practitioner is granted temporary disaster privileges and begins providing services.**

# Volunteer Application for Non-Clinical Staff

## Description

The following form may serve as the personnel verification form for existing facilities (if one has not already been developed).

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.

This tool can also be found in Volume I: Hospitals, Section 8.1: Verification of Non-Clinical Staff.

## Instructions

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: | Previous Address: |
|---|---|
| Street: | Street: |
| City:                          State: | City:                              State: |
| Zip: | 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 whom you are responsible.

| Name | Place of Residence/ Telephone Number | Relationship |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |

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
☐ 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:**   /   /

# Volunteer Application for Clinical Staff

## Description

The following form may serve as the emergency credentialing and privileging form for existing facilities (if one has not already been developed).

This tool can also be found in Volume I: Hospitals, Section 7.4.3: Volunteer Application for Clinical Staff.

## Instructions

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.

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:<br>Street:<br>City:                    State:<br>Zip: | Previous Address:<br>Street:<br>City:                    State:<br>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        ☐ Medical Reserve Corps
☐ California Medical Assistance Team     ☐ Disaster Medical Assistance Team
☐ 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 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

| | |
|---|---|
| _____<br>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. |
| _____<br>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. |
| _____<br>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. |
| _____<br>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:**    /    /

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

## Hospital Operational Tools Manual: Supplies, Pharmaceuticals and Equipment



California Department of PublicHealth

## Detailed Supplies and Equipment List

### Description

This list provides a detailed list of supplies and equipment that may be needed during a healthcare surge. The list used is the Disaster Resource Center Cache. The number of patients that could be treated varies based on the type and mix of patients. 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 healthcare surge scenario.

This tool can also be found in Volume I: Hospitals, Section 10.3.2: Inventory Based - Detailed Supplies and Equipment List.

### Instructions

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 | | | | |

# Detailed Supplies and Equipment List

| 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" | | | | |

## Detailed Supplies and Equipment List

| 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" | | | | |

# Detailed Supplies and Equipment List

| | Current Supply | Total Potential Requiring Treatment | Package Size (if applicable) | Quantity / Cache |
|---|---|---|---|---|
| Syringe/needle, 1 ml, 25 gauge X 5/8" | | | | |
| Syringe/needle 1 ml, 29 gauge X ½" | | | | |
| Sharps container | | | | |
| **AIRWAY MANAGEMENT SUPPLIES** | | | | |
| 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 | | | | |

## Detailed Supplies and Equipment List

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 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 | | | | | | | |

## Detailed Supplies and Equipment List

| | Current Supply | Total Potential Requiring Treatment | Package Size (if applicable) | Quantity / Cache |
|---|---|---|---|---|
| Suction catheters 14 french | | | | |
| Yankauer suction | | | | |
| Suction tubing | | | | |
| Suction Canisters | | | | |
| NG Tubes | | | | |
| Thoracostomy Tubes, assorted sizes | | | | |
| Pleurivac & Heimlich valves | | | | |
| **INFECTION CONTROL SUPPLIES** | | | | |
| 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 | | | | |

## Detailed Supplies and Equipment List

| 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 | | | | |

## Detailed Supplies and Equipment List

| | Current Supply | Total Potential Requiring Treatment | Package Size (if applicable) | Quantity / Cache |
|---|---|---|---|---|
| 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 | | | | |

California Department of Public Health

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## Detailed Supplies and Equipment List

| | | |
|---|---|---|
| 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 | | |

## Detailed Supplies and Equipment List

| | |
|---|---|
| EZ Up Shades | |
| Security Upgrades and hardening | |
| Post Decontamination clothing sets | |
| Pharmacy Cache | |
| CHEMPACK location site | |
| Medical/Surgical Supply Cache | |
| Prime Mover (tow vehicle) | |

| | |
|---|---|
| Sources: | |
| 1) Disaster Resource Center Supplies List -Revised 2006 | |
| 2) State of Research in High - Consequence Hospital Surge Capacity, Carl H. Schultz, MD, Kristi L. Koenig, MD | |

**HRSA Standards and Surge Capacity Definition:**

**The components necessary to care for a sudden, unexpected increase in patient volume that exceeds current capacity.**
**The ability to care for 500 cases per one million population with infectious diseases, 50 cases per one million with chemical toxicity, 50 cases per one million with burns or trauma (blast) and 50 cases per one million with radiation injury within a 24-hour period.**

**The goal is to be able to expand hospital capacity by 20-25% in the first 24 hours.**

California Department of Public Health

## 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.

This tool can also be found in Volume I: Hospitals, Section 10.2.1: Inventory Based Pharmaceuticals by General Classifications.

## 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 their 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.

    1)  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 | | | | | | | | | | | |

# 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 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 | | | | | | | | | | | |
| Diazepam | 5mg / ml | Injectable | | | | | | | | | | | |
| Dimercaprol | 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 | | | | | | | | | | | |

# Critical Pharmaceuticals That May Be Needed During a Surge

**Antidotes for Radiological & Nuclear Agents**

| 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 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 | | | | | | | | | | | |
| Potassium Iodide | 130mg | Oral | | | | | | | | | | | |
| Prussian Blue | 500 mg | Oral | | | | | | | | | | | |
| Sodium Iodide | 130mg | Oral | | | | | | | | | | | |
| Trisodium Calcium Diethylenetriamine Pentaacetate | 1g | 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 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 | | | | | | | | | | | |

## 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Vaccines** | | | | | | | | | | | | | |
| Tetanus Toxoid | N/A | Injectable | | | | | | | | | | | |

**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**

# Pharmaceutical Storage Checklist

## Description

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 seven major categories including:

- Inventory management
- Environmental management
- Security
- Caches
- Licensing
- Ease of access

This tool can also be found in Volume I: Hospitals, Section 10.5.1: Pharmaceuticals.

## Instructions

Check off all completed tasks. Note that some category fields may not apply to your facility.

# Pharmaceutical Storage Consideration Checklist

## 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.

## Description

This checklist identifies considerations that organizations should assess when staging their resources. The tool is useful for facilities where there are areas that items are stored with the potential need for immediate use.

This tool can also be found in Volume I: Hospitals, Section 10.8: Staging Considerations.

## Instructions

Check off all completed tasks. Note that some category fields may not apply to your facility.

## 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.

# Supplies and Equipment Storage Checklist

## Description

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 across seven major categories including:

- Inventory management
- Environmental management
- Security
- Caches
- Transport
- Ease of access

This tool can also be found in Volume I: Hospitals, Section 10.5.2: Supplies and Equipment.

## Instructions

Check off all completed tasks. Note that some category fields may not apply to your facility.

## Supplies and Equipment Storage Consideration Checklist

### 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)

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

## Hospital Operational Tools Manual: Operations/Structure



California Department of PublicHealth

# Decision Making Tool for Disclosure of Protected Health Information (PHI)

## Description

Flow chart created by the US Office for Civil Rights that helps answer the following central question for covered entities: "May I disclose protected health information for public health emergency preparedness purposes?"[8]

This tool can also be found in Volume I: Hospitals, Section 11.3: HIPAA Compliance During Healthcare Surge.

## Instructions

Answer questions beginning at "Start." Continue answering questions until resolution is provided regarding disclosure of Protected Health Information.

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[8] http://www.hhs.gov/ocr/hipaa/decisiontool/

# Decision Making Tool for Disclosure of Protected Health Information (PHI)

AT A GLANCE – May I disclose protected health information for public health emergency preparedness purposes?

(From the perspective of the source of the information)

**Disclosure to a Public Health Authority**

START

Am I a covered entity? §160.103
- YES
- NO → The Privacy Rule does not apply to non-HIPAA covered entities → Disclosures can be made without regard to the Privacy Rule

Is the intended recipient a public health authority (PHA)? §164.501
- YES → Is the PHA authorized by law to collect or receive information for the purpose of preventing or controlling:
  - disease,
  - injury, or
  - disability
  including, for purposes of emergency preparedness? §164.512(b)(1)(i)
  - YES → Disclosures can be made without regard to the Privacy Rule
  - NO
- NO

**Disclosures related to treatment & public health**

Is the intended recipient an agency that seeks information for public health purposes?
- YES
- NO → Is the intended recipient a health care provider that uses or discloses information for treatment purposes?
  - YES
  - NO → Is the disclosure by a provider and is the recipient another person or agency that would use or disclose information for treatment or certain health care operations?
    - YES
    - NO → The disclosure may **NOT** be made unless there is a signed authorization

**Disclosure of a Limited Data Set**

Are you disclosing only a limited data set (LDS)? §164.514(e)
- YES → Do you have a data use agreement with the recipient of the information? §164.514(e)
  - YES → You may make a disclosure subject to minimum necessary §164.502(b), §164.514(d)
  - NO
- NO

**Disclosure with individual authorization**

Obtain individual authorization, unless the disclosure is otherwise permitted by another provision of the Privacy Rule §164.508

The disclosure **CAN** be made

California Department of Public Health

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# Disaster Incident Number Policy and Label

## Description

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 people based on their medical need) or other unique patient identified.

This tool can also be found in Volume I: Hospitals, Section 11.1.1: Disaster Incident Number.

## Instructions

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.

## 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<br><br>and Disaster Incident Number |
| Street Address: | |
| City: | BAR CODE<br><br>and Disaster Incident Number |
| Social Security Number: | |
| Tel: | BAR CODE<br><br>and Disaster Incident Number |
| Cell: | |
| Destination: | BAR CODE<br><br>and Disaster Incident Number |
| Facility Name: | |

Condition (indicate condition with check mark):

| | |
|---|---|
| Minor compromise:  [       ] | Not compromised:  [       ] |
| Major compromise:  [       ] | Shelter only:       [       ] |

# Facility Damage Report (Limited Assessment)

## Description

It is recommended that facilities should create plans that guide decision making around operating or abandoning a degraded environment. Facilities should develop a list of "fatal deficiencies/flaws" that would trigger immediate evacuation. Plans should identify an organizational person to perform an immediate assessment.

A high-level assessment of the facility should be conducted to ensure that the facility has maintained its structural integrity. When ramping up for a mass medical emergency, the facility should be checked to ensure the following:

- Capability of providing essential patient care (routine care as well as management of injuries or disaster related conditions if any)
- Integrity of structure is in intact with no obvious damage and availability of access to all areas
- Availability of essential services such as power, water, gas and communications
- Availability of adequate staff, supplies and equipment for the next 72 hours (e.g., food, water, medicines, O2, hygiene and fuel)
- Ability to function without assistance for the next 72 hours

This tool can also be found in Volume I: Hospitals, Section 5.4.1: Facility Post-Disaster Status Assessment.

## Instructions

Complete the facility damage report to assess structural integrity of your 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 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.

## Description

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. During a catastrophic emergency, the facility should be checked to ensure the following:

- Structural integrity
- Availability of communications and elevators (if applicable)
- Availability of water: from utility, drinking and hot
- Functionality of building systems such as electricity, emergency power, fuel reserve, heating and cooling, and sewage disposal
- Availability of supplies including food, medications, linens and other items
- Availability of resources such as administration, nursing, dietary and housekeeping

This tool can also be found in Volume I: Hospitals, Section 5.4.1: Facility Post-Disaster Status Assessment.

## Instructions

Complete all sections of this report to assess structural integrity and operability of your facility. 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 | YES | NO |
|---|---|---|
| ELECTRICITY | | |
| EMERGENCY POWER | | |
| FUEL RESERVE | | |
| HEAT/ COOLING | | |
| SEWAGE DISPOSAL | | |

| SUPPLIES | YES | NO |
|---|---|---|
| FOOD | | |
| MEDICATIONS | | |
| LINEN | | |
| 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

## Description

This process flow can help hospitals identify and secure sensitive areas within their facilities that may require restricted access during a healthcare surge.

This tool can also be found in Volume I: Hospitals, Section 5.10.2: Lock-Down vs. Restricted Access/Visitation.

## Instructions

Review the process flow and identify the areas in the facility that may require additional security during an emergency.

| Input | Facility Security Plan Activities | Output |
|-------|----------------------------------|--------|

| | | |
|---|---|---|
| List of all sensitive areas within facility* | Define locations requiring access controls | List of sensitive ares requiring access controls |
| • Criteria for access controls<br>• Features / detractors of access control methods | Define Facility Access Controls | Access Control Selected |
| Access control implementation steps | Define implementation of access controls | Access controls implementation plan |
| Criteria for access controls validation | Define access control validation | Access control validation defined |

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

- Birthing Center (Maternity, Nursery, L&D, 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

## Description

The purpose of this template is to assist healthcare facilities develop a healthcare surge plan to guide their response to healthcare surge. Each facility is encouraged to incorporate this template into their individual plans and protocols. This template does not replace the facility's emergency operations plan, but it is to be used in conjunction with the plan to ensure that adequate surge provisions are included in the emergency management plan. The template lists the essential elements that facilities need to address in order to plan and prepare for healthcare surge. The template is scaleable and adaptable for different facility types. Since this is an all facilities template, including alternate care sites, certain sections might not apply to some facilities. For example, the questions within the supplies, pharmaceuticals and equipment section are more applicable to hospitals than to other nonhospital facilities.

## Instructions

The template is in a "fill-in-the-blank" format and includes forms needed to create a plan. The template is intended to serve as a guide. The contents of this template are based largely on the Standards and Guidelines Manual and the associated operational tools. In order to build and effectively use this template, each facility is expected to apply the concepts from the Standard and Guidelines Manual to their unique circumstances.

This template is only a starting point. The elements of the template are intended to be adapted to facilities needs, environments, resources and existing plans. Facilities are encouraged to review, use and modify the template over time. Furthermore, facilities may need to develop additional emergency management tools. Users of the template should feel free to modify the order and content of template sections.

# 1. Introduction

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 local and 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.

## 1.1 How to Use This Template

The purpose of this template is to help hospitals develop a surge plan in order to guide their response to healthcare surges that occur during catastrophic events. Each hospital is encouraged to incorporate this template into their individual plans and protocols. This template does not replace a hospital's emergency operations plan, but it is to be used in conjunction with the plan to ensure that adequate healthcare surge provisions are included in the emergency management plan. The template lists the essential elements that facilities in order to plan for healthcare surges. This template is scaleable and adaptable to different types of hospitals.

The template is a "fill-in the blank" format to identify potential planning needs and includes forms needed to create a plan. The contents of this template are based largely on the Healthcare Surge Standards and Guidelines manual and the associated operational tools and the California Hospital Association Surge Plan Checklist.

The elements of the template are intended to be adapted to hospitals' needs, environments, resources, and existing plans. Hospitals are encouraged to review, use and modify the template over time.

## 2.    Command and Management

During an incident it will be important for hospitals to identify what procedures to employ and to quickly disseminate easily understood instructions. To ensure that the hospital will successfully respond to an event, the Surge plan should include important triggers and decision-making processes for activating both the Surge Plan and the Emergency Operations Plan (EOP). Examples of these triggers and processes include:

- Initial assessment of the event type, scope and magnitude, estimated influx of patients, real and potential impact on the hospital
- Activation of the Incident Command Center and the Hospital Command Center.
- Notification to appropriate local governmental point of contact of the surge status and activation of the EOP and surge plan
- Internal notification/communications and staff call-back protocols
- Processes, procedures and paperwork for contacting local or regional licensing authority for potential or actual request for temporary permission to exceed staffing ratios
- Establish ongoing communications with local governmental point of contact to report: patient census, bed capacity, hospital status, critical issues and resource requests
- Activation of resource management system including inventory, tracking, prioritizing, procuring and allocating of resources

**Describe the triggers and the decision-making processes for activating the Emergency Operations Plan (EOP) and surge plan in response to a surge event at your facility.**

<< >>

*Considerations from the California Hospital Association Surge Plan Checklist:*

| Status | Location | Plan Elements |
|---|---|---|
| **Command and Management** | | |
| | | ☐  Plan identifies triggers and decision-making processes for activating the Emergency Operations Plan (EOP) and surge plan in response to a surge event. |
| | | ☐  Initial assessment of the event type, scope and magnitude, estimated influx of patients, real or potential impact on the hospital, and special response needs (e.g., infectious disease, hazardous materials) |
| | | ☐  Activation of the Incident Command System (e.g., Hospital Incident Command System) and determination of appropriate ICS positions to be activated. |
| | | ☐  Activation of the Hospital Command Center (HCC) |
| | | ☐  Notification to appropriate local governmental point of contact (e.g., local health department, local emergency medical services agency, Medical and Health Operational Area Coordinator) of the surge status and activation of |

| Status | Location | Plan Elements |
|--------|----------|---------------|
| | | the EOP and surge plan.1 The EOP identifies the local government points of contacts and 24/7 contact numbers, alternate contacts and appropriate notification priorities and processes. |
| | | ☐ Internal notification/communications and staff call-back protocols (call trees, contact information, etc.) |
| | | ☐ Processes, procedures and paperwork for contacting local or regional licensing authority (e.g., California Department of Public Health Licensing and Certification) for potential or actual request for temporary permission to exceed staffing ratios or utilize non-traditional patient care delivery areas. Include the licensing authority's contact information in the plan, templates and checklists). |
| | | ☐ Establish ongoing communications with local governmental point of contact to report<br>   o Patient census, bed capacity, using standardized reporting terminology (e.g., HAvBED or as established by your local government point of contact).<br>   o Hospital status, critical issues and resource requests |
| | | ☐ Activation of resource management system including inventory, tracking, prioritizing, procuring and allocating of resources. |

## 3.    Expanding Hospital Space and Operations

Healthcare surge capacity is the patient care capacity under the control of a hospital's asset base which can be flexed to comply with the standard of care for a healthcare surge arising out of emergencies.  To meet the healthcare needs of a large number of patients, hospitals should develop plans/protocols to:

- Activate and operate holding areas for patients awaiting triage, decontamination, treatment, admission, discharge or transport to lower levels of care,
- Activate and operate additional treatment areas to allow the emergency department to focus on higher acuity patients,
- Expand ambulatory and inpatient capacity beyond licensed capacity and use of alternative care areas (e.g., dialysis, outpatient surgery centers, etc.)
- Increase capacity and capability for ancillary/diagnostic services during a healthcare surge,
- Activate and perform decontamination, as necessary and to continue to provide essential services such as infection control, waste management and security.

## 3.1.    Immediate Response

## 3.1.1.    Triage

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)[i] 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."

One of the initial activities or shifts that should be considered during a surge event will be to activate triage efforts focusing on maximizing the number of lives saved.  For example, 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.

Another shift is making triage decisions that affect the allocation of all available resources across the spectrum of care, from the scene to hospitals to alternate care sites should also be considered.  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
- Regular medical care wards may become isolation or other specialized response units.

**Describe polices or procedures for shifting the provision of care from focusing on patient-based outcomes to population-based outcomes.**

<< >>

**Describe plans for activating and operating additional/alternate triage area(s) during a surge event.**

<<>>

*Considerations from the California Hospital Association Surge Plan Checklist:*

| Status | Location | Plan Elements |
|---|---|---|
| | | **Triage:** Plan to activate and operate additional/alternate triage area(s) during a surge event. |
| | | ☐ Activation triggers for establishing alternate/additional triage areas are defined |
| | | ☐ Set-up (checklists) and operations plan |
| | | ☐ Identifies primary and alternate triage areas (consider external triage areas, event type, and facility damage. |
| | | ☐ Responsibility and processes for set-up and operation of triage area(s) are defined |
| | | ☐ Communications plan for communications between triage areas, Emergency Departments, other key departments and the HCC (e.g., landlines, handi-talkies, radios) |
| | | ☐ Staffing of the alternate triage sites |
| | | ☐ Provision of supplies and equipment for the triage area (consider scope and type of event, based on the facility HVA) |
| | | ☐ Infectious and/or exposed patient triage area(s) and protocols (universal precautions, staff PPE, ventilation, infection control protocols for staff and patients) |
| | | ☐ Flow of patients to and from the triage area |
| | | ☐ Signage for directing patients to triage area(s) |
| | | ☐ Communication with the HCC to identify available community resources (checklist with level of care capability and contact information) |
| | | ☐ Triage protocols for internal and external patient disposition (e.g., minor care, delayed care, holding, ACS, etc.) |

## 3.1.2. Decontamination

Hospitals need a plan to set up and operate holding and decontamination area(s). Plans should include methods to segregate and prioritize contaminated individuals as well as methods for directing patient to decontamination area(s). 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. 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 OSHA)
- 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

**Describe the notification procedures with local agencies during a hazardous materials emergency.**

<<>>

**Describe policies and procedures to triage, treat, decontaminate and medically screen staff, family members, and patients in a hazardous material emergency.**
<< >>

*Considerations from the California Hospital Association Surge Plan Checklist:*

| Status | Location | Plan Elements |
|---|---|---|
| | | **Decontamination:** Plan to activate and perform decontamination, as necessary |
| | | ☐ Plan for set-up (checklist) and operation of holding and decontamination area(s) (list individuals responsible) |
| | | ☐ Plan for segregation and prioritization of contaminated individuals for decontamination |
| | | ☐ Methods for directing patients to decontamination area(s) (e.g., signage, stations, cones, etc.) |
| | | ☐ Primary and alternative decontamination areas (consider external areas, event/agent, and facility damage potential) |
| | | ☐ Communications protocols within the decontamination area(s) and between other units |
| | | ☐ Staffing Plan considering scope and type of event |
| | | ☐ Equipment and supplies |

## 3.1.3.  Infection Control

Healthcare facilities across the nation have seen a steady increase in the risk of hospital acquired infections during recent decades.  During a catastrophic event, the risk infection is even greater due to the dramatic increase of patients.

Current Joint Commission standards for infection control specify requirements to be considered in hospitals' emergency management activities. These requirements state that hospitals should have plans in place that:

- Prevent the introduction of infections into the hospital
- Identify whether existing patients have become infected and/or determine how to contain the risk or spread of infection
- Halt services and/or admissions
- Delay transfers and/or discharges
- Limit visitors within a hospital
- Assess the extent to which the community is affected by an epidemic or infection to determine an appropriate response
- Assess the types of services the hospital offers and the hospital's capabilities

**Describe procedures for assessing the extent to which the community is affected by an epidemic or infection and how it will impact your hospital facility.**

<<>>


**Describe the plans for preventing the introduction of infections into your facility during a surge event.**

<<>>


**Describe the process for isolating and quarantining infected patients from the rest of the patient population during a surge event.**

<<>>


### 3.1.4. Overcrowding and Diversion

During a healthcare surge, due to a large influx of patients and acute casualties arriving on their own or by ambulance, hospitals need to develop a plan to address overcrowding and the need for hospital diversion including a rapid communication plan with EMS units that allow them to determine a destination immediately at any time.


**Address what will occur when other hospitals within the operational area are on a divert status and individuals are continuing to arrive at your facility by ambulance and/or self-referral.**
<< >>


**Describe the communication process used with EMS agencies/units to direct them where to deliver patients.**
<< >>


**Describe the differences between diverting incoming patients and transferring patients already at the hospital.**
<< >>


**If hospitals in the region become overwhelmed, describe the plan for where to send patients (within your region and across regional boundaries).**

<<>>


### 3.1.5  Security

Controlling the movement of individuals into, throughout and out of the hospital during an emergency is essential to the safety of patients and staff, and to the security of critical supplies, equipment and utilities. The hospital determines the type of access and movement to

be allowed by staff, patients, visitors, emergency volunteers, vendors, maintenance and repair workers, utility suppliers, and other individuals when emergency measures are initiated.

Hospital disaster plans should include the following:

- Process for identifying supplemental personnel that may be needed to assist on-duty security staff
- Measures for initiating facility lockdown or limited access
- Protocol for the identification of medical staff and others (fire, law enforcement, public health, etc.) that will have access to the facility
- Protocol for identifying supplemental personnel to assist the on-duty security staff, depending on the type and length of the incident
- Process for establishing a security perimeter
- Protocol for communications with and among security personnel

**Describe plans for lockdown and setting up perimeters around your hospital facility.**
<< >>

**How will perimeters be maintained (i.e., police presence, hospital security personnel, etc.)?**
<< >>

**Describe the policies and procedures for employee identification to allow for crossing the perimeter?**
<< >>

**Describe how additional security personnel will be obtained, if needed.**
<< >>

**What type of communication process has been setup between your hospital and other hospitals regarding transferring patients when security is in place at each facility?**
<< >>

*Considerations from the California Hospital Association Surge Plan Checklist:*

| Status | Location | Plan Elements |
|---|---|---|
| | | **Security – Facility Access:** Plan(s) for securing and limiting facility access during a surge event. |
| | | ☐ Security assessment with plans to address vulnerabilities. |
| | | ☐ Plan for activating traffic control measures for access to facility (pre-planned traffic control measures, tools, etc) |
| | | ☐ Road map outlining ingress, egress and traffic controls during surge event (coordinated with law enforcement) |
| | | ☐ Specific staffing assignments and instructions for traffic control (who, what, how) during surge event |
| | | ☐ Plan for initiating facility(ies) lock-down and/or limited access and entry |
| | | ☐ Identification/diagram of all access points in facility(ies) |
| | | ☐ Identification of limited access points for entry and procedures for monitoring/managing (staff) |
| | | ☐ Criteria and protocols for facilities entry and exit, including staff, volunteers, patients, family and other individuals (e.g., who, identification requirements) |
| | | ☐ Staffing plan manning closed entrances (which will only be locked for external entry) |
| | | ☐ Communication (between lead security, manned areas and HCC) |
| | | ☐ Special considerations following a terrorist attack (e.g. creating a secure perimeter, restricting access to adjacent parking areas, etc.) |
| | | ☐ Training for staff who may be utilized in security roles (including protocols, handling abusive behavior, etc.) |
| | | ☐ Plan and mutual aid agreements for assistance with hospital security (hospital staffing pool, local law enforcement, outside agencies) |

**Additional Tools Found in the Operational Tools Manual:**
- Sample Lock-Down Policy and Procedure Tool
- The Standardized Security Assessment/Vulnerability Tool.

## 3.2.   Direct Patient Care

## 3.2.1 Expanding of Patient Care Areas

Considering that hospitals should maximize use of their space during a healthcare surge, use the matrix below to plan for expansion of patient care areas for your hospital. The column to the left lists all the different types of patient care areas.  The columns to the right contain fields for regular and negative pressure bed capacity under normal and healthcare surge situations. The column to the far right provides fields to identify sources or hospital areas for expanded capacity.

In completing this matrix, hospitals should keep in mind alternate spaces in their facility which would better serve as patient care areas and prioritize accordingly. For example, if the cafeteria is an open space with better ventilation and is in closer proximity to the pharmacy, that space should be considered as a source of expanded capacity during a healthcare surge. Additional expansion activities include:

- 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
- 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
- Avoid using 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
- Convert or open spaces for use as patient/inpatient treatment areas. These potential treatment areas include such 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)

| # | Type of Unit | Normal Capacity | | Expanded Capacity | | Source of expanded capacity* |
| | | A | B | C | D | |
| | | Reg | Neg Press | Reg | Neg Press | |
|---|---|---|---|---|---|---|
| 1. | Medical / Surgical (Include GYN) | | | | | |
| 2. | Perinatal (exclude Newborn / GYN) | | | | | |
| 3. | Pediatric | | | | | |
| 4. | Intensive Care | | | | | |
| 5. | Coronary Care | | | | | |
| 6. | Acute Respiratory Care | | | | | |
| 7. | Burn | | | | | |
| 8. | Newborn Nursery | | | | | |

| # | Type of Unit | Normal Capacity | | Expanded Capacity | | Source of expanded capacity* |
|---|---|---|---|---|---|---|
| | | A | B | C | D | |
| | | Reg | Neg Press | Reg | Neg Press | |
| 9. | Intensive Care Newborn Nursery | | | | | |
| 10. | Rehabilitation Center | | | | | |
| 11. | Chemical Dependency Recovery Hospital | | | | | |
| 12. | Acute Psychiatric | | | | | |
| 13. | Skilled Nursing | | | | | |
| 14. | Intermediate Care | | | | | |
| 15. | Intermediate Care / Developmentally Disabled | | | | | |
| 16. | Other (specify) | | | | | |
| 17. | **Total Inpatient beds** | | | | | |
| 18. | Surgical Suites | | | | | |
| 19. | Emergency Department | | | | | |
| 20. | Outpatient Services (Surgicenter, Endoscopy, etc.) | | | | | |
| 21. | Pain Clinic | | | | | |
| 22. | Dialysis | | | | | |
| 23. | Urgent Care | | | | | |
| 24. | Swing bed or attached Nursing Home | | | | | |
| 25. | Rehabilitation | | | | | |
| 26. | Other (specify) | | | | | |
| 27. | Other (specify) | | | | | |
| 28. | Other (specify) | | | | | |
| 29. | **Total Outpatient beds** | | | | | |

* Hospital area being used/converted to create additional patient care capacity

**For each applicable patient care area for your hospital listed above, describe how additional capacity will be created/converted.**

<< >>

*Considerations from the California Hospital Association Surge Plan Checklist:*

| Status | Location | Plan Elements |
|---|---|---|
| | | **DIRECT PATIENT CARE AREAS** |
| | | Specific protocols for creating surge capacity to care for a significant surge of both ambulatory care and inpatient disaster patients. |

| Status | Location | Plan Elements |
|---|---|---|
| | | ☐ Agreements with area hospitals, long term care facilities and other health providers to accept or receive patients and share resources as appropriate and possible. **Tool: Model MOU** |
| | | ☐ Plan for immediate cancellation/delay of scheduled/non-emergent admissions, procedures and diagnostic testing |
| | | ☐ Inpatient admissions (scheduled surgeries/procedures) |
| | | ☐ Clinic visits |
| | | ☐ Outpatient surgeries and procedures (e.g., GI, Catheterization, Radiologic.) |
| | | ☐ Diagnostic/Ancillary services (e.g., Imaging, Neurology) |
| | | ☐ Protocols for rapid and periodic review of patients for admission, discharge or transfer by teams of physicians, nurses and discharge planners for: |
| | | ☐ Emergency Department (ED) |
| | | ☐ Inpatients by Unit or Service |
| | | ☐ Outpatient Surgery and Procedure Areas (e.g., colonoscopy) |
| | | ☐ Clinics |
| | | ☐ For potential/actual terrorist or criminal event, chain-of-evidence for law enforcement is addressed |
| | | ☐ Communication and coordination with HCC regarding activated and available community resources to triage, discharge or transfer to (plan should include checklist with location, level or care and contact information). |
| | | **Capacity Plan Contents:** Specific protocols for expanding ambulatory and inpatient capacity beyond licensed capacity. |
| | | ☐ Identify how ED, inpatient units, clinics, clinical areas and other hospital areas (e.g., cafeteria, auditorium, conference rooms, open spaces, etc.), will be utilized to expand surge capacity. Address all key elements for use (form and protocols for each area.)3 See Sample Tool |
| | | ☐ Capacity and use, considering cohorting of patients (e.g., Inpatient, minor care, holding) |
| | | ☐ Activation (define responsibility and activation process) |
| | | ☐ Management and operation of the area (describe responsibilities and procedures) |
| | | ☐ Equipment and Supplies (including re-supply) |
| | | ☐ Staffing (identify requirements and staffing plan) |
| | | ☐ Management of special needs patients (hearing impaired, blind, wheelchair dependent, other) |
| | | ☐ Method of triage to, and discharge from, area, including transport method(s) |
| | | **Inpatient Capacity:** Specific plans for increase bed capacity to care for surge of inpatients, including expanding beyond licensed capacity on inpatient units and use of alternative care areas (dialysis, outpatient surgery, recovery, etc.) while maintaining continuity of operations and care for current patients who cannot be discharged or transferred.2 |
| | | ☐ Trauma (assume all hospitals will receive trauma cases when trauma |

| Status | Location | Plan Elements |
|---|---|---|
| | | center capabilities exceeded) |
| | | ☐ Critical Care (expand bed capacity in existing units, use of other areas/units)4 |
| | | ☐ Burn (assume all hospitals will receive burn patients when burn center capabilities exceeded) |
| | | ☐ Isolation (identify specific hospital unit(s) or areas for negative pressure or isolation through independent ventilation if event involves contagious/infectious disease) |
| | | ☐ Medical/Surgical Acute Care5 |
| | | ☐ Pediatric (assume all hospitals will be receive pediatric cases when pediatric center capabilities exceeded) |
| | | ☐ NICU (includes disaster victims and/or continuity of operations) |
| | | ☐ Maternity (assume continuity of operations) |
| | | *Ambulatory Care Capacity:* Specific plans for expanding capacity to care for surge of emergency/ambulatory patients, including use of ambulatory care centers, and opening Alternative Treatment Areas (e.g., surge tents, clinics, other hospital areas and facilities). |

**Additional Tools Found in the Operational Tools Manual:**

- Facility System Status Report
- Facility Damage Report (Limited Assessment)
- Facility On-Site Damage Report/Operability Form

## 3.2.2  Managing Services Provided to Patients

In addition to expanding patient care areas, healthcare surge capacity can be created by managing the services provided to patients.   Processes for managing services in the following areas should be considered:

a.  Rapid discharge of emergency department (ED) and other outpatients who can continue their care at home safely

b.  Cancellation of elective surgeries and procedures, with reassignment of surgical staff members and space

c.  Reduction of the usual use of imaging, laboratory testing, and other ancillary services

d.  Transfer of patients to other institutions in the State, interstate region, or across the nation

e.  Facilitation of home-based care for patients in cooperation with public health and home care agencies

**For each of the options above, complete the Healthcare Surge Capacity - Patient Management Template below.**

**Healthcare Surge Capacity - Patient Management Template:**

| | <<Healthcare Surge Capacity - Patient Management Option>> |
|---|---|
| i. | **Have processes been defined to implement the option:** ❏ Y ❏ N ❏ N/A |
| ii. | **Has staff been trained to implement the option:** ❏ Y ❏ N ❏ N/A |
| iii. | **Have patient communication strategies been defined:** ❏ Y ❏ N ❏ N/A |
| iv. | **Describe key elements of the solution:**<br>&lt;&lt; &gt;&gt; |

### 3.2.3. Support Areas

The hospital will require pre-designated areas that will be used for purposes other than patient care, such as waiting areas for family and friends, counseling areas, and rest areas. These pre-designated areas can include:

- Pre-existing waiting rooms
- Conference rooms
- Medical office buildings
- Temporary shelters on facility premises (cots in tents)
- Cafeterias

**Complete the following Healthcare Surge Support Area Matrix to designate support areas within the hospital. Once the matrix is completed, describe how the designated hospital area will be converted for each applicable healthcare surge support area for your hospital.**

| Healthcare Surge Support Areas | |
|---|---|
| **Type of support area** | **Designated hospital area** |
| Family Waiting | |
| Counseling | |
| Media | |
| Child Care | |
| Other | |
| Other | |

## 3.3.  Ancillary and Support Services

## 3.3.1 Ancillary Services

If a hospital experiences a healthcare surge, it will need a plan for appropriate utilization of ancillary/diagnostic services. Important steps or activities a hospital should consider include:

- Increasing capacity and capability for laboratory, imaging (including MRI, CT, Ultrasound, etc.) and other ancillary/diagnostic services
- Reducing usual utilization of imaging, laboratory testing, and other ancillary services
- Opening lines of communication and reporting with local and state laboratories.

**Describe the hospitals plan for assessing the appropriate utilization of ancillary/diagnostic services (i.e. increasing or decreasing utilization) during a surge event.**

<<>>

**Describe the communication plan with local and state laboratories.**

<<>>

*Considerations from the California Hospital Association Surge Plan Checklist:*

| Status | Location | Plan Elements |
|---|---|---|
| | | ☐ ***Ancillary Services:*** Specific plans have been established for increasing capacity and capability for ancillary/diagnostic services during a surge event. |
| | | ☐ Laboratory services, including communication and reporting to and from County Laboratory |
| | | ☐ Imaging services (including MRI, CT, Ultrasound, etc) |
| | | ☐ Other ancillary and diagnostic services |

## 3.3.2  Fatality Management

When a catastrophic emergency occurs, hospital morgues will quickly reach capacity. In addition, public coroners/medical examiners and private mortuaries may be unable to immediately respond to remove the dead.  To prepare for a healthcare surge event, hospitals should establish internal mass fatality plans for the management and disposition of deceased patients. Plans should include:

- Mortality estimates by type of event to anticipate and secure supply needs
- Memoranda of understanding with trucking companies to provide refrigerated trucks
- Procedures for expanding morgue capacity with the potential to use alternative areas
- Processes for converting areas in the hospital into temporary morgues in a mass casualty event
- Guidelines for the appropriate bagging and storage of the dead, and consideration of evidentiary needs (bodies stored with some space/distance between bodies, appropriate identification/labeling of the body)
- Procedures for the bagging, handling and labeling of contaminated bodies
- Procedures for providing information about viewing the dead by family members
- Guidelines for the careful identification and tracking of the dead.

**When a catastrophic emergency occurs, normal public or hospital mortuaries may be overwhelmed to deal with prolonged mortuary work, forensic examinations and other associated activities.  Describe the hospital's approach for expanding morgue capacity**.

<<>>

**Describe the communication plan with hospital mortuary, public coroners/medical examiners, private mortuaries, and other external agencies during a surge event.**

<<>>

*Considerations from the California Hospital Association Surge Plan Checklist:*

| Status | Location | Plan Elements |
|---|---|---|
| | | ☐ **Fatality Management:** Plans have been established for management and disposition of deceased patients |
| | | ☐ Plans are consistent and coordinated with Operational Area Fatality Management plan (ME/Coroner Plans) |
| | | ☐ Includes mortality estimates by type of event to anticipate and secure supply needs (e.g., body bags, shroud packs) |
| | | ☐ Plan for expanding morgue capacity, including alternative areas (identify capacity) |
| | | ☐ Agreements with external agencies for refrigerated trucks or mortuary support (contacts and capacity) |

### 3.3.3  Medical Waste

In a catastrophic emergency, the potential for overloading the waste handling capacity of the hospital is greatly increased. Because of this potential, each hospital must develop protocols in addition to existing waste management plans that address the challenges associated with the increased volume of medical and hazardous waste. 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°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.

**Describe a plan coordinating the expedient and safe disposal of the medical waste that will be generated at each hospital by an event of bioterrorism.**
<< >>


**Describe a plan for coordinating the expedient and safe disposal of hazardous waste by a hazardous waste dispersal emergency.**
<< >>


*Considerations from the California Hospital Association Surge Plan Checklist:*

| Status | Location | Plan Elements |
|---|---|---|
| | | ☐ ***Medical Waste***: Plans have been established for storage and/or disposition of increased medical waste during a surge event. |
| | | ☐ Expansion of storage facilities and/or disposition capabilities |
| | | ☐ Agreements with vendor(s) to increase pick-up |

# 4. Expanding the Workforce

It is essential for hospitals to have a plan and strategy to not only increase staff that provide patient care but also train and protect the staff. Hospitals may draw from existing staff in which case plans should address contingency staffing plans and identifying minimum staffing needs and prioritizing critical and non-essential services. Plans should also address staff notification and call-back protocols as well as cross-training and reassignment of staff to support critical/essential services.

Workforce may also be augmented through use of volunteers in which case hospital plans should include volunteer check-in protocols, registration, credentialing and privileging protocols, systems to collect and maintain volunteer information and protocols for assignments and roles by type of volunteer.

**Describe how the need for additional medical staff will be addressed. For each staffing source below, complete the Relationship Box Template:**
   a. American Red Cross (ARC)
   b. California Medical Assistance Team (CalMAT)
   c. Community Emergency Response Teams (CERT)
   d. Disaster Medical Assistance Team (DMAT)
   e. Disaster Service Worker (DSW)
   f. Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP)
   g. Medical Reserve Corps (MRC)

**Relationship Box Template**

| 6. <<Entity Name>> | |
|---|---|
| i. | **Type of personnel sourced (clinical, ancillary, etc.):** _____ |
| ii. | **Does an MOA/MOU exist with this entity:** ❑ Y    ❑ N   ❑ N/A |
| iii. | **If yes, MOA/MOU reference #:** _____ |
| iv. | **If no, what is the action plan to obtain such support/services?** <br> << >> |
| v. | **Describe key elements of the relationship with the entity:** <br> << >> |
| vi. | **Business and Emergency Contact Information:** (Add more contacts as required) <br> Name: <br> Designation: <br> Tel: <br> Cell: <br> Fax: <br> Email: |

**Describe the process for emergency credentialing and privileging of licensed healthcare professionals?**
<< >>


**Describe the policies and procedures for personnel verification.**
<< >>


**What is the process to accept and deploy augmented staff?**
<< >>


**How will required documentation be tracked for non-licensed healthcare professionals and volunteers who have been granted temporary disaster privileges?**
<< >>


**What is the process for tracking and registering volunteers?**
<< >>


**Describe the staffing plan (or utilization plan) and expected assignments for all personnel.**
<< >>


**Describe the role and specific actions assigned to the personnel staging team leader during a healthcare surge.**
<< >>


*Considerations from the California Hospital Association Surge Plan Checklist:*

| Status | Location | Plan Elements |
|---|---|---|
| | | ***Staffing:*** Specific plans for staffing during a significant surge event using hospital staff, contracted pools, and mutual aid resources taking into consideration type and scope of event. |
| | | ☐ Identification of staffing needs by staff type, service area, and status of regulatory waivers regarding staffing ratios, licensure and scope of practice |
| | | ☐ Contingency staffing plan identifies minimum staffing needs and prioritizes critical and non-essential services |
| | | ☐ Staff contact information (updated) available to HCC and individuals responsible for contacts (redundant) |
| | | ☐ Staff disaster response assignments/roles (labor pool, specific |

| Status | Location | Plan Elements |
|--------|----------|---------------|
| | | units/areas, etc considering event type) |
| | | ☐ Staff notification and call-back protocols, including responsibility(ies) (multiple methods, automated if possible) |
| | | ☐ Agreements with staffing agencies (assume multiple organizations have agreement with the same agencies) |
| | | ☐ Protocols for requesting and for receiving staff resources (volunteers, special needs/teams, etc.) through HCC to local government point of contact) |
| | | ☐ Cross-training, and reassignment, of staff to support critical/essential services |
| | | ☐ Establish Just In Time (JIT) training for key areas to allow staff to be assigned where most needed (e.g., Pediatrics, Burns, Respiratory, security, critical care) |
| | | ☐ Address shift change, rotation, rest areas and feeding of staff |
| | | ☐ Protocols for shift changes and rotation of staff (consider type of event) |
| | | ☐ Specific areas designated for staff respite and sleeping (identify areas, responsibilities) |
| | | ☐ Supplies to ensure food and water for staff and volunteers (for a minimum of 96 hours self-sufficiency) |
| | | *Volunteers:* Plan includes utilization of non-facility volunteers including policies and procedures for accepting, credentialing, orienting, training and using volunteers during a surge event. |
| | | ☐ Volunteer check-in protocols including staffing of check-in location (single entry) |
| | | ☐ Registration, Credentialing and Privileging protocols, including use of local MRC and ESAR-VHP |
| | | ☐ Systems to collect and maintain volunteer information |
| | | ☐ Issuance of identification badge and other means of identification (e.g., colored/printed armband) |
| | | ☐ Protocols for assignments and roles by type of volunteer (consider buddy systems as appropriate) |
| | | ☐ Just-in-Time (JIT) training as appropriate to volunteer role(s) |

### Additional Tools Found in the Operational Tools Manual:

- Sample Policy for Surge Capacity Staffing Emergency Plan
- List of Potential Staffing Sources
- Staff Assessment Tracking Sheet
- Volunteer Application for Healthcare Professionals
- Volunteer Application for Support Staff

## 4.1 Augmenting Clinical Staff

### Scope of Practice (for reference purposes only)

The following table provides an overview of the responses received from the various California licensing boards with regards to the extent to which their professionals' scope of practice may be flexed or altered during a declared emergency. Where applicable, the Board representatives' comments and suggestions have also been noted.

| Board | Current Scope of Practice | Scope of Practice / Liability in an Emergency | Comments/ Recommendation |
|---|---|---|---|
| Pharmacy | Business & Professions Code §4052.1 – 4052.5 outline the normal scope of practice for pharmacists. | Per Business & Professions Code §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. | N/A |
| Physician Assistant | Business & Professions Code §3502 outlines the normal scope of practice for physician assistants. | In the event of an emergency (as defined by Government Code §8558), the scope of practice for physician assistants is defined by Business & Professions Code §3502.5 which states that they may perform those medical services permitted pursuant to §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." | N/A |
| Podiatric Medicine | Business & Professions Code §2472 outlines the normal scope of practice for doctors of podiatric medicine (DPM). | Per Business & Professions Code §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 DPMs. | It is recommended by the Legal Office of the California Board of Podiatric Medicine that §2397(d) be amended or sunsetted. |
| Respiratory Care | Business & Professions Codes §3702 and 3702.7 outline the normal scope of practice for a professional licensed by the Respiratory Care Board of California. | Per Business & Professions Code §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 & Professions Code §3765, the Respiratory Care Practice Act does not prohibit respiratory care services in case of an emergency.<br><br>Additionally, per Business & Professions Code §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 | N/A |

| Board | Current Scope of Practice | Scope of Practice / Liability in an Emergency | Comments/ Recommendation |
|---|---|---|---|
| | | the person in rendering the emergency care. This section does not grant immunity from civil damages when the person is grossly negligent." | |

**Describe how medical staff's scope of practice will be flexed or altered during a declared emergency?**

<<>>

## 4.2.  Maintaining the Workforce

In the event of a healthcare surge, hospitals should have mechanisms in place to address staff needs and general workforce resiliency, including protocols to monitor and assess staff for physical health and stress related concerns. Hospital plans should also include arrangements for dependent care including food, boarding and special needs.

**Describe your hospital's policies and procedures for identifying which staff will wear personal protective equipment and which staff will be responsible for patient decontamination.**
<< >>

**What is the prioritization policy for vaccinating or treating population groups (for example healthcare workers and those at increased risk)?**
<< >>

**What are the key elements of the workforce resilience policy at your hospital?**
<< >>

**Describe your staff support provisions.**
<< >>

**Describe the policies and procedures for sheltering and feeding of staff and volunteer dependents during a disaster or other emergency situations.**
<< >>

*Considerations from the California Hospital Association Surge Plan Checklist:*

| Status | Location | Plan Elements |
|---|---|---|
| | | ***Staff/Family Needs:*** Specific plans for addressing staff needs, family and domestic concerns during a surge event |
| | | ☐ Internal or external arrangements for dependent care to include, if necessary, boarding, food, and special needs to remove barriers that may prevent staff from coming to work (encourage staff to have family disaster plan and to pre-arrange, if possible) |
| | | ☐ Internal or external arrangements for pet care (encourage staff to pre-arrange) |
| | | ☐ Protocols and specific assignment of appropriately trained professionals to monitor and assess staff for both stress related and physical health concerns |
| | | ☐ Plan for providing staff and family with psychological support and resources |

## Additional Tools Found in the Operational Tools Manual:

- Sample Policy for Workforce Resiliency
- Sample Policy for Dependent Care
- Sample Policy for Family Emergency Plan

## 4.3. Training

Hospital plans should establish Just In Time (JIT) training for key areas to allow staff to be assigned where most needed and should also include methods to facilitate cross-training and reassignment of staff to support critical/essential services.

According to The Policy for Workforce Resilience during a disaster (included in Operations Training Manual), 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:
   a. Stressors related to pandemic influenza
   b. Signs of distress
   c. Traumatic grief
   d. Psychosocial aspects related to management of mass fatalities
   e. Stress management and coping strategies
   f. Strategies for building and sustaining personal resilience
   g. Behavioral and psychological support resources
   h. Strategies for helping children and families in times of crisis
   i. 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

**For each of the training areas identified, complete the Training Assessment Template:**

1. Incident Management System (or a NIMS compliant system like HICS for hospitals)
2. Decontamination
3. Infection Control Procedures
4. Medical Waste Management
5. Population Based Care
6. Healthcare surge administrative procedures and forms
7. Security
8. Other

**Training Assessment Template**

| <<Training Area>> | |
|---|---|
| i. | **Has the staff received training in this area: ❏ Y    ❏ N   ❏ N/A** |
| ii. | **If yes, when was the last training conducted: _____** |
| iii. | **If no, what is the action plan to provide training in this area?**<br>**<< >>** |
| iv. | **Describe key elements and the type of training provided (table top exercise, classroom, etc.):**<br>**<< >>** |
| v. | **Contact Information of Staff Trained:** (Add more contacts as required)<br>Name:<br>Department:<br>Designation:<br>Tel:<br>Cell:<br>Fax:<br>Email: |

**Additional Tools Found in the Operational Tools Manual:**

- Policy for Workforce Resiliency

## 5. Supplies, Pharmaceuticals and Equipment

During healthcare surges, supplies, pharmaceuticals, and equipment will become scarce. Hospitals need to determine how the supplies, pharmaceuticals and equipment will be obtained and the quantities required. 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. This planning can be supplemented with a Hazard Vulnerability Analysis.

**How will your hospital access additional supplies, pharmaceuticals, and equipment at the local and regional level?**
<< >>

**Describe how your hospital will request supplies, pharmaceuticals, and equipment through the SEMS process. List key individuals who will participate in the communication process.**
<< >>

**List the memoranda of understanding (MOU) with vendors and other hospitals to assist in acquiring needed supplies, pharmaceuticals, and equipment in the event of a healthcare surge?**
<< >>

**List the non-governmental organizations (NGOs) that your hospital has developed relationships with to assist in acquiring supplies, pharmaceuticals, and equipment during a healthcare surge?**
<< >>

**Describe the processes and planning have been set up for the storage of supplies, pharmaceuticals, and equipment (for example security, space, location)?**
<< >>

**Describe plans for sharing clinical resources across the region (for example ventilators, personal protective equipment, decontamination systems, etc.)?**
<< >>

**Describe the process to identify the type and quantity of supplies, pharmaceuticals, and equipment required during a healthcare surge.**
<< >>


**List the quantities of critical supplies, pharmaceuticals, and equipment that may be needed during a healthcare surge. There should be enough of these supplies, pharmaceuticals, and equipment to sustain operations for 72-96 hours taking into consideration a 20-25% increase in patients above the facility's Average Daily Census (ADC)?**
<< >>


**For each emergency situation likely to occur in your community, determine the types of clinical resources that may be needed.**
<< >>


*Considerations from the California Hospital Association Surge Plan Checklist:*

| Status | Location | Plan Elements |
|---|---|---|
| Supplies, Pharmaceuticals and Equipment | | |
| | | ☐ Plan addresses supplies, pharmaceuticals and equipment (SPE) for patients and staff for a 96 hour period of self-sufficiency for a significant surge event. |
| | | ☐ Essential equipment, supply and pharmaceutical needs have been identified and summarized (consider event type and patient age) |
| | | ☐ Equipment and furnishings (e.g., beds, cots, ventilators, IV pumps, etc.) |
| | | ☐ Supplies |
| | | ☐ Personal Protective Equipment (masks, respirators, gowns, gloves, hand hygiene products) |
| | | ☐ Pharmaceuticals (including prophylaxis for inpatients, staff and family members) |
| | | ☐ Plans to meet SPE needs have been established (who, how, where ) |
| | | ☐ Standard hospital resources/supplies |
| | | ☐ Hospital caches (including pallets, trailers and how transported/delivered) |
| | | ☐ Agreements with vendors for surge SPE (list of contacts and deliverables in plan) and list of alternative vendors (assume multiple organizations have agreements with the same vendors) |
| | | ☐ Agreements with local pharmacies and stores (list of contacts and deliverables in plan) |
| | | ☐ Community caches (list of cached items, methods for requesting). |
| | | ☐ Other resources (list of caches and method for requesting, including state and federal) |
| | | ☐ Security needs during transport, delivery and storage of SPE |
| | | ☐ Needs and plans have been shared with local government point of contact and planning partners |

| Status | Location | Plan Elements |
|--------|----------|---------------|
|        |          | ☐  Describe responsibilities and protocols for accepting and distributing mutual aid resources at hospital (who, where, how). |
|        |          | ☐  Strategies/protocols included for how priorities would be established if there is a need to allocate limited patient equipment, pharmaceuticals and other resources. |
|        |          | ☐  Plan includes a process to report to HCC real-time information regarding status of SPE resources available and/or needed, and urgency of needs through local government point of contact. |

## Additional Tools Found in the Operational Tools Manual:

- Inventory based Pharmaceutical Classification
- Detailed Supplies and Equipment List
- Pharmaceutical Storage Checklist

# 6. Administration

During a disaster current methods of collecting medical record information via electronic systems within hospitals may be unavailable.  Therefore, paper-based methods for capturing medical record information may be required.  A Surge Plan should consider 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. It is recognized that during a disaster the numbers of displaced persons could be significant. Patient tracking mechanisms could potentially be extended to tracking displaced persons.

- *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. Given these issues, electronic systems should be included as a future consideration.

**Describe your policies and procedures to register patients and record patient insurance information during a healthcare surge.**
<< >>

**Describe how patient health information will be captured during a healthcare surge when your electronic systems are unavailable or nonfunctional.**
<< >>

**Describe the processes and staff training plans have been put in place to determine when and how to disclose protected health information for public health emergency preparedness purposes.**
<< >>

**Describe processes for tracking individuals seeking medical attention within your facility and disposition of those transferred to other facilities during a healthcare surge.**
<< >>


**What are the policies, procedures, and agreements for inter-hospitals transfer of patients?**
<< >>


**Describe how valuables will be stored and logged within the hospital?**
<< >>


**Describe the policies and procedures to capture charges for service, medication, and supplies for individual patients.**
<< >>


**List the facility reporting requirements. Describe the processes for reporting requirements during a healthcare surge?**
<< >>


**<u>Additional Tools Found in the Operational Tools Manual:</u>**
- Patient Tracking Form
- Paper-Based Intra-Hospital Patient Tracking
- Sample Paper-Based Face Sheet
- Short Form Medical Record

# 7. Memoranda of Understanding (MOU)/Memoranda of Agreement (MOA)

Healthcare surge capacity planning efforts must extend beyond optimizing internal emergency management plans and focus on integrating with other healthcare and non-healthcare assets in the community, public and private.

**The Relationship Box Template (on the next page) enables the hospital to capture the type and extent of relationship that exists for each community entity. Listed below are the potential community entities followed by the Relationship Box Template. Complete the Relationship Box Template for each entity with which your hospital has a relationship/agreement.**

1. Local healthcare facilities including but not limited to:
    a. Hospitals
    b. Ambulatory centers
    c. Surgery centers
    d. Community clinics
    e. Rural health clinics
    f. Nursing homes
    g. Long term care facilities (e.g. Skilled Nursing Facilities)
    h. Home healthcare centers
    i. Hospice care centers
    j. Physicians' offices and private physicians
    k. Laboratories and radiology centers
    l. Dental offices
    m. Kidney dialysis centers
    n. Psychiatric facilities
    o. Other healthcare related service providers: pharmacies, blood banks, poison control

2. Local, state, and federal organizations including but not limited to:
    a. Law enforcement, fire, and coroner
    b. Local emergency medical services agencies
    c. Local federal offices
    d. Local public health
    e. Local state offices
    f. National Guard and military establishments\

3. Volunteer organizations including but not limited to:
    a. Community Emergency Response Teams (CERT)
    b. Medical Reserve Corps (MRC)
    c. Neighborhood Emergency Response Teams (NERT)
    d. Red Cross/Salvation Army and other nonprofit organizations

4. Commercial organizations and business partners
    a. Area airports
    b. Board of realtors
    c. Chambers of commerce
    d. Communication companies (e.g., private cell, two-way radio, broadcast television)
    e. Major employers and business continuity, especially big-box retailers (e.g., Costco, Sam's Club)
    f. Mortuaries
    g. Private security firms
    h. Public works and local utility companies
    i. Restaurants, caterers, party supply stores

5. Community organizations
    a. City unified school districts and community colleges
    b. Faith-based organizations
    c. Public transportation
    d. Nursery schools/preschools
    e. Veterinary shelters/pet boarding and care

## Relationship Box Template

| 1. <<Entity Name>> | |
|---|---|
| i. | **Type of resource provided / shared: _____** |
| ii. | **Does an MOA/MOU exist with this entity:** ❑ **Y**    ❑ **N**   ❑ **N/A** |
| iii. | **If yes, MOA/MOU reference #: _____** |
| iv. | **If no, what is the action plan to obtain such support/services?**<br>**<< >>** |
| v. | **Describe key elements of the relationship with the entity:**<br>**<< >>** |
| vi. | **Business and Emergency Contact Information:** (Add more contacts as required)<br><br>Name:<br>Designation:<br>Tel:<br>Cell:<br>Fax:<br>Email: |

## Description

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[10].

This tool can also be found in Volume I: Hospitals, Section 5.4.1: Facility Post-Disaster Status Assessment.

## 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**.

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[9] California Emergency Services Authority. Hospital Incident Command System (HICS) Guidebook. August 2006.
 http://www.emsa.ca.gov/hics/hics.asp

[10] California Emergency Services Authority. Hospital Incident Command System (HICS) Guidebook. August 2006.
 http://www.emsa.ca.gov/hics/hics.asp

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<br>☐ Partially functional<br>☐ Nonfunctional | |
| **Information Technology System (email/registration/patient records/time card system/intranet, etc.)** | ☐ Fully functional<br>☐ Partially functional<br>☐ Nonfunctional | |
| **Nurse Call System** | ☐ Fully functional<br>☐ Partially functional<br>☐ Nonfunctional | |
| **Paging - Public Address** | ☐ Fully functional<br>☐ Partially functional<br>☐ Nonfunctional | |
| **Radio Equipment** | ☐ Fully functional<br>☐ Partially functional<br>☐ Nonfunctional | |
| **Satellite System** | ☐ Fully functional<br>☐ Partially functional<br>☐ Nonfunctional | |
| **Telephone System, External** | ☐ Fully functional<br>☐ Partially functional<br>☐ Nonfunctional | |
| **Telephone System, Proprietary** | ☐ Fully functional<br>☐ Partially functional<br>☐ Nonfunctional | |
| **Video-Television-Internet-Cable** | ☐ Fully functional<br>☐ Partially functional<br>☐ Nonfunctional | |
| **Other** | ☐ Fully functional<br>☐ Partially functional<br>☐ 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<br>☐ Partially functional<br>☐ Nonfunctional | |
| **Fire Detection/Suppression System** | ☐ Fully functional<br>☐ Partially functional<br>☐ Nonfunctional | |
| **Food Preparation Equipment** | ☐ Fully functional<br>☐ Partially functional<br>☐ Nonfunctional | |
| **Ice Machines** | ☐ Fully functional<br>☐ Partially functional<br>☐ Nonfunctional | |
| **Laundry/Linen Service Equipment** | ☐ Fully functional<br>☐ Partially functional<br>☐ Nonfunctional | |
| **Structural Components (building integrity)** | ☐ Fully functional<br>☐ Partially functional<br>☐ Nonfunctional | |
| **Other** | ☐ Fully functional<br>☐ Partially functional<br>☐ 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<br>☐ Partially functional<br>☐ Nonfunctional | |
| Digital Radiography System (e.g., PAlternate Care Site) | ☐ Fully functional<br>☐ Partially functional<br>☐ Nonfunctional | |
| Ethylene Oxide (EtO)/Sterilizers | ☐ Fully functional<br>☐ Partially functional<br>☐ Nonfunctional | |
| Isolation Rooms (positive/negative air) | ☐ Fully functional<br>☐ Partially functional<br>☐ Nonfunctional | |

| Other | ☐ Fully functional<br>☐ Partially functional<br>☐ 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<br>☐ Partially functional<br>☐ Nonfunctional | |
| Surveillance Cameras | ☐ Fully functional<br>☐ Partially functional<br>☐ Nonfunctional | |
| Other | ☐ Fully functional<br>☐ Partially functional<br>☐ 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.)* |
| Electrical Power-Primary Service | ☐ Fully functional<br>☐ Partially functional<br>☐ Nonfunctional | |
| Sanitation Systems | ☐ Fully functional<br>☐ Partially functional<br>☐ Nonfunctional | |
| Water | ☐ Fully functional<br>☐ Partially functional<br>☐ Nonfunctional | (Reserve supply status) |
| Natural Gas | ☐ Fully functional<br>☐ Partially functional<br>☐ Nonfunctional | |
| Other | ☐ Fully functional<br>☐ Partially functional<br>☐ 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<br>☐ Partially functional<br>☐ Nonfunctional | |
| Electrical Power, Backup Generator | ☐ Fully functional<br>☐ Partially functional<br>☐ Nonfunctional | (Fuel status) |
| Elevators/Escalators | ☐ Fully functional<br>☐ Partially functional<br>☐ Nonfunctional | |
| Hazardous Waste Containment System | ☐ Fully functional<br>☐ Partially functional<br>☐ Nonfunctional | |
| Heating, Ventilation, and Air Conditioning (HVAC) | ☐ Fully functional<br>☐ Partially functional<br>☐ Nonfunctional | |
| Medical Gases, Other | ☐ Fully functional<br>☐ Partially functional<br>☐ Nonfunctional | |
| Oxygen | ☐ Fully functional<br>☐ Partially functional<br>☐ Nonfunctional | (Reserve supply status) |
| Pneumatic Tube | ☐ Fully functional<br>☐ Partially functional<br>☐ Nonfunctional | |
| Steam Boiler | ☐ Fully functional<br>☐ Partially functional<br>☐ Nonfunctional | |
| Sump Pump | ☐ Fully functional<br>☐ Partially functional<br>☐ Nonfunctional | |
| Well Water System | ☐ Fully functional<br>☐ Partially functional<br>☐ Nonfunctional | |
| Vacuum (for patient use) | ☐ Fully functional<br>☐ Partially functional<br>☐ 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.)* |
|---|---|---|
| Water Heater and Circulators | ☐ Fully functional<br>☐ Partially functional<br>☐ Nonfunctional | |
| Other | ☐ Fully functional<br>☐ Partially functional<br>☐ Nonfunctional | |
| **6. CERTIFYING OFFICER** | | |
| **7. FACILITY NAME** | | |

# Hospital Patient Valuables Deposit Form

## Description

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.

This tool can also be found in Volume I: Hospitals, Section 11.4.2: Inventorying Valuables.

## Instructions

The hospital staff member 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 this 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
## HOSPITAL 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 |
|---|---|

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# Lock-Down Policy and Procedure Sample

## Description

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. This tool provides procedures and guidance on when the need to lock-down a 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.

This tool can also be found in Volume I: Hospitals, Section 5.10.2: Lock-Down vs. Restricted Access/Visitation.

## Instructions

Consider the following lock-down policy and procedure for a facility during a mass medical emergency to isolate and control access to the site.

# Lockdown Policy and Procedure Sample

## 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, clinical and non-clinical.

## 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.

# Paper-Based Intra-Hospital Patient Tracking Process

## Description

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

This tool can also be found in Volume I: Hospitals, Section 11.1.3: Paper-Based Intra-Hospital Patient Tracking Process.

## Instructions

Facilities should consider the intra-facility tracking process as an option for tracking patients if no current process exists.

# Paper-Based Intra-facility Patient Tracking Process

## 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.

## Patient Tracking Form

### Description

Form used for the purposes of tracking individuals seeking medical attention within a facility and disposition of those transferred to other facilities during a healthcare surge.

This tool can also be found in Volume I: Hospitals, Section 11.1.2: Patient Tracking Form.

### Instructions

Print legibly, and enter complete information.

1. INCIDENT NAME If the incident is internal to the treating facility, the name may be given by the treating facility's incident commander. If the incident affects the larger community, the name may be given by a local authority (e.g., fire department, local EOC, 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 facility'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. disaster incident number Disaster Identification Number is the unique identifier assigned to that patient for the healthcare surge

   d. MR #/Triage # Medical record (MR) number and/or triage number assigned to patient at the facility

   e. SEX Record "M" for male and "F" for female

f.  DOB/AGE Date of Birth for that patient. Should be recorded as MM/DD/YYYY. If available and/or time permits, age should be recorded as well.

g.  TIME IN Record the time the patient was received at the facility. 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.

h.  AREA TRIAGED TO The area or zone a patient is triaged to

i.  DISPOSITION The specific area, facility or location the patient is being transferred or discharged to

j.  TIME OUT Record time of patient transfer or discharge. Use international standard date notation YYYY-MM-DD, where YYYY is year, MM is month of year between 01 (Jan. ) and 12 (Dec.), 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 international standard notation hh:mm, where hh is number of complete hours that have passed since midnight (00-24), and mm is number of complete minutes that have passed since the start of the hour (00-59). For example, 5:04 pm written as 17:04. 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 this 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. FACILITY NAME Record the facility name. Use when transmitting the form outside of the treating facility.

11. PHONE Record the facility phone number.

12. FAX Record the facility 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. Operational period is defined by the medical health operational area coordinator.

# 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 # | disaster incident number | Last Name | First Name | Sex | DOB/ Age | Time In | Area Triaged To or Ambulance Unit | Disposition | Time Out |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | |
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**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:** _____

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# Patient Valuables Control Log

## Description

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.

This tool can also be found in Volume I: Hospitals, Section 11.4.4: Patient-Valuables Control Log.

## Instructions

Complete all applicable fields upon deposit/removal of patient valuables.

| PATIENT VALUABLES CONTROL LOG | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | | INITIALS | | | INITIALS | |
| Date Received | Patient Name | Disaster Incident Number | Envelope Control Number | Employee Witness | Employee Depositing Valuables | Date Released to Patient | Employees Witness | Employee Releasing |
| | | | | | | | | |
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## Description

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.

This tool can also be found in Volume I: Hospitals, Section 5.12: Business Continuity Planning.

## Instructions

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 Sample Business Continuity Checklist summarizes areas to consider when developing a business continuity plan.

| | 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 |

# Sample Business Continuity Plan Template

## Description

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 template provides a sample 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, critical 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.

This tool can also be found in Volume I: Hospitals, Section 5.12: Business Continuity Planning.

## Instructions

Business continuity planners of each organization should reference this template and consider using it to help identify key elements to be included in the plan.

# 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 | Location | Contact | Work Phone | Cell Phone |
|---|---|---|---|---|
| | | | | |
| 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.

# Sample Hazard Vulnerability Analysis

## Description

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.

The diagram below is an example of a natural disaster type 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.

This tool can also be found in Volume I: Hospitals, Section 3.8: Developing a Hazard Vulnerability Analysis.

## Instructions

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

- Probability
- Magnitude
- Mitigation
- Risk

The first three categories use a point system, ranging from zero to three.  For each hazard, a point estimate of zero (N/A) to three (high) is given.

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.

## 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 |

# Sample Paper–Based Face Sheet

## Description

Form is used to record patient registration information.

This tool can also be found in Volume I: Hospitals, Section 11.2.1: Sample Registration Down-time Procedures.

## Instructions

Registration personnel should complete all available fields upon patient registration.

# Sample Paper-Based Face Sheet[11]

**Patient Information:**

Name: _____ disaster incident number: _____ 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_____

---

[11] Adapted from UC Davis Health System

# Sample Paper–Based Insurance Verification Form

## Description

Form is used to record patient insurance information.

This tool can also be found in Volume I: Hospitals, Section 11.2.1: Sample Registration Down-time Procedures.

## Instructions

Registration personnel should complete all available fields upon patient registration. Although during disaster time periods insurance verification and eligibility requirements may be relaxed, the information should be resumed as soon as possible.

# Paper-Based Insurance Verification Form[12]

## 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 | Primary ☐ Secondary ☐ Tertiary ☐ Payor |
|---|---|

| ☐ HMO Plan ☐ POS Plan ☐ PPO Plan ☐ Indemnity (Commercial) Plan ☐ Worker Comp Indemnity ☐Workers Comp Managed | ☐ In-network   ☐ Out of Network |
|---|---|

| CWF/HDX/Medicheck Checked:   ☐ Yes ☐ No Active Coverage ☐ Yes ☐ No | Card Copied ☐ Yes   ☐ No |
|---|---|

Referral required for the Facility:   ☐ Yes ☐ No Active Obtained ☐ Yes ☐ No   Referral Number:

| Subscriber: | Relationship to patient |
|---|---|

| ID/Policy Number: | Group Number: | Coverage Effective Date: |
|---|---|---|

| WC/Auto Claim #: | Date of Accident/Injury: | Open Claim ☐ Yes ☐ No |
|---|---|---|

| Verification Phone # | Contact Person/Adjuster |
|---|---|

| Deductible/co-pays: | Frequency: | Major Medical Benefits |
|---|---|---|
| Maximum $ Policy Limits | Maximum Benefit Days: | |

Benefits:

Claims:

Attention:

| Verification Completed By: | Date: |
|---|---|

| Pre-certification Required:  ☐ Yes ☐ No | Pre-Cert Phone Number: | Contact Person: |
|---|---|---|

Pre-certification ☐ Initiated Only-UM Dept must call with clinical information ☐ Denied ☐ Approved ☐ Number of Days Approved

Pre-certification Authorization/Reference Number:

| Pre-certification Initiated By: | Date & Time |
|---|---|

| Pre-certification Completed by or confirmed by: | Date & Time |
|---|---|

Miscellaneous/Comment Section:

---

[12] Tenet Health Systems, Business Office Procedure, Manual, 2003.

# Sample Registration Log

## Description

Form is used to log all patients registered and includes fields medical record number, disaster incident #, last name, first name.

This tool can also be found in Volume I: Hospitals, Section 11.2.1: Sample Registration Down-time Procedures.

## Instructions

Complete log for all registered patients. Multiple logs at each registration/access point may be needed.

*Medical Record #:* Enter patient medical record number if available.

*Disaster Incident #:* Enter patient disaster incident number. [13]

*Last Name:* Enter patient's last name.

*First Name:* Enter patient's first name.

---

[13] A disaster incident number is a unique identifier established at the county level for persons being treated at facilities during healthcare surge.

## Registration Log

| # | Medical Record # | Disaster Incident # | Last Name | First Name |
|---|---|---|---|---|
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |
| 4 | | | | |
| 5 | | | | |
| 6 | | | | |
| 7 | | | | |
| 8 | | | | |
| 9 | | | | |
| 10 | | | | |
| 11 | | | | |
| 12 | | | | |
| 13 | | | | |
| 14 | | | | |
| 15 | | | | |
| 16 | | | | |
| 17 | | | | |
| 18 | | | | |
| 19 | | | | |
| 20 | | | | |
| 21 | | | | |
| 22 | | | | |
| 23 | | | | |
| 24 | | | | |
| 25 | | | | |
| 26 | | | | |
| 27 | | | | |
| 28 | | | | |

# Short Form Medical Record

## Description

The sample short form is to be used to collect patient information during a healthcare surge when electronic systems for documenting the provision of care are unavailable or nonfunctional. The short form medical record can be initiated during a healthcare surge and should be utilized to capture pertinent assessment, diagnosis and treatment information.

This tool can also be found in Volume I: Hospitals, Section 11.2.2: Minimum Requirements for Medical Record Documentation.

## 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 (disaster incident number)[14] and/or medical record number, known allergies and primary physician. If patient labels or stickers 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 | • Respiration - enter patient's rate of respiration |
| • Significant Medical History - enter notes on patient's medical history | • Blood Pressure - enter patient's systolic and diastolic blood pressure |
| • Glasgow Coma Scale - enter score for each area | • Intake - enter patient fluid intake |
| • Field Triage Category - enter category | • Output - enter patient fluid output |
| • Site Triage Category - enter category | • Special Dietary Needs - enter patient's special dietary needs |
| • Pupil Size - enter pupil size | • Medications - indicate medications the patient is currently taking including name, dose, route, and time |
| • Reactive - circle yes/no | |
| • Pain - circle patient's level of pain | |
| • Temp - indicate patient's temperature | • Last Menstrual Period - indicate last period |

---

[14] A disaster incident number is a unique identifier established at the county level for persons being treated at facilities during healthcare surge. See Patient and Valuables Tracking.

| • Pulse - indicate patient's pulse | • 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 | • Discharge medications |
| • Procedure performed | • Follow-up visit information |
| • Findings | • Condition on discharge/transferred to |
| • Condition of the patient post procedure | • Date, time and physician's signature authorizing discharge |
| • A check box to indicate if discharge instructions were provided in printed form and/or verbally | • Time admitted |
| • Dietary restrictions | • Physician order notes/other notes |
| • Activity restrictions | |

# 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

| 0 NO HURT | 1 HURTS LITTLE BIT | 2 HURTS LITTLE MORE | 3 HURTS EVEN MORE | 4 HURTS WHOLE LOT | 5 HURTS WORST |
|---|---|---|---|---|---|

| Time recorded: | | | | Intake | | Output | |
|---|---|---|---|---|---|---|---|
| Temp: | | | | | | | |
| Pulse: | | | | | | | |
| Respiration: | | | | | | | |
| Blood Pressure: | | | | | | | |
| Notes:_____ | | | | 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.

California Department of Public Health

# Standard Operating Procedure Template for Equipment, Plant and Utilities

## Description

It is essential to involve facility engineering personnel in the patient management planning processes in order to ensure maintenance of a safe environment 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, room/hood exhaust, steam distribution, internal transport system, medical gases system, roads and grounds, waste and debris, and water delivery/portability. Development of these procedures is critical to the recovery of business operations.

This tool can also be found in Volume I: Hospitals, Section 5.12.1: Development of Standard Operating Procedures for Maintaining Infrastructure During a Healthcare Surge.

## Instructions

Review procedure and consider following it for the development of patient management planning processes.

## Standard Operating Procedure Tool 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 their Emergency Management Program Guidebook, 2005, provide extensive guidance around hazardous waste management

(http://www1.va.gov/emshg/page.cfm?pg=114). Go to "Emergency Management Program Concepts," Chapter 2 (Hazardous Materials Regulations and Standards section).

## Description

Without proper safety and security measures at a healthcare facility, the lives of patients and personnel will be in jeopardy. It is recommended that a security assessment and vulnerability report be completed by security personnel to ensure the well-being and safety of patients and personnel during a mass medical emergency.

This tool can also be found in Volume I: Hospitals, Section 5.10: Security Planning.

## Instructions

Complete all sections of the assessment form to identify potential gaps in security and vulnerability at your facility.

# Standardized Security Assessment/Vulnerability Tool

| # | Security Assessment / Vulnerability Tool | Yes | No | If 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 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. | | | | | |

# Workers' Compensation Process Flow

## Description

This tool includes process flows depicting how workers' compensation may play a role during a healthcare surge for general employees and disaster service workers, including rules and requirements for employees, employers and payers. This tool also includes a sample of the state of California workers' compensation claim form (DWC1) that employees injured at work can complete and submit during a healthcare surge.

This tool can also be found in Volume I: Hospitals, Section 11.5: Workers' Compensation for Hospital Employees and Volunteers.

## Instructions

Employees, employers and payers can refer to these process flows for the rules and requirements that must be followed to submit claims for workers' compensation. Employees can use the sample workers' compensation claim form to document and submit their injuries for processing and payment.

# Workers' Compensation Process Flow

## Workers' Compensation During Declared Disaster – General Population

| | | |
|---|---|---|
| **Population** | Employee | **Worker's Compensation Eligibility**<br>• 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)<br>• Workers' Compensation does not cover first aid (Labor Code Section 5401)<br>• 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) |
| **Change in Event(s)** | Catastrophic event causes injuries to employees while at work | **Employee Responsibility**<br>• Report any injury or illness to employer as soon as possible.<br>• Complete the Workers' Compensation Claim Form and submit to employer within 30 days of the date of injury (Labor Code Section 5400)<br>• 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). |
| **Subsequent Coverage** | Employer provides employee with a claim form within one working day of awareness of injury or illness and subsequently reports the injury or illness within five days. — Employee seeks medical attention for his or her injuries at a pre-designated provider, or provider in his employer's medical provider network, if available during the surge.<br><br>Employee submits claim form to his or her employer within 30 days of the date of injury.<br><br>Employer authorizes medical treatment within one day after an employee files a claim form, as required and limited by the law.<br><br>Workers' compensation carrier processes claim and pays for all authorized treatment | • 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.<br>• The law states that employees are not responsible for co-payments or balance-due after the workers' compensation insurance carrier has paid the provider.<br><br>**Employer Responsibility**<br>• 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))<br>• Submit the completed claim form to the appropriate workers' compensation insurance carrier.<br>• 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.<br>• 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).<br>• Employer must pay for workers' compensation and must have insurance or be self-insured. (Labor Code Section 3600 and Section 3700)<br><br>**Payer Responsibility**<br>• Accept or deny new claim within a reasonable time (Labor Code Sections 5814 and 5814.6; 8 CCR Section 10109)<br>• New claim presumed to be covered by workers' compensation if not denied within 90 days (Labor Code Section 5402(b))<br>• The workers' compensation insurance carrier pays for all authorized treatment. |

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

## Hospital Operational Tools Manual: Sources of Funds

# Advancing and Expediting Payment

## Description

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.

This tool can also be found in Volume I: Hospitals, Section 12.2.4: Advancing and Expediting Payment.

## Instructions

Providers should review and understand the table for guidance on options available by payer type with respect to advancing and expediting payment during a healthcare surge.

## Advancing and Expediting Payment

| 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.[15] |
| **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[16] |
| **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 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.<br><br>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 |

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[15] U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, "Hurricane Questions and Answers," http://questions.cms.hhs.gov/cgibin/cmshhs.cfg/php/enduser/std_adp.php?p_faqid=5605

[16] U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, "Hurricane Questions and Answers," http://questions.cms.hhs.gov/cgibin/cmshhs.cfg/php/enduser/std_adp.php?p_faqid=5605

[17] Information gleaned from interviews with representatives from Medi-Cal, May 2007.

| Payer | Option Available | Examples |
|---|---|---|
|  |  | 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 some time to orchestrate given the number of hospitals that may be requesting it.[17] |
| **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.[18] |

[18] From discussions with several California private payer representatives.

# Federal Emergency Management Agency Public Assistance Process and Checklist

## Description

Federal Emergency Management Agency Public Assistance Process and Checklist for Local Subapplicant(s) or Subgrantee(s) is designed to be a reference guide for how to apply for and receive funds from FEMA during a disaster. Understanding the key steps of the process may assist healthcare entities in providing the appropriate staff and completing the appropriate documentation to obtain reimbursement for services provided during a healthcare surge.

Additional information for this tool can be found in Volume I: Hospitals, Section 12.4.1: Federal Emergency Management Agency Public Assistance.

## Instructions

Review the process flow and checklist to become familiar with its contents and train the appropriate staff.

# Stakeholder: Local Subapplicant(s) or Subgrantee(s)

| Public Assistance Steps | Stakeholder: Local Sub applicant(s) or Subgrantee(s) | Checklist |
|---|---|---|
| (1) Preliminary Damage Assessment (PDA) | • Visited by Regional FEMA/state team to view damage, assess scope of damage, and estimate repair costs | ❑ Provides personnel to work with FEMA and the state on the damage assessment and project application process<br>❑ Tours of all damages<br>❑ Provides documentation, environmental or historic issues, and insurance coverage information<br>❑ Identifies and explains immediate expenditures for emergency work and decides whether or not to apply for Immediate Needs Funding (INF)<br>❑ Reads Public Assistance Policy Digest - FEMA Report 321 |
| ↓ | ↓ | ↓ |
| (2) Presidential Disaster Declaration | • Pays attention to FEMA eligible costs and coverage aid types (Individual Assistance and/or Public Assistance) for eligible regions | ❑ Read Applicant Handbook - FEMA Report 323 |
| ↓ | ↓ | ↓ |
| (3) Applicants' Briefing by Grantee | • Attends briefing to gather available assistance and eligibility requirements<br>• Prepare and submit requests for PA no later than 30 days of the date designation of any area. | ❑ Subgrantee's management representative attends Briefing<br>❑ Meets with state Liaison<br>❑ Mentions any Immediate Needs Funds (INF) requests<br>❑ Completes and submits FEMA form (FF) 90-49 Request for PA |
| ↓ | ↓ | ↓ |
| (4) Submission of Request for Public Assistance by Applicant | • If not done during briefing, submits to state/applicant request for PA 90-49 FEMA form via fax, mail, or delivery within 30 days of the date of designation of any area. | ❑ If not submitted at briefing then submit FF 90-49 Request for PA<br>❑ Second chance to apply for INF |
| ↓ | ↓ | ↓ |
| (5) Kick-off Meeting with Public Assistance Coordinator (PAC) | • Individual meeting with FEMA PAC for which contact is made 1 week from the submittal of the request for PA<br>• State liaison provides state-specific details on documentation and reporting requirements<br>• Identify special considerations that require special review, such as insurance coverage, environmental resource issues, and historic preservation<br>• Request any clarification | ❑ Sends appropriate management including risk manager to kick off<br>❑ Identify management that will fully manage all repair projects including small projects<br>❑ Contacts state liaison if have not heard from PAC 2 weeks of request for PA submission<br>❑ Regularly meets with PAC<br>❑ Compiles list of all damages |

| Public Assistance Steps | Stakeholder: Local Sub applicant(s) or Subgrantee(s) | Checklist |
|---|---|---|
| | | ❑ Reviews with state liaison specific details on documentation and reporting requirements <br><br> ❑ Identify with PAC and state liaison circumstances that require special review |
| ↓ | ↓ | ↓ |
| (6) Project Formulation and Cost Estimating | • Complete project worksheets <br><br> • Document extent of facility damage, identify eligible scope of work estimate costs associated with scope of work for each project, plan repair work <br><br> • Administratively consolidate multiple work items into single projects to expedite approval and funding and project management <br><br> • Divide work projects into small (up to $59,700 for FFY2007) and large projects[19] <br><br> • Identify and provide basic description of project and broad coast estimate <br><br> • Maintain records of completed work and work to be completed <br><br> • If necessary, specialist reviews with subgrantee special considerations questionnaire | ❑ Complete project worksheets: <br><br> ❑ Project Worksheet (PW) FF90-91 <br><br> ❑ PW FF90-91A Damage Description and Scope of Work Continuation Sheet <br><br> ❑ PW FF90-91B Cost Estimate Continuation <br><br> ❑ PW FF90-91C Maps and Sketches Sheet <br><br> ❑ PW FF90-91D Photo Sheet <br><br> ❑ If necessary complete FEMA Special Considerations Questions FF90-120 <br><br> ❑ Organize records by the following suggested summary forms: <br><br> ❑ Force Account Labor Summary FF 90-123 <br><br> ❑ Force Account Equipment Summary FF 0-127 <br><br> ❑ Materials Summary Record Summary FF 90-124 <br><br> ❑ Rented Equipment Summary Record FF 90-125 <br><br> ❑ Contract Work Summary Record FF 90-126 <br><br> ❑ Applicant's Benefits Calculation Worksheet FF 90-128 <br><br> ❑ Establish file for each project and record specific costs and scope of work by site <br><br> ❑ Retain all documentation up to 3 years from the date the state closes subgrantee grant <br><br> ❑ Escort PO and state representative on a site visit and collaboratively develop a complete scope of work and accurate large project cost estimate |
| ↓ | ↓ | ↓ |

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[19] Federal Register. October 10, 2006 (Volume 71, Number 195) pp. 59513-59514.
http://www.fema.gov/txt/government/grant/pa/frn_small_proj.txt Accessed 14 May 2007.

| Public Assistance Steps | Stakeholder: Local Sub applicant(s) or Subgrantee(s) | Checklist |
|---|---|---|
| (7) Project Review and Validation | • PAC schedules review with subgrantee for preparation of records for review<br>• 20% or 2 small projects is the minimum level of review for projects submitted within 30 days after the Kickoff meeting<br>• 100% validation for projects submitted after 30 days<br>• Validation can normally be completed within 15 days of submission of all Project Worksheets to the PAC<br>• If total variances on the first sample projects do not exceed 20% of the cost of the sampled projects, the results of validation are satisfactory. | ❑ Prepare records subject to validation |
| ↓ | ↓ | ↓ |
| (8) Obligation of Federal Funds and Disbursement to Subgrantees | • Notified of availability of federal FEMA funds and state cost share funds<br>• Submit documentation of actual incurred costs associated with approved scope of work for subgrantees with large projects<br>• Certify large project work has been completed in accordance with FEMA standards and policies | ❑ Documentation of incurred costs for large projects |
| ↓ | ↓ | ↓ |
| (9) Appeals and Closeout | • File appeal with supporting documents to the state | ❑ Complete debris cleaning within 6 months, emergency work within 6 months, and permanent within 18 months of the date of declaration of the area. Debris and emergency work can be extended up to an additional 6 months, and permanent restoration work may be extended an additional 30 months.<br>❑ File appeal with state within 60 days of receipt of a notice of any action that is being appealed<br>❑ Provide documentation explaining why the original determination is wrong or overrun costs and the amount of adjustment being requested<br>❑ Closeout large projects as each project is completed, and reconcile estimated and actual costs when large projects are complete<br>❑ Close small projects when all small projects have been funded and completed<br>❑ Notify state when projects are compete<br>❑ Return any unused money to state<br>❑ Certify to the state that all funds were suspended and all the work described in the project scope of work is complete<br>❑ Retain documentation for up to 3 years subject to audit |

\* Special Considerations is a term used by FEMA to refer to matters that require specialized attention. These include insurance, historic, environmental and hazard mitigation issues. FEMA and the state are required to ensure that all funding actions are in compliance with current state and federal laws, regulations and agency policy. You can assist FEMA and the state in resolving special considerations issues in order to expedite disaster recovery funding.[20]

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[20] United State Department of Homeland Security Federal Emergency Management Authority Public Assistance Special Considerations. http://www.fema.gov/government/grant/pa/considerations.shtm. Accessed 11 May 2007.

# Graduate Medical Education (GME) Reallocation Guidelines

## Description

The following policy was developed as a result of Hurricane Katrina and may provide guidance for Host Hospitals who accept displaced residents following a disaster.

This tool can also be found in Volume I: Hospitals, Section 12.3.1: Graduate Medical Education Reallocation Guidelines.

## Instructions

Academic hospitals should review the Centers for Medicare and Medicaid Services interim final rule included in the Graduate Medical Education Reallocation Tool to understand how host hospitals – those taking on displaced residents – could receive payment for training additional residents displaced by a healthcare surge.

## 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.[21]

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.

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**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

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[21] Centers 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

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."

## Graduate Medical Education (GME) Transfer Checklist

### Description

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. Hospitals can use this checklist to implement the Graduate Medical Education Reallocation Guidelines. This checklist was put together from reference material developed by the Centers for Medicare and Medicaid Services following Hurricane Katrina.

This tool can also be found in Volume I: Hospitals, Section 12.3.1: Graduate Medical Education Reallocation Guidelines.

### Instructions

Academic hospitals should review and understand the CMS interim final rule to understand how host hospitals – those taking on displaced residents – could receive payment for training additional residents displaced by a healthcare surge. Use the GME transfer checklist to help guide you through the payment transfer following the collapse of a program or facility.

# Graduate Medical Education Payment Transfer Overview and Checklist[22]

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."[23]

- "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."[24]

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).[25]

- 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.[26]

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[22] CMS Post-Katrina Provisions, 9/22/05: http://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std_adp.php?p_faqid=5605
[23] Centers for Medicare and Medicaid Services Post-Katrina Provisions, 9/22/05: http://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std_adp.php?p_faqid=5605
[24] Centers for Medicare and Medicaid Services Post-Katrina Provisions, 9/22/05: http://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std_adp.php?p_faqid=5605
[25] Centers for Medicare and Medicaid Services Post-Katrina Provisions, 9/22/05: http://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std_adp.php?p_faqid=5605
[26] Federal Registers (66 FR 39899 and 67 FR 50058), August 1, 2001 and the August 1, 2002

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[27]

  ○ 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.

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[27] 42 CFR 413.75(d)

## Description

During a healthcare surge, public health issues or specific medical needs may require transfer of patients 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 a reference tool during disaster planning.

This tool can also be found in Volume I: Hospitals, Section 12.3.2: Patient Transfer and Coverage Rules During a Healthcare Surge.

## Instructions

Facilities providing medical care should review and understand the table for guidance on how to receive payment for patient transfer during healthcare surge.

| 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).<br><br>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.<br><br>**Inpatient:** Payment is included in the diagnosis-related group payment amounts made to hospitals paid under the prospective payment system.<br><br>**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.<br><br>**Recommended Approach**<br><br>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. |
| 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.<br><br>Transportation resources can be broadly classified as traditional medical, ambulances, gurney vans, wheelchair cars, etc., and nonmedical, school and/or transit buses, |

| Payer | Scenario | Examples |
|---|---|---|
| | | 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. |

## Description

The sample form presented is to be used to capture charges for service, medication, and supplies for individual patients during a healthcare surge and was developed from the suggested minimum data list for charge capture.

This tool can also be found in Volume I: Hospitals, Section 12.2.1: Minimum Required Data Elements and Templates for Charge Capture.

## Instructions

One form should be completed per patient.

*Unique Patient Identifier:* Enter patient disaster incident number or other identifier if available.

*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.

## 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:** | | |

| Service Description | Department | Units of Service or Quantity | Date of Service | **To be completed by Billing** Code: Service / Revenue/ Current Procedural Terminology/Healthcare Common Procedure Coding System | Service Price | Posted Charge |
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| **Total Charges** | | | | | | |

# Sample Charge Capture Form 2 (Acuity Charge Sheet)

## Description

A set of forms (acuity and procedure forms) are to be presented as options for capture charges for service, medication and supplies for individual patients. The 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.

This tool can also be found in Volume I: Hospitals, Section 12.2.1: Minimum Required Data Elements and Templates for Charge Capture.

## Instructions

One set of forms should be completed per 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

| INFUSIONS, INJECTIONS & BLOOD | | I&D/FOREIGN BODY REMOVAL | |
|---|---|---|---|
| BLOOD TRANSFUSION | | ARTHOCENTESIS-INTERMED JOINT | |
| INJECTION IM/SQ                    x_____ | | ARTHOCENTESIS-MAJOR JOINT | |
| INJECTION IV PUSH               x_____ | | ARTHOCENTESIS-MINOR JOINT | |
| IV INFUSION INITIAL HOUR | | DRN/INJ/JT/BURSA/LIG | |
| IV INFUSION EA ADD HOUR        x_____ | | EVAC OF SUBUNGUAL HEMATOMA | |
| TETANUS TOXOID IM ADMIN | | FB RMVL EXT EAR CANAL/IMP1-2 | |
| VENIPUNCTURE | | FB RMVL EXT EYE | |
| **TUBE PROCEDURES** | | FB RMVL EXTEYESUPERFICIAL | |
| INSERT EMERGENCY AIRWAY | | FB RMVL EXTEYEWITHOTSLITLMP | |
| INSERTION OF CHEST TUBE | | FB RMVL EXTEYEWITHSLITLAMP | |
| URINARY CATH COUDE | | FB RMVL LARYNX NON-OPERATIV | |
| URINARY CATH FOLEY | | FB RMVL NOSE | |
| URINARY CATH STRAIGHT | | FB RMVL SQ | |
| **FRACTURES / DISLOCATIONS** | | I&D DEEP ABS BURSA/HEMA | |
| CAST REPAIR | | I&D SKIN ABS/PUNC ASPIR/G CYST | |
| LEVEL I STRAP/CAST/SPLINT/APP | | **PROCEDURES** | |
| LEVEL II STRAP/CAST/SPLINT APP | | ABDOMINAL PARACENTESIS | |
| NF FINGER/TOE SPLINT/STRAP | | ANOSCOPE EXAM | |
| NF LONG ARM SPLINT/STRAP | | APPLY CRANIAL TONGS | |
| NF LONG LEG SPLINT/STRAP | | BLOOD PATCH | |
| NF SHORT AMR SPLINT/STRAP | | BURR HOLE | |
| NF SHORT LEG SPLINT/STRAP | | CENTRAL LINE REPLACEMENT | |
| TX FX/DISLOC W OR W/O MAN-SMP | | CONTROL OF NOSE BLEED | |
| TX FX/DISLOC W OR W/O MAN-CPLX | | CONTROL OROPHARYN BLEED | |
| **WOUND** | | EAR IRRIGATION | |
| DEBRIDE SKIN/TISSUE/MUSCLE | | FLOROSCOPY UP TO ONE HOUR | |
| DEBRIDE SKIN-PARTIAL & FULL | | GASTRIC INTUBATION/LAVAGE | |
| PENETR, WOUND EXPLOR, EXTR | | INTRAOSSEOUS PLACEMENT | |
| WD/LACERATION RPR-COMPLEX | | LARYNGOSCOPY | |
| WD/LACERATION RPR-INTERM | | RESUSCITATION & DEFRIBILLATION | |
| WD/LACERATION RPR-SIMPLE | | SPINAL FLUID TAP - DX | |
| TX OF BURNS (S) | | **CARDIAC** | |
| **NAIL/FINGER** | | EXTERNAL FACING | |
| DEBRIDE NAIL 1-5 | | PERI CARDIOCENTESIS | |
| FB RMVL NAIL/FINGER TIP | | **SEDATION/PAIN BLOCKS** | |
| REPAIR/RECONSTRUCT OF NAIL | | NERVE BLOCK | |