California Department of Health Services

Development of Standards and Guidelines for Healthcare Surge during Emergencies

Volume VI: Non-Licensed Healthcare Facilities Section: Management and Administrative

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Volume Introduction

The Non-Licensed Healthcare Facilities Volume was developed to assist non-licensed healthcare facilities in better preparing for and responding to a surge event. This Volume includes recommended considerations for the planning, operational execution and logistical requirements that must be evaluated and implemented, with consideration for existing regulations and standards.

Target Audience

The target audience for this section is those individuals who perform management or supervisory functions within non-licensed healthcare facilities. These include executives, legal counsel, compliance directors, risk management, department managers, and supervisors.

Contents

This section contains six chapters. Each chapter contains several topics that pertain to individuals with a Management-Admin function within a non-licensed healthcare facility. The topics reference Operational Tools contained in Module IV of the Standards and Guidelines Manual and they reference the Training Curriculum.

Chapter one defines Surge and provides the basis for emergency declarations and triggers.

The second chapter cover surge Standards of Care and Surge Capacity and Capability. This section provides literature review and definition of standard of care during a healthcare surge. In addition, it covers regulations, standards, waivers, and liability protection associated with standard of care including scope of services, and non-traditional treatment means.

The third chapter covers the Workforce. This section discusses methods by which a healthcare workforce may be augmented through various sources (e.g., Emergency System for the Advanced Registration of Volunteer Healthcare Professionals), recommendations for how to address staffing regulations and how to provide support services for employees and ensure workforce resiliency. It also provides an overview of the liability issues associated with caregivers delivering care outside of their licensed scope of practice.

The fourth chapter covers Supplies, Pharmaceuticals and Equipment particularly the application of the Standardized Emergency Management System (SEMS) to the acquisition process, and recommendations for the planning, storage, staging and deployment processes.

The fifth chapter covers Operations and discusses topics such as HIPAA compliance during healthcare surge, recommendations and strategies to address issues related to medical record documentation, charge capture documentation, patient and valuables tracking, and facility reporting requirements.

The final chapter covers Sources of Funds and includes guidance on existing laws and rules governing emergency provisions, opportunities for waivers and declarations, recommendations for how providers may prepare for, and respond to, a surge and an overview of the disaster planning funding sources.

Module IV: Operational Tools

This module contains operational tools that enable planning, management, delivery of care and administrative functions that can be used for surge planning during catastrophic healthcare emergencies by healthcare facilities, alternate care sites, and professionals. These tools are referenced in the section above.

Training Curriculum

The Training Curriculum enables planning, management, delivery of care and administrative functions that can be used for surge planning during catastrophic healthcare emergencies by healthcare facilities, alternate care sites, and professionals. The Training Curriculum is companion to Modules III and IV of the Standard and Guidelines Manual. The Training Curriculum is referenced in the section above.

1 Introduction to Healthcare Surge

1.1 Definition of a Healthcare Surge

"Healthcare surge" means different things to people from different disciplines.
To the operators of healthcare facilities (hospitals, clinics, or other kinds of health care facilities): A healthcare surge can refer to 'a routine increase in the number of patients which push the facility to or even beyond the limitations imposed on that facility by regulatory agencies.'
To regulatory agencies: A healthcare surge can refer to a 'routine situation in which a waiver of certain regulatory requirements to facilitate patient care is justified.'
To local and regional emergency response planners: A healthcare surge can refer to 'a situation in which a sudden increase in demands on the healthcare system overwhelms local resources, requiring the waiver of regulatory mandates and activating mutual aid.'
To statewide emergency response planners: A healthcare surge refers to 'an overwhelming increase in demands for medical care services arising out of a moderate to severe emergency.' In such circumstances, the combined federal, state and local public and private resources needed to provide care consistent with optimal patient outcomes may be exhausted, and the exercise of extraordinary powers may be necessary to allow more effective disaster mitigation to occur.
The purpose of this document is not to address the concept of "healthcare surge" in all its permutations. On the other hand, a clear definition of "healthcare surge" is a necessary first step under SEMS (Standardized Emergency Management System) for local government to inform state government when extraordinary measures may be warranted, and to determine the substance of the extraordinary measures taken to mitigate the effects of the emergency.

Healthcare surge is not the frequent emergency department overcrowding experienced by healthcare facilities (for example, Friday/Saturday night emergencies). It is also not a local casualty event that might overcrowd nearby facilities but have little to no impact on the healthcare delivery system. Healthcare providers and regulators have well-established procedures for addressing these routine fluctuations in the demand for emergency medical services. Local, regional and hospital emergency planners have Emergency Operations plans and procedures and the Standardized Emergency Management System (SEMS) to address larger local emergencies and to invoke mutual aid from adjacent jurisdictions and facilities, which can permit the timely augmentation of resources to respond to the increased demand. A healthcare surge, as referenced in this guide, specifically relates to a mass casualty or catastrophic event that overwhelms the healthcare delivery system, thus implicating the extraordinary emergency powers of the Governor available under the California Emergency Services Act.1

For purposes of this document, "healthcare surge" means the following:
A Surge Event is proclaimed in a local health jurisdiction when an authorized local official, such as a local health officer or other appropriate designee2, using professional judgment determines, subsequent to a significant event or circumstances, that the healthcare delivery system has been impacted, resulting in an excess in demand over capacity and/or capability in hospitals, community care clinics, public health departments, other primary and secondary care providers, resources, and/or emergency medical services. The local official uses the situation assessment information provided from the healthcare delivery system partners to determine overall local healthcare jurisdiction/operational area medical and health status.

1.2 Standard of Care

The Standard of Care in California is defined by the scope of practice each provider is licensed to provide. It provides a framework to identify the professional responsibilities of licensed personnel and permit individual licensed personnel to be rationally evaluated, to ensure that it is safe, ethical and

consistent with the professional practice of the licensed profession in California[162]. Standard of Care is a legal concept that not only encompasses the diagnosis and treatment of patients but overall management of patients as well.[163]

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

For the purposes of this document, **Standard of Care during a Healthcare Surge is the degree of skill, diligence and reasonable exercise of judgment in furtherance of optimizing population outcome during a healthcare surge event that a reasonably prudent person or entity with comparable training experience or capacity would have used under the circumstances.**

Under normal conditions, current standards of care might be interpreted as employing appropriate health and medical resources to improve the health status and/or save the life of each individual patient. However, according to a report by, Health Systems Research Inc., *Altered Standards of Care in Mass Casualty Events;* an AHRQ[164] Publication, April 2005) in the aftermath of a mass casualty event, the demand for care provided in accordance with normal conditions (current standards) would exceed system resources resulting in a healthcare surge. Therefore, it is critically important to identify, plan, and prepare for making the necessary adjustments in current health and medical care standards to ensure that the care provided in response to a healthcare surge results in as many lives being saved as possible.

The AHRQ report further states that currently no universally accepted definition of Standard of Care during a mass casualty event exists. Joint Commission refers to such standards as “graceful degradation” under which care and access to caregivers may become rationed. Per the AHRQ report, Altered Standards of Care is referred to as "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." According to the report, examples of shift in care include:

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

scarce and valuable equipment, such as ventilators, may not be used without staff available who are trained to operate them.

- Delays in hospital care due to backlogs of patients. Patients will be waiting for scarce resources, such as operating rooms, radiological suites, and laboratories.
- Providers that may need to make treatment decisions based on clinical judgment. For example, if laboratory resources for testing or radiology resources for x-rays are exhausted, treatment based on physical exam, history, and clinical judgment will occur.
- The psychological impact of the event on providers. Short- and long-term stress management measures (e.g., Critical Incident Stress Management programs) are essential for providers and their families.
- Current documentation standards that will be impossible to maintain. Providers may not have time to obtain informed consent or have access to the usual support systems to fully document the care provided, especially if the health care setting is damaged by the event.
- Backlog in processing fatalities. It may not be possible to accommodate cultural sensitivities and attitudes toward death and handling bodies. Numbers of fatalities may make it difficult to find and notify next of kin quickly. Burial and cremation services may be overwhelmed. Standards for completeness and timeliness of death certificates may need to be lifted temporarily."

While the examples suggest how clinical practices might shift, the definition of Altered Standards of Care does not explore the liability and compliance issues that could arise. The following principles were used to support the definition of "Standard of Care" described at the beginning of the section.

Guiding Principles

- The Adjusted or Altered Standard of Care during a healthcare surge will be **"the"** Standard of Care available and should be termed "Standard of Care during a Healthcare Surge".
- The Standard of Care definition, under normal conditions, adapted for large number of victims as opposed to individual patients, would apply to healthcare surges.
- The definition should broaden the scope of caregivers and afford protection to not just licensed personnel but also volunteers and facilities.
- The “under the circumstances” clause in the definition for “Standard of Care during a Healthcare Surge” provides some protection to healthcare providers (facilities, personnel and volunteers) during a healthcare surge as long as there is evidence to support that there was no negligence, appropriate steps were taken (planning, periodic training, relevant documentation, etc.) and that there was reasonableness demonstrated

1.3 The Exercise of Extraordinary Powers during a Healthcare Surge

1.3.1 The Progression of Medical Mutual Aid in Response to a Mass-Casualty Event

When a mass-casualty event occurs, resources within individual hospitals are mobilized under an incident command system, such as HICS, to deal with the actual or anticipated influx of patients. If conditions within the hospital are sufficiently strained, the hospital may consult with regulatory agencies to determine if specific requirements related to staffing and patient management can be waived to maximize the hospital’s response capabilities.[3] If circumstances become overwhelming, the hospital may, following local Emergency Medical Services Agency’s policies, divert incoming ambulance patients to other hospitals, if available. The hospital may also draw upon resources from other hospitals and facilities to augment its response capabilities.

At this point in the progression, a “healthcare surge,” within the meaning of this document, **does not yet exist**. However, hospital administrators can inform appropriate local governmental officials about the limitations of their resources and, more importantly, to request additional resources. This is the first step in the process of identifying a “healthcare surge.” It is important to note that there is not a proclamation of surge. The existence of a surge is a determination, which is then communicated within the Standardized Emergency Management System (SEMS) for purposes of obtaining mutual aid and/or seeking the exercise of the Governor's powers.

Local resources would be activated to provide medical mutual aid. Local officials may contact and request aid from other local jurisdictions in the operational area. When local resources in the operational area are overwhelmed, as determined by the authorized local official, it may be determined that a condition of “healthcare surge” exists in the operational area. Separately, a local emergency may be proclaimed by the local governing body or designated official.

The medical and health status of the operational area will be communicated, for example, by the medical health operational area coordinator (MHOAC) or other authorized official, to Regional and State Emergency Operations Centers. The State Emergency Operations Center can draw upon resources statewide to acquire requested mutual aid.

Finally, the Governor has the additional authority to proclaim a “State of Emergency,” which can make the resources of state agencies available to mitigate the effects of the emergency. In addition, the Governor’s Office can, if needed, request federal resources after proclaiming a “State of Emergency.”

1.3.2 Regulatory Standards as Potential Obstacles to Mitigating Medical Disasters

Up until this point, the focus of the emergency response is the acquisition of requested mutual aid. However, a disaster could be so severe that mutual aid resources statewide are exhausted. For example, it is conceivable that a pandemic of influenza could cause a medical and health disaster in every operational area of the state, with no operational area having resources to share because all jurisdictions are utilizing every available resource to mitigate the disaster within their operational area. Further, it may not be possible in all circumstances to deliver requested medical mutual aid to an affected operational area in a timely fashion. For example, a severe-magnitude earthquake in the San Francisco Bay region could make roads and bridges into San Francisco impassable, while at the same time causing a “healthcare surge” within that operational area.

In addition to the consequences of such a proclamation which occur by operation of law, the Emergency Services Act (ESA) authorizes the Governor during a “state of emergency” to suspend any regulatory statute, or statute prescribing the procedure for conduct of state business, or the orders, rules, or regulations of any state agency, where the Governor determines and declares that strict compliance would in any way prevent, hinder, or delay the mitigation of the effects of the emergency.[4] The authority to suspend statutes is unique to the Governor. Local governing bodies and officials acting under a proclaimed local emergency do not have this power.

The Act also authorizes the Governor to make, amend, and rescind orders and regulations necessary to carry out the provisions of the Act, and further provides that the orders and regulations have the force and effect of law.[5]

The effect of a suspension of regulatory statutes and regulations can have several consequences. During the period of the proclaimed emergency and suspension, the suspended statutes and regulations have no force and effect. Consequently, regulatory and law enforcement agencies cannot prevent or penalize persons for failing to comply with the statute or regulation. Further, the statute or regulation cannot provide a basis for finding negligence as a matter of law, which can lessen the potential for civil liability should a person be unintentionally harmed by emergency response activities. The absence of specific regulatory restraints can serve as an incentive for persons to act beneficially to mitigate the effects of the emergency and generally to protect the health and safety and preserve

the lives and property of the people of the state without fear of subsequent criminal, administrative or civil liability.

In a medical or health disaster, a suspension of appropriate healthcare-related regulatory statutes and regulations could be used to increase the capacity and/or capability of providers of care to render medical services which, under normal standards, might not be available. Most medical care in California is delivered by persons and entities in the private sector who are highly regulated through the imposition of licensure and certification requirements. Under normal circumstances, a failure to comply with these requirements can result in criminal, administrative, and/or civil liabilities. Not all requirements, however, are indispensable under all circumstances to protect the consumer. For example, a mandated nurse-to-patient staffing ratio, while consistent with expectations for patient care under normal circumstances, may be unworkable in an emergency. This requirement may even be an obstacle to providing care to the increased number of patients in need of care, if hospitals divert ambulance patients for lack of adequate nurse staffing.[6]

Generally, state regulatory agencies have administrative discretion in the enforcement of regulatory requirements. During an emergency, the state, including its political subdivisions, is responsible for the mitigation of the effects of the emergency.[7] If the strict enforcement of a regulatory requirement will serve as a disincentive to persons who can assist the state in mitigating the effects of the emergency, it would be in the interest of the state to administratively relax its enforcement of that requirement.

However, the relaxation of administrative or criminal enforcement of a requirement does not eliminate the requirement itself. The requirement is still the law, and as such could provide a basis for the imposition of civil liability. Everyone, including every medical practitioner, is responsible for any injury occasioned to another by his or her want of ordinary care or skill in the management of his or her property or person, unless the injured person has, willfully or by want of ordinary care, brought the injury upon himself or herself.[8] The failure to exercise ordinary care is commonly referred to as negligence.

What constitutes ordinary care by a medical practitioner or facility is determined in part by whether the care conforms to the standard exercised by prudent practitioners acting under the same or similar circumstances. Ordinary care may also be determined by the standard established by statutory and regulatory requirements applicable to the medical provider. Thus, failure to comply with these requirements, even if not enforced by the regulatory agency, can establish negligence as a matter of law and lead to liability if the failure to comply with the requirement is a proximate cause of harm to a person.

The determination of what constitutes ordinary care is generally made by the courts, often long after the act or omission which gave rise to the alleged claim or injury. It can be difficult even under normal conditions to describe what constitutes ordinary care by a medical practitioner. What constitutes ordinary care under conditions of disaster may be even less certain. Thus, a provider of medical care faced with a perceived need during an emergency to deviate from the normal standards of care to save a disaster victim's life may have no way of knowing with any degree of certainty prior to rendering care whether rendering assistance may subsequently subject him or her to civil liability. If the perceived risk of liability is too great, the provider may choose to withhold care, or may feel bound to provide care and utilize scarce resources for the one patient rather than benefit a number of patients.

1.3.3 Immunities from Liability Available in an Emergency

To some extent, the Legislature has already recognized this dilemma. There are several statutes providing qualified immunity to persons rendering aid during an emergency. These immunity provisions instruct the courts not to impose liability in specified emergency circumstances. Thus, if the immunity applies, there can be no liability. This, in turn, may reduce the need for a suspension of regulatory requirements, because the immunity already contemplates that the standard of care is altered in emergency circumstances.

Therefore, before examining more closely the authority and procedures for suspending regulatory statutes or promulgating emergency orders and regulations, or what regulatory statutes, or state agency orders, rules or regulations, if suspended, would assist in the mitigation of the effects of a medical and health emergency, we must first examine the immunities available by law for emergency care.

Healthcare Services during a Proclaimed Emergency at Request of Responsible Government Official
Under the ESA, any physician or surgeon (whether licensed in this state or any other state), hospital, pharmacist, nurse, or dentist who renders services during any state of war emergency, a state of emergency, or a local emergency at the express or implied request of any responsible state or local official or agency is immune from liability for any injury sustained by any person by reason of such services, regardless of how or under what circumstances or by what cause such injuries are sustained.[9] This immunity, however, does not apply "in the event of a willful act or omission."

It has been argued that the phrase "willful act or omission" completely negates the immunity, because every act undertaken by a health facility or professional to render services during an emergency is willful, i.e., the product of a deliberate choice. However, there does not appear to be any case to support such an interpretation of Government Code section 8659. To the contrary, cases interpreting section 2395 of the Business and Professions, the "Good Samaritan" statute for physicians (see below), which contains an identical exclusion for a "willful act or omission," have repeatedly supported the application of immunity notwithstanding very deliberate actions on the part of the defendants in those cases to treat their patient. For example, in ***Burciaga v. St. John's Hospital,***[10] a pediatrician summoned under emergency circumstances to the delivery room administered suction and applied oxygen to an infant in respiratory distress, then secured a transfer of the infant to a neonatal unit in a different hospital, and was still found to be immune. Similarly, in *Bryant v. Bakshandeh*,[11] a urologist who was summoned to assist in the catheterization of an infant patient prior to surgery, but despite repeated attempts was unable to do so due to complications, was also found to be immune.

As a general rule, the purpose of statutory construction is to ascertain the intent of the legislature so as to effectuate the purpose of the law.[12] The clear purpose of the Government Code section 8659 is to induce providers of medical care to render emergency aid to individuals who otherwise would not receive it. To construe section 8659 to exclude any deliberate attempt to render emergency aid would completely defeat the statute's apparent purpose. Although it remains unclear precisely what the Legislature intended by the words "willful act or omission," it seems obvious that it did not intend that the qualification would negate the purpose of the statute altogether.

The immunity provided by section 8659 is distinctive in other ways. Unlike the immunity provided by the Good Samaritan statute for physicians (see below), the services rendered do not need to be emergency care. It appears sufficient that the care was rendered at the express or implied request of an authorized official. Also, unlike the immunity provided to disaster service workers under the ESA (see below), the providers of care do not need to be registered disaster services workers in order to receive the immunity. The facility or professional simply needs to fall within one the licensure categories described in the statute.
Emergency Care at the Scene of an Emergency

Business and Professions Code section 2395 provides immunity from civil damages to physicians for acts and omissions in rendering emergency care in good faith at the scene of an emergency. The statute specifically includes, but is not limited to, the emergency rooms of hospitals in the event of a medical disaster within the meaning of the phrase "the scene of an emergency." The phrase "medical disaster" specifically refers to a duly proclaimed state of emergency or local emergency declared pursuant to the ESA. It applies to acts or omissions which occur after the declaration of a medical disaster and those which occurred prior to such declaration but after the commencement of such medical disaster.

Similar provisions exist for nurses,[13] dentists,[14] licensed vocational nurses,[15] physician's assistants,[16] any person providing on-scene emergency care,[17] physicians providing instructions to EMT-IIs or paramedics,[18] law enforcement and emergency response personnel providing on-scene emergency

care,[19] and public entities and emergency rescue personnel providing emergency care.[20] In some cases, the immunity will not apply where the person is grossly negligent.[21] In other cases, it will apply if the person acted simply in good faith.[22]

Failure to Obtain Informed Consent Under Emergency Conditions
Physicians and surgeons are also immune from civil damages for injuries in emergency situations in their office or in a hospital on account of a failure to obtain fully informed consent where the (1) the patient was unconscious, (2) the lack of informed consent was due to the provider's reasonable belief that a medical procedure should be undertaken immediately and that there was insufficient time to fully inform the patient or a person authorized to give such consent for the patient.[23] Either criteria could easily apply under emergency conditions. However, it is unclear whether the concept of "insufficient time" applies only to the needs of the patient being treated, or includes a lack of time due to an overwhelming number of patients requiring treatment.

Lawfully Ordered Services by Disaster Service Workers
In an emergency, the service of persons not already employees of the state will be utilized. These persons may be volunteers registered with the state or local disaster councils, or they may be impressed into service.[24] The state Office of Emergency Services is required to develop a plan for state and local governmental agencies to utilize volunteer resources during a state of emergency proclaimed by the Governor.[25] Whether a volunteer or someone impressed into service, a person providing disaster relief is referred to as a "disaster service worker."[26] In addition, all state and local public employees are, by law, disaster service workers.[27] Disaster service workers are covered, to the extent funds are available, by worker's compensation for injuries sustained in the course of training for or providing relief work.[28] Volunteer disaster service workers are not compensated, but may be reimbursed for expenses.[29]

Disaster service workers are also entitled to the same immunities as public employees,[30] and if performing services during a proclaimed disaster under the ESA are also immune from civil damages on account of personal injury to or death of any person or damage to property resulting from any act or omission in the line of duty, except one that is willful.[31]

Some volunteers will be medical staff, who will staff casualty stations, establish and operate medical and public health field units; assist in hospitals, out-patient clinics, and other medical and public health installations.[32] These persons would have immunity for their negligent acts and omissions.

Facilities Used as Mass Care Centers
The same Civil Code section that provides immunity for disaster service workers provides immunity to anyone, including a public agency, who owns or maintains any building or premises which is used as a mass care center, first aid station, temporary hospital annex, or other necessary facility for mitigating the effects of an emergency. The immunity is from liability to any person, who has entered to seek refuge, treatment, care or assistance and while in or upon the premises, for injuries sustained as a result of the condition of the building or premises, or as the result of any act or omission, or as a result of the use or designation of the premises as a mass care center, first aid station, temporary hospital annex, or other necessary facility for emergency purposes. The only exclusions are the willful acts of the owner or occupant or their employees.[33]

Health Facilities with Inadequate Resources
By law, emergency services and care must be provided to any person upon request for any condition in which the person is in danger of loss of life, or serious injury or illness, at any health facility licensed by the State that maintains and operates an emergency department to provide emergency services to the public when the health facility has appropriate facilities and qualified personnel available to provide the services or care.[34] However, the health facility and its employees, including any physician, surgeon, dentist, clinical psychologist and podiatrist, are immune from liability in any action arising out of a refusal to render emergency services or care if the refusal is based on the determination, exercising reasonable care, that the person is not suffering from an emergency medical condition, or that the health facility does not have the appropriate facilities or qualified personnel available to render those services.[35]

Hospital Rescue Teams
For purposes of the immunity provision, a "rescue team" is a special group of physicians and surgeons, nurses, and employees of a health facility who have been trained in cardiopulmonary resuscitation and have been designated by the health facility to attempt, in cases of emergency, to resuscitate persons who are in immediate danger of loss of life.[36] So long as good faith is exercise, any act or omission of any rescue team of a licensed health facility, or operated by the federal or state government, a county, or by the Regents of the University of California, done or omitted while attempting to resuscitate any person who is in immediate danger of loss of life, is immune from any liability that might otherwise be imposed upon the health facility, the officers, members of the staff, nurses, or employees of the health facility, including, but not limited to, the members of the rescue team, or upon the federal or state government or a county.

Violation of Statute or Ordinance under Emergency Orders
As previously discussed, violation of a statute can provide the basis for a claim of negligence as a matter of law. In an emergency, however, it is a misdemeanor to refuse or willfully neglect to obey any lawful order or regulation promulgated or issued under the ESA.[37] Such orders and regulations may compel a person to violate a statute. Consequently, the law also provides that the violation of any statute or ordinance shall not establish negligence as a matter of law where the act or omission involved was required to comply with any regulation, directive, or order of the Governor promulgated under the California Emergency Services Act.[38] In addition, a person cannot be prosecuted for a violation of any statute or ordinance when the violation was required in order to comply with any regulation, directive, or order of the Governor.[39]

1.3.4 Suspension of Regulatory Statutes Where Needed to Expand Availability of Care

For purposes of the following discussion, we must assume that the Governor has determined that, despite all the mutual aid provided and the immunities available to professionals and facilities providing emergency care, extraordinary measures must be taken to suspend regulatory statutes under Government Code section 8571 in order to induce providers of medical care to render emergency aid to individuals who otherwise would not receive it. Whether this point is ever achieved may depend upon several factors. For example, some organized health systems may have a contractual responsibility to provide medical care to their members even under disaster conditions, and therefore may be willing to provide care to their customers despite a perceived increased risk of liability. There may also be good reasons, from the standpoint of maintaining good will in the community, for a health facility to do everything within its power following a disaster to provide the medical care services needed by the community. Many of the immunities discussed in the following paragraphs would apply, and these immunities may be sufficient to justify the provision of services despite degraded circumstances.

Nevertheless, there may be a sufficient number of health facilities for which the availability of immunity is uncertain. It is possible that these facilities will continue to provide care as best they can under the circumstances, hoping that subsequently the courts will agree that the circumstances altered the standard of ordinary care or that an immunity will be found to apply. However, some could refuse to provide care beyond what is enabled by activation of the hospital incident command system, because it cannot provide services at a level normally consistent with ordinary care. There is no general statutory or regulatory requirement that healthcare providers be available to provide care to the public under all circumstances.[40,41] Indeed, this fact accounts for the existence of the Good Samaritan laws discussed above.[42]
Therefore, the Governor may be persuaded to suspend those regulatory requirements perceived to be an obstacle to the emergency mitigation effort. The suspension would be implemented through an executive order of the Governor either suspending specific regulatory requirements, or delegating to another state official, e.g. the Director of the Office of Emergency Services, the Emergency Medical Services Authority, or the Department of Public Health, the authority to suspend requirements consistent with the Governor's authority to do so. The proclamation of a state of emergency alone is not sufficient to effectuate a suspension. The proclamation would also need to include a separate

order as described above, or would need to implement pre-approved standby orders of a similar nature.[43]

It should be emphasized that, until such an order is issued subsequent to a proclamation of a state of emergency, no regulatory requirement is suspended (except to the extent that the regulatory agency has waived enforcement).[44] Therefore, medical providers not operating under emergency conditions offering immunity must ascertain the existence and scope of the proclaimed state of emergency, and extent and applicability of any suspension of regulatory requirements.

1.3.5 Issuance of Emergency Regulations Amending Standards of Care

In addition to the Governor's authority to suspend regulatory requirements, the Governor is also authorized to issue necessary orders, rules and regulations to carry out the provisions of the ESA. These orders and regulations have the force and effect of law.[45] As previously noted, willful violation of these orders and regulations is a misdemeanor.[46] Such orders and regulations could be used during a medical and health emergency to establish altered standards of care consistent with the ESA's goal of preserving lives.

As with the suspension of regulatory requirements, the decision to issue orders or regulations altering standards of care will depend upon several factors. For example, to what extent will the provision of mutual aid avoid the need to alter standards of care? To what extent will the available immunities provide sufficient protections to professionals and facilities providing emergency care? Given these factors, is an alteration of the standards of care necessary to induce providers to render emergency aid to individuals who otherwise would not receive it?

Orders and regulations of the Governor must be in writing, and take effect immediately. Thus, a proclamation of emergency alone is insufficient to change the standard of care. A separate order, or implement of pre-approved standby orders in conjunction with the proclamation, would be needed.

1.3.6 Commandeering of Facilities and Personnel

During a proclaimed state of emergency, the Governor is authorized to commandeer or utilize any private property or personnel deemed by him necessary in carrying out the responsibilities hereby vested in him as Chief Executive of the state.[47] The power to commandeer exists only under a state of emergency, and may only be exercised by the Governor or an authorized designee. It is not available under a local emergency.[48] It must also be distinguished from other, more commonly used methods, such as contracts and agreements, to obtain necessary resources.

It is conceivable that this power could be exercised to take over the operations of any facility that is unwilling to risk providing expanded services due to a perceived increased risk of liability. However, it is unclear how an order to commandeer a facility or personnel would be implemented. Further, the state is required to pay the reasonable value of the property or personnel commandeered or used.[49]

1.4 Emergency Preparedness and Response in California

1.4.1 California Emergency Services Act[50]

The California Emergency Services Act (ESA) recognizes the State's responsibility to mitigate the effects of natural, manmade, or war-caused emergencies which result in conditions of disaster or in extreme peril to life, property, and the resources of the state, and generally to protect the health and safety and preserve the lives and property of the people of the state.[51] To insure adequate preparations to deal with emergencies, the ESA confers emergency powers upon the Governor and upon the chief executives and governing bodies of political subdivisions of the State, provides State assistance for the organization of local emergency response programs, and creates the Office of Emergency Services (OES) within the Office of the Governor.

The ESA recognizes the need to assign emergency functions to State agencies and to coordinate and direct the emergency actions of those agencies. It provides for the rendering of mutual aid by the State and its political subdivisions to carry out the purposes of the ESA. Further, the ESA makes it State policy that all State emergency services functions be coordinated as far as possible with the comparable functions of its political subdivisions, of the federal government, of other states, and of private agencies of every type, to make the most effective use of all manpower, resources, and facilities for dealing with any emergency that may occur.

1.4.2 Role of the Governor

The Governor is given broad powers under the ESA. Some powers granted to the Governor have been previously discussed, e.g., the power to make, amend and rescind orders and regulations having the force and effect of law,[52] to suspend regulatory statutes and regulations,[53] and the power to use and commandeer property and personnel.[54] In addition, the Governor has powers which are specific to the type of emergency proclaimed.[55] For example, during a state of emergency, the Governor has authority over all agencies of State government and the right to exercise all police power vested by law in the State within the area designated.[56] Also during a state of emergency, the Governor can direct all state government agencies to utilize and employ state personnel, equipment, and facilities for the performance of any and all activities designed to prevent or alleviate actual and threatened damage due to the emergency, and he can direct them to provide supplemental services and equipment to political subdivisions to restore any services which must be restored in order to provide for the health and safety of the citizens of the affected area.[57]

In carrying out his/her responsibilities under the ESA, the Governor is assisted by the California Emergency Council.[58] Among other duties, the California Emergency Council must consider, recommend, and approve orders and regulations that are within the province of the Governor to promulgate.[59] This would include orders and regulations to suspend regulatory requirements or to alter standards of care.

The Governor is also assisted by the Emergency Response Team for State Operations,[60] whose task is to improve the ability of state agencies to resume operations in a safe manner and with a minimum of delay if their operations are significantly interrupted by a business interruption.[61]

1.4.3 Governor's Office of Emergency Services

The Office of Emergency Services (OES) is created by the ESA in the Governor's Office.[62] The Governor is required to assign all or part of his powers under the ESA to the Office of Emergency Services,[63] but cannot delegate to OES his/her authority to issue orders and regulations.[64] During a state of emergency or a local emergency, the Director of OES is responsible to coordinate the emergency activities of all state agencies in connection with such emergency.[65] It does so through the State Operations Center (SOC) and Regional Emergency Operations Centers (REOC).

OES has established three OES Administrative Regions, the Southern Region, the Coastal Region, and the Inland Region.[66] These Administrative Regions coordinate emergency management in the six mutual aid regions created by the Governor (see The Concept of Mutual Aid, below).

Within the SOC, the REOCs and Operational Area Emergency Operations Centers, the ICS structure organizes emergency response disciplines into Branches under the Operations Section. The Medical and public health issues are handled by the Medical and Health Branch.

1.4.4 State Emergency Plan

The Governor is responsible to coordinate the State Emergency Plan and programs necessary for the mitigation of the effects of an emergency. He is also responsible for coordinating the preparation of local plans and programs, and to see that they are integrated into and coordinated with the State Emergency Plan and the plans and programs of the federal government (and of other states) to the fullest possible extent.[67] By law, the State Emergency Plan is in effect in each political subdivision of the state, and the governing body of each political subdivision is obligated to take whatever action may be necessary to carry out its provisions.[68]

As part of the state plan, the Governor can assign to a state agency any activity concerned with the mitigation of the effects of an emergency of a nature related to the existing powers and duties of the agency, including interstate activities. Such an assignment makes it the duty of the agency to undertake and carry out that activity on behalf of the state.[69]

In accordance with the State Emergency Plan, the Governor can plan for the use of any private facilities, services, and property and, when necessary, and when in fact used, provide for payment for that use under the terms and conditions as may be agreed upon.[70] This planning authorization is consistent with the Governor's power, described above, to commandeer property and personnel.[71]

1.4.5 Emergency Medical Services Authority

The Emergency Medical Services Authority (EMSA)[72] is required by law to respond to any medical disaster by mobilizing and coordinating emergency medical services mutual aid resources to mitigate health problems.[73] The State Emergency Plan (see below) designates the EMSA as the lead state agency for the medical response to an emergency.[74] Also, EMSA is responsible under the Plan for medical situation status and analysis in conjunction with the Department of Public Health.[75]

Generally, any attendant in a publicly or privately owned ambulance must possess evidence of specialized training as set forth in the emergency medical training and educational standards for ambulance personnel established by EMSA.[76] However, this requirement does not apply in any state of emergency declared under the ESA when it is necessary to fully utilize all available ambulances in an area and it is not possible to have the ambulance operated or attended by persons with the qualifications required by EMSA.[77]

1.4.6 State Department of Public Health

The State Department of Public Health (DPH)[78] is designated the lead for the public health component of the Medical and Health Services operations set forth in the State Emergency Plan (see below).[79] Both EMSA and DPH share responsibility for the lead in the Medical/Health Branch. Also, DPH, in conjunction with EMSA, is responsible under the Plan for public health situation status and analysis.[80]

DPH is also the agency which regulates acute care hospitals and many other health-related facilities.[81] Therefore, during the early stages of an incident when acute care hospitals are reaching the limits of their capacity, hospital administrators may contact the Licensing and Certification Division of DPH in their region to obtain waivers of specific regulatory requirements.[82]

1.4.7 The Concept of Mutual Aid

Mutual aid is a concept under which separate jurisdictional or organizational units share and combine resources in order to accomplish their mutual goals. The ESA recognizes that, during emergencies, the rendering of mutual aid by State government, including all its departments and agencies, and its

political subdivisions will be necessary to mitigate the effects of the emergency. Public agencies are authorized by law to enter into joint powers agreements, and these agreements can be for the purposes of providing assistance to each other.[83] However, given the number of cities and counties in the State, it would be impractical to require that each jurisdiction have a separate agreement with each other jurisdiction in order to assist each other in the event of an emergency.

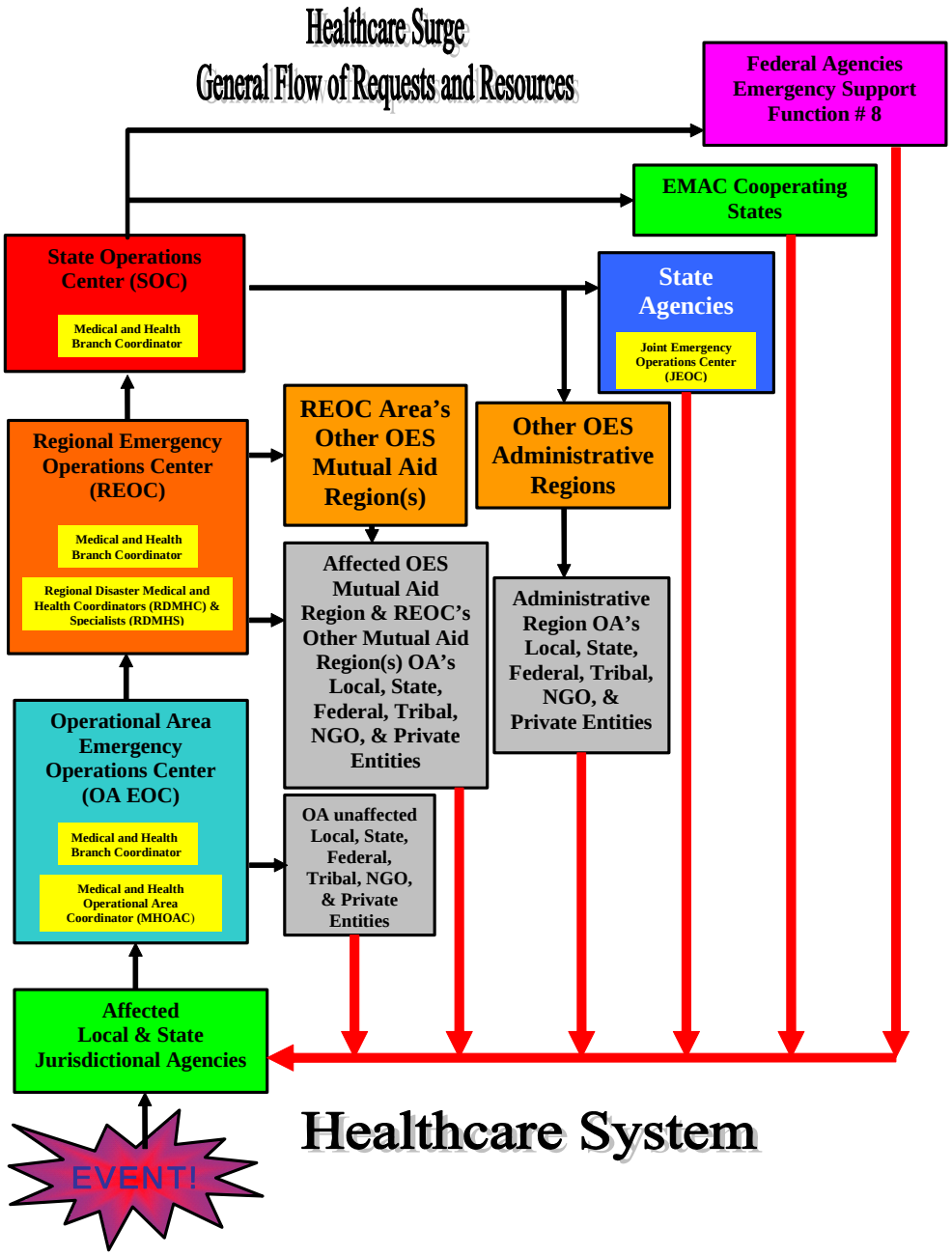
Accordingly, one purpose of the ESA is to make it unnecessary for public agencies to execute written agreements to render aid to areas stricken by an emergency.[84] It accomplishes this goal by authorizing state and local public agencies to exercise mutual aid powers in accordance with the California Disaster and Civil Defense Master Mutual Aid Agreement, and local plans, ordinances, resolutions and agreements.[85] The Master Mutual Aid Agreement requires that each party develop a plan providing for the effective mobilization of all its resources and facilities, both public and private, to cope with any type of disaster.[86] These plans are known as “mutual aid operational plans.” Under the ESA, a duly adopted and approved emergency plan is deemed to satisfy the Master Mutual Aid Agreement’s requirement for a “mutual aid operational plan.”[87]

As previously discussed, the Governor is authorized to divide the state into mutual aid regions for the more effective application, administration, and coordination of mutual aid and other emergency-related activities.[88] A "mutual aid region" is part of the state, not local, emergency services organization, and is established to facilitate the coordination of mutual aid and other emergency operations within an area of the state consisting of two or more county operational areas.[89] (See discussion of Operational Areas, below.) Currently, the State is divided into six mutual aid regions for general mutual aid coordination.[90] Each mutual aid region consists of designated counties/operational areas.

Within each mutual aid region, there may be a Regional Disaster Medical and Health Coordinator (RDMHC), who is appointed by the Directors of EMSA and DHS.[91] The RDMHC must be either a county health officer, a county coordinator of emergency services, an administrator of a local EMS agency, or a medical director of a local EMS agency (see below for a discussion of these officials). The job of the RDHMC during an emergency is to coordinate the acquisition of requested medical or public and environmental health mutual aid in an affected region to deliver to the area affected by the disaster. In a proclaimed emergency and at the request of EMSA, DHS or OES, an RDMHC in an unaffected region may also coordinate the acquisition of requested mutual aid resources in his/her region.[92]

Mutual aid is not limited to aid between jurisdictions in California. The Governor may also enter into reciprocal aid agreements or compacts, mutual aid plans, or other interstate arrangements for the protection of life and property with other states and the federal government, either on a statewide or a political subdivision basis.[93] The State has entered into two interstate compacts; the Interstate Civil Defense and Disaster Compact[94] and the Emergency Management Assistance Compact.[95] The State can also seek federal mutual aid by requesting a Presidential Declaration of an Emergency or Major disaster under the provisions of the Stafford Act.[96] A Presidential declaration makes federal assistance programs available, depending on the level of the declaration, as outlined in the Federal Response Plan, which includes contributions from several federal agencies and non-governmental organizations, such as the American Red Cross.

The healthcare surge general flow requests and resources is described in the following chart.



1.4.8 Local Emergency Plans and Local Disaster Councils

The ESA defines "emergency plans" to mean those official and approved documents which describe the principles and methods to be applied in carrying out emergency operations or rendering mutual aid during emergencies. These plans include such elements as continuity of government, the emergency services of governmental agencies, mobilization of resources, mutual aid, and public information.[97] During a state of emergency, outside aid must be rendered in accordance with approved emergency plans, and public officials are required to cooperate to the fullest extent possible to carry out such plans.[98]

Cities and counties are authorized to create disaster councils by ordinance.[99] If created, the disaster council is responsible for developing emergency plans.[100] The plans must meet any condition constituting a local emergency or state of emergency, including, but not limited to, earthquakes, natural or manmade disasters specific to that jurisdiction, or state of war emergency, and must provide for the effective mobilization of all of the resources within the political subdivision, both public and private.[101]

The primary motivation for organizing a disaster council is that the disaster council can register "disaster service workers." Under the ESA, the OES is authorized to adopt regulations for the classification and registration of disaster service workers.[102] The regulations provide that a disaster service worker is a person registered either with OES, a state agency authorized to register disaster service workers, or a disaster council.[103] Registered disaster service workers can be afforded worker's compensation benefits and liability protections for their acts and omissions during an emergency.

Disaster councils may become accredited by the Office of Emergency Services, by agreeing to comply with the ESA and submitting to the office a certified copy of the ordinance which provides for the disaster council and its leadership, the local emergency organization and compliance with the ESA.[104] The main reason for a disaster council to receive and maintain accreditation is that the term "disaster service worker," for purposes of worker's compensation benefits, only applies to person registered by an "accredited disaster council" or a state agency.[105] Thus, if a volunteer is registered with an unaccredited disaster council, the volunteer arguably is not a "disaster service worker" for purposes of worker's compensation coverage.

The governing body of a city or county is authorized to provide by ordinance or resolution for the organization, powers and duties, divisions, services, and staff of the emergency organization.[106] This ordinance or resolution, in effect, authorizes individuals within the city or county to take actions in accordance with the emergency plan. The city or county can also authorize public officers, employees, and registered volunteers to command the aid of citizens when necessary during a state of war emergency, a state of emergency, or a local emergency.[107]

It is the legal duty of each organizational component, officer, and employee of each political subdivision of the state to render all possible assistance to the Governor and to the Director of the Office of Emergency Services in mitigating the effects of an emergency. Their emergency powers are subordinate to any emergency powers exercised by the Governor.[108]

1.4.9 Standardized Emergency Management System

The Standardized Emergency Management System (SEMS) is a system for managing the response to multiagency and multi-jurisdictional emergencies in California.[109] OES has developed regulations to implement SEMS.[110] All state agencies are required to use SEMS to coordinate multiple jurisdiction or multiple agency emergency and disaster operations.[111] Every local agency, in order to be eligible for any funding of response-related (i.e., personnel) costs under disaster assistance programs, must also use SEMS to coordinate multiple jurisdiction or multiple agency emergency and disaster operations.[112] This means that local emergency plans must also incorporate SEMS, assuming the local government wants to be reimbursed for emergency personnel costs.

Incident Command System (ICS)
SEMS is required to be based in part on the concept of the Incident Command System (ICS),[113] which had been developed and used by the fire services to respond to all types of emergencies. The system standardizes the organizational structure and terminology used by every response agency. ICS recognizes that every response, regardless of size, requires that five management functions be performed:

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

Even the issuance of a speeding ticket involves each of these five ICS functions, i.e. a policy against speeding, the intelligence gathering which detects and identifies a speeding driver, the operation of pulling the driver over and issuing the citation, the logistics of providing the equipment (car, radar, ticket book) needed to conduct the operation, and the administrative tracking of submitting the citation into the court system. At the other extreme there may be a multi-jurisdictional wildland fire involving the same functions, i.e. a policy of protecting lives and property, intelligence and planning on how to stop the fire, operations in which firefighters and equipment are committed to the fireline, logistics to obtain, equip and support the firefighting operation, and finance/administration to determine how to pay for it all.

As an incident expands in scope, the ICS expands and adapts with it. When multiple jurisdictions or agencies become involved, a “unified command” management organization is formed, under which members representing different organizations at the Incident Command Post establish a common set of objectives and strategies and a single incident action plan.

Multi-Agency Coordination System
Together with ICS, SEMS incorporates the Multi-Agency Coordination (MAC),[114] in which jurisdictions and organizations work together to coordinate and prioritize the allocation of resources and emergency response activities. In practical application, facilities, equipment, personnel, procedures and communications are integrated into a common system under an organization typically located as part of an emergency operations center. The multi-agency organization does not direct operational activities, but rather ensures situational and resource status awareness, helps establish policies and priorities, acquires and allocates resources, plans for anticipated resource requirements, and provides strategic coordination.

Mutual Aid
SEMS also embraces the concept of mutual aid, discussed above.[115] SEMS applies this concept by recognizing five organizational levels for response. The levels are in the order in which the levels become involved in the response under the mutual aid concept:

1. Field – where diverse local response organizations (law enforcement, fire, public health) use their own resources to carry out tactical decisions and activities.
2. Local – where local governments, e.g. cities, counties and special districts, manage and coordinate the emergency response and recovery.
3. Operational Area – the entity that coordinates resources, the provision of mutual aid, emergency response and damage information.
4. Regional – manages and coordinates resources and information among operational areas.
5. State – this level is responsible for statewide resource allocation. If State resources are inadequate, this level is integrated with federal agency resources.

It should here be emphasized that under the ESA, unless the parties to a mutual aid agreement expressly provide otherwise, the responsible local official in whose jurisdiction an incident requiring mutual aid has occurred remains in charge at such incident, including the direction of personnel and equipment provided through mutual aid.[116] Thus, the fact that higher organizational levels become involved in coordinating resources and information does not mean that officials at that higher level take charge of the incident.

Operational Area
The State and regional levels have been discussed previously and are reflected in the ESA. The Operational Area (OA) is also defined in the ESA, and is a required concept of SEMS.[117] In accordance with SEMS and the ESA, the OA consists of a county and all political subdivisions within the county area, and serves as an intermediate level of the state emergency services organization.[118] The governing bodies of each county and of the political subdivisions in the county are authorized to organize and structure their OA. An OA is used by the county and the political subdivisions comprising the OA for the coordination of emergency activities and to serve as a link in the communications system during a state of emergency or a local emergency.[119]

There are 58 OAs in California. Practically speaking, the OA within the SEMS structure is embodied in its emergency operations center (EOC). An EOC is a location from which centralized emergency management can be performed.[120] Political subdivisions within a county may have their own EOCs in addition to the Operational Area EOC. OES has an Operational Area Coordinator assigned to each OA.

The OA EOC must be distinguished from department operations centers (DOC). Under SEMS, a DOC is an emergency operations center used above the field level by a specific discipline (e.g., flood operations, fire, medical, hazardous material), or a governmental unit (e.g., Department of Public Works or Department of Health).[121] There may be as many DOCs as there are public agencies involved in the response above the field level.

Communications
Finally, SEMS addresses the concept of emergency communications by supporting networks to ensure that all levels of government can communicate during a disaster. Two systems have been established:

1. The Response Information Management System (RIMS) – an electronic data management system that links emergency management offices throughout California.
2. The Operational Area Satellite Information System (OASIS) – a portable satellite-based network that provides communication when land-based systems are disrupted.

In addition, there are discipline specific communications systems, such as the California Health Alert Network (CAHAN). CAHAN is the emergency preparation and notification system used by the California Department of Health Services and many emergency preparedness stakeholders and partners associated with public health. CAHAN contains both an alerting system that provides rapid notification of emergencies to public health stakeholders and partners and a highly secure web-based document repository used for the creation and collaboration of information pertaining to preparation and/or response to various incidents or events.

1.4.10 Medical and Health Disaster Plans

If an operational area has a medical health operational area coordinator (MHOAC), the MHOAC is responsible for the development of a discipline-specific operations plan known as the “medical and health disaster plan” for the provision of medical and health mutual aid for the operational area. The medical and disaster plans must comply with the framework established by SEMS.[122]

At a minimum, the medical and health disaster plan, policy, and procedures must include the following components relevant to healthcare surge:

1. Assessment of immediate medical needs.
2. Coordination of disaster medical and health resources.

3. Coordination of patient distribution and medical evaluations.
4. Coordination with inpatient and emergency care providers.
5. Coordination of out-of-hospital medical care providers.
6. Coordination and integration with fire agencies personnel, resources, and emergency fire pre-hospital medical services.
7. Coordination of providers of non-fire based pre-hospital emergency medical services.
8. Coordination of the establishment of temporary field treatment sites.
9. Health surveillance and epidemiological analyses of community health status.
10. Provision or coordination of mental health services.
11. Provision of medical and health public information protective action recommendations.
12. Investigation and control of communicable disease.[123]

During a medical or health disaster, the MHOAC is responsible for implementing this plan, and coordinating with the Regional Disaster Medical Health Coordinator (RDMHC) on the acquisition of resources or the movement of patients to other jurisdictions.

1.4.11 Persons Responsible for Local and Regional Emergency Response Related to Healthcare Surge

Thus far, we have discussed the role of the following State officials at the State and, to some extent, regional levels in emergency preparedness and response:

1. Governor
2. California Emergency Council/State Emergency Response Team
3. Office of Emergency Services (OES)
4. Emergency Medical Services Authority (EMSA)
5. Department of Health Services (DHS)
6. OES Administrative and Mutual Aid Regions
7. Regional Disaster Medical Health Coordinator (RDMHC)

It is often said that all emergencies are local. We have already discussed the role of the Operational Area within the SEMS framework, and the fact that the Operational Area consists of the political subdivisions within a county. We now discuss the local officials involved in emergency response as it relates to healthcare surge.

Local Governing Body
The local governing body can be either the county board of supervisors or a city council. These bodies are authorized to proclaim a "local emergency."[124] They may also designate an official by ordinance who can proclaim local emergencies.[125] During a proclaimed local emergency, political subdivision of the state have full power to provide mutual aid to any any affected area in accordance with local ordinances, resolutions, emergency plans, or agreements,[126] and state agencies are authorized to provide mutual aid in accordance with mutual aid agreements, or upon direction from the Governor.[127]

The local governing body is also authorized during a local emergency to promulgate orders and regulations necessary to provide for the protection of life and property, including orders or regulations imposing a curfew within designated boundaries where necessary to preserve the public order and safety.[128]

County Director of Emergency Services
Counties may appoint a County Director of Emergency Services, however in absence of this, by virtue of his/her office, the county sheriff serves in this role.[129] The county director of emergency services has all the duties prescribed by state law and executive order, the California Disaster and Civil Defense Master Mutual Aid Agreement, mutual aid operational plans, and by county ordinances and resolutions.[130]

County Emergency Medical Services Agency/Medical Director
Each county is authorized to develop an emergency medical services program. Each county developing such a program must designate a local EMS agency. It may be the county health department, or a separate agency established and operated by the county. It may also be an entity with which the county contracts or a joint powers agency created for the administration of emergency medical services by agreement between counties.[131]

Every local EMS agency shall have a full- or part-time licensed physician and surgeon as medical director, to provide medical control and to assure medical accountability throughout the planning, implementation and evaluation of the EMS system.[132]

Health Officer
Each county is required to appoint a health officer.[133] The county health officer is responsible to enforce and observe in the unincorporated territory of the county, the orders and ordinances of the

board of supervisors pertaining to the public health and sanitary matters, orders, including quarantine and other regulations, prescribed by DPH, and statutes relating to public health.[134]

There is similar authority for the appointment of city health officers.[135] However, most cities contract with the county health officer to provide local public health services.[136] At present, only three cities in California operate their own public health departments. Thus, in most counties, the county health officer has jurisdiction throughout the county.

Both city and county health officers are authorized, regardless of whether or not an emergency is declared, to take measures as may be necessary to prevent the spread, or the occurrence of additional cases, of any communicable disease that he or she reasonably believes may exist within his or her jurisdiction.[137] This includes the power to quarantine and isolate persons, animals or places, conduct investigations and examinations, and to disinfect where necessary to protect public health.[138] The local health officer can also require, during an outbreak of disease, or when an outbreak appears imminent, that health care providers disclose their inventories of critical medical supplies, equipment, pharmaceuticals, vaccines, or other products that may be used for the prevention of, or may be implicated in the transmission of communicable disease.[139]

In addition, during any "state of war emergency," "state of emergency," or "local emergency," a local health officer is authorized to take any preventive measure within his or her jurisdiction that may be necessary to protect and preserve the public health from any public health hazard. For purposes of this authorization, the term "preventive measure" means abatement, correction, removal or any other protective step that may be taken against any public health hazard that is caused by a disaster and affects the public health.[140]

In some jurisdictions, the local health officer is authorized by the governing body to declare a local emergency.[141] A local health officer may also declare a "local health emergency" whenever there is an imminent and proximate threat of the introduction of any contagious, infectious, or communicable disease, chemical agent, non-communicable biologic agent, toxin, or radioactive agent, in the jurisdiction or any area thereof affected by the threat to the public health.[142] However, such a declaration does not carry all the implications of a "local emergency." Only the immunity granted to hospitals, physicians and other medical practitioners under section 8659 of the Government Code (see above) is implicated.[143] Otherwise, the declaration only authorizes the exercise of mutual aid,[144] allows the exchange of health information, and authorizes the determination of the cause of the emergency.[145]

When an incident first arises, the local health officer may issue an order authorizing first responders to immediately isolate exposed individuals that may have been exposed to biological, chemical, toxic, or radiological agents that may spread to others. Such an order lasts only two hours, but may be sufficient time to allow the health officer to reach the scene of the incident, and to issue more comprehensive orders if needed.[146]

County Director of Environmental Health

Some counties have separated the public health and environmental health responsibilities of the local health officer by creating a comprehensive environmental health agency.[147] During a local emergency or a state of emergency, the county director of may be responsible for the coordination of emergency response under his/her jurisdiction. However, during a health emergency declared by the board of supervisors, or a county health emergency declared by the local health officer (see above), the local health officer shall have supervision and control over all environmental health and sanitation programs and personnel employed by the county during the state of emergency.[148]

Medical Health Operational Area Coordinator

Each OA may appoint a Medical Health Operational Area Coordinator (MHOAC). The MHOAC may be the local health officer and the county emergency medical services coordinator acting jointly, or a separate person appointed by these officials. The MHAOC is responsible, under the local emergency plan, to coordinate with inpatient and emergency care providers, assess medical needs, and coordinate disaster medical and health resources, among other things.[149]

In the event of a local, state, or federal declaration of emergency, the MHOAC must assist the OES operational area coordinator in the coordination of medical and health disaster resources within the OA.[150] The MHOAC is also the point of contact in that OA, for coordination with the RDMHC, OES at the regional level, DPH, and EMSA.

County Coroner

Each county in California has either a Sheriff/Coroner, a Coroner, or a Medical Examiner.[151] His/her duty is to manage the remains of deceased persons within the county, their personal effects if necessary,[152] and to inquire into the cause of deaths under specified circumstances.[153] In a mass casualty event also involving mass fatalities, this officer serves as the OA Coroner Mutual Aid Coordinator.[154] The state is divided into seven coroners mutual aid regions, and each region has a Coroners Regional Mutual Aid Coordinator.

Each operational area Coroner/Medical Examiner is advised to develop local contingency plans to deal with mass fatality events, including those involving chemical, biological and radiological contamination of human remains. These plans should also address issues such a storage capacity for human remains, and disposition of remains, including cremation, isolated burial, mandatory mass disposition, and return to family.[155]

1.4.12 Healthcare Surge Emergency Response

When a mass-casualty event occurs, hospitals would activate Emergency Operations Plans and mobilize under an incident command system, such as the Hospital Incident Command System (HICS) to manage the actual or anticipated influx of patients. If conditions within the hospital are sufficiently strained, the hospital may consult with regulatory agencies to determine if specific requirements related to staffing and patient management can be waived to maximize the hospital's response capabilities. If circumstances become overwhelming, the hospital can divert inbound ambulance patients, if possible, or patients that have been medically screened and deemed stable for transfer to other hospitals, or to alternate care sites established by local authorities.

All private entities,(e.g., private hospitals, clinics, pre-hospital providers, and ambulance services), would obtain their necessary day-to-day support and operational resources through their internal systems and suppliers. However, it is important even at this stage for healthcare providers to early establish their contacts with the local/OA medical and health coordinators to apprise them of the provider's status and anticipated needs. The reliance upon internal systems and suppliers would hold true until the impact of the situation overwhelmed the entities' normal support mechanisms or a local or state of emergency was declared.

Under these conditions, the specific entity's logistical functions would place their medical and health-related support or resource requests through the local jurisdictional medical and/or health coordinator. It is important to note that, during a declared local or state of emergency, private entities must direct their requests for medical and health support and resources through the SEMS process that often times utilizes Multi-Agency Coordinating Groups to coordinate activities and establish allocation of scarce resources among competing entities.

The local medical and health coordinator for the affected jurisdiction would identify the situation, contact the MHOAC if necessary, and request the resources that are needed based on the event. The MHOAC, in cooperation with the OES OA EOC, would attempt to acquire the needed resources within the OA.

At this point in the progression, a "healthcare surge" within the meaning of this document does not yet exist. However, a request for additional resources represents the first step in establishing the existence of surge. If the demands for resources become overwhelming at the local level, then the "healthcare surge" status of that OA would be changed to reflect that a surge exists in that OA.

The MHOAC can request mutual aid from other OAs, and contact the RDMHC for regional assistance. The RDMHC, in coordination with the Regional EOC, would attempt to acquire the needed resources within the region.

The Medical Health Branch Representative in the State Operations Center would be notified. The Medical and Health Branch Representative (either from CDHS or EMSA) would coordinate with the CDHS Department Operations Center (CDHS DOC), Emergency Medical Services Authority Department Operations Center (EMSA DOC) or when co-located, the Joint Emergency Operation Center (JEOC). The medical and health branch in the SOC would coordinate with unaffected regions. CDHS and EMSA would fill the request at the State level from resources under their control and would be responsible for processing the resource request(s) received via the SOC. If the request(s) cannot be filled from within the state, the State would then contact the Federal Emergency Management Agency (FEMA) to request deployment of federal resources.

At any point in this progression, a “local emergency” or “state of emergency” could be proclaimed. Once a state of emergency is proclaimed, even RDMHCs from unaffected regions can be utilized to coordinate the acquisition of requested mutual aid on behalf of the affected region.

Finally, if the Governor has determined that, despite all the mutual aid provided and the immunities available to professionals and facilities providing emergency care, extraordinary measures must be taken to suspend regulatory statutes under Government Code section 8571 in order to enable providers of medical care to render emergency aid to individuals who otherwise would not receive it. In addition, the Governor could issue orders and regulations to establish altered standards of care consistent with the ESA’s goal of preserving lives, or to commandeer property and personnel.

1.4.13 Termination of the Emergency

A local emergency proclaimed by a designated local official terminates by operation of law after seven days, unless the proclamation has been ratified by the local governing body.[156] If a local emergency has been proclaimed by the local governing body, the governing body must review the need for continuing the local emergency at it regularly scheduled meetings until the emergency is terminated.[157] The governing body must proclaim the termination of the local emergency at the earliest possible date that conditions warrant.[158]

Similarly, the Governor must proclaim the termination of a state of emergency at the earliest possible date that conditions warrant.[159] All of the powers granted to the Governor under the ESA for a state of emergency terminate upon the proclamation.[160] Thus, to the extent that the Governor has suspended regulatory statutes or altered standards of care by regulation, those suspensions and alterations would automatically end when the Governor proclaims the termination of the state of emergency.

2 Surge Capacity and Capability: An Overview

2.1 Community Based Surge Capacity and Capability

The concepts, ideas and content in this section are based on the discussions of the expert panel and references from a report by The CNA Corporation, *Medical Surge Capacity and Capability: A Management System for Integrating Medical and Health Resources during Large-Scale Emergencies*, August 2004.

Currently, patient care during emergencies or disasters is provided primarily at community-based hospitals, integrated healthcare systems, private physician offices, and other point-of-service medical facilities. The delivery of care is based on individual facility's preparedness, capacity and capability. However, this approach to response during a healthcare surge is sub-optimal from a population outcome perspective as well as from a scarce resource utilization perspective. In a mass casualty incident, healthcare facilities may lack the necessary resources and/or information to individually provide optimal patient care.

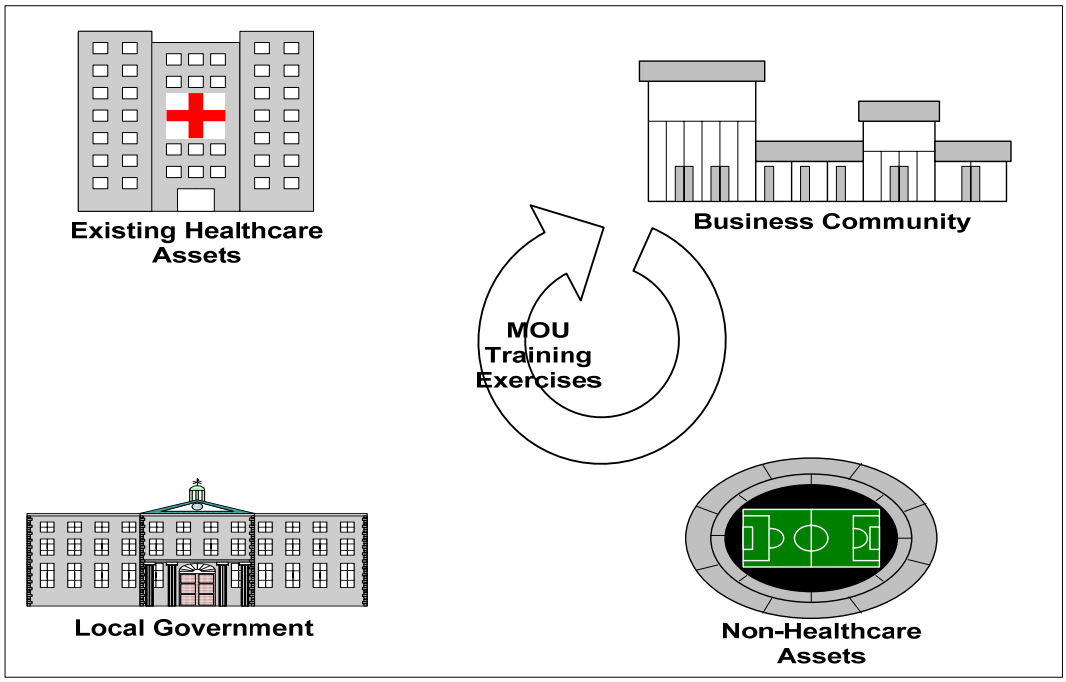
According to the CNA report, "research has shown that most individual healthcare facilities possess limited surge supplies, personnel, and equipment, and that vendors or anticipated “backup systems” for these critical assets are often shared among local and regional healthcare facilities. This “double counting” of resources diminishes the ability to meet individually projected surge demands across multiple institutions" during a healthcare surge.

These community healthcare assets, therefore, must collaboratively develop community surge capacity and capability. This does not, however, preclude or diminish the need for individual healthcare facilities to have a comprehensive emergency management plan that addresses mitigation, preparedness, response, and recovery activities. However, 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. For example, communities should consider developing Memorandum of Understanding (MOU) for transfer of patients from hospitals to skilled nursing facilities (SNF). If SNFs and nursing homes can support the hospital or even hold their own then it will save a lot of hospital beds for the victims during a healthcare surge. Refer to the Appendix for Alameda County's MOU with SNFs and rehabilitation facilities to voluntarily coordinate mutual aid services during a disaster. Similarly, during a Pandemic Influenza, Home Health Care will play a critical role, especially when such patients are either infected or when hospitals are overwhelmed. Community based planning to define the role of home health care and availability of personnel to support such care will enable communities to better respond to an outbreak. Community based planning would allow existing healthcare resources in the public and private sectors as well as other non-healthcare assets to be optimally leveraged. Advantages of community based planning include, shared costs and funding, regulatory/standards compliance, purchasing coalitions, and shared knowledge. To encourage community based planning the government could consider tax breaks for participating members.

One of the challenges in creating a community surge capacity is the possible lack of buy-in from medical clinics, private physician offices, and other healthcare and non-healthcare assets. Because the private medical community is diverse, there are differences in capacity, capability, and constraints to implementing these processes. It is important to recognize that many community healthcare assets do not have the management infrastructure or personnel necessary to establish complex processes for incident preparedness and response. Thus, it is imperative that larger healthcare facilities in the community take a leadership role to initiate and maintain communication, develop trust and make the community planning effort inclusive.

The community based surge capacity and capability is composed of healthcare facilities and non-healthcare facilities to form a unified entity in a defined geographic area. During a surge, a unified entity facilitates effective communications and consistent information sharing with local government. While the community assets retain their management autonomy during surge response, they coordinate and participate in information and asset sharing. A critical component of community based surge capacity and capability response is mutual aid—the sharing of personnel, facilities, equipment, or supplies. Since not all healthcare facilities, especially smaller hospitals and non-hospital facilities, participate in Hospital Preparedness Program (HPP) funded activities, mutual aid becomes critical for these clinics to be able to successfully participate in community based response plans. Mutual aid provides surge capacity and capability that is immediately operational, reliable, and cost-effective.

Community Based Surge Capacity & Capability



2.2 Community Participants

An important element of the community based capacity and capability is inclusion and integration of non-healthcare entities in the community. Below is a checklist of community members to consider for community based planning:

	Community Participant	Role
☐	Local Emergency Medical Services Authority	Local implementing arm of the Emergency Medical Systems Authority.
☐	Law Enforcement and Fire	Emergency first responders
☐	Public works & local Utility Companies	Essential services
☐	Communication Companies	Communication needs
☐	Major employers and business community, especially big-box retailers (e.g. Costco, Sam's Club)	Essential supplies and services
☐	Area Airports	Transportation
☐	Red Cross/Salvation Army and other non-profit organizations	Volunteers and Supplies Aid
☐	National Guard and Military Establishments	Transportation and infrastructure support
☐	Chamber of Commerce	Business community support
☐	Board of Realtors	Help coordinate additional space for healthcare facilities
☐	City Unified School District and Community Colleges	Alternate Care Sites
☐	Public transportation	Transportation
☐	Faith based organizations	Translation and funeral services
☐	Private security firms	Security services
☐	Mortuaries	Funeral services
☐	Community emergency response teams	Volunteers
☐	Medical Reserve Corps (MRC)	Volunteers
☐	Miscellaneous services	Financial, accounting, general services
☐	Vetrinary Shelters/Pet Boarding and Care	Pet care for workers/evacuees

The community based capacity and capability may include healthcare and non-healthcare assets from multiple jurisdictions. This may be desirable especially in rural areas, where health and medical assets are scattered. Since rural isolated facilities cannot rely on receipt of supplies, medications and durable medical equipment from Strategic National Stockpile in a timely manner, they have an even greater need to form a community based capacity and capability especially with private sector.

2.3 Community Based Surge Capacity and Capability Standards

The Joint Commission's Environment of Care provides guidance on standards for community based surge capacity and capability. These standards will become effective January 1, 2008

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

  An emergency in a health care organization or in its community can suddenly and significantly affect demand for its services or its ability to provide those services. The organization's Emergency Management Program defines a comprehensive approach to identifying risks and mobilizing an effective response within the organization and in collaboration with essential response partners in the community.

- EC.4.12: The organization develops and maintains an emergency operations plan.

  A successful response relies upon planning around the management of six critical areas: communications; resources and assets; safety and security; staffing; utilities; and clinical activities. While the Emergency Operations Plan can be formatted in a variety of ways, it must address these six critical functions to serve as a blueprint for managing care and safety during an emergency. Some emergencies can escalate unexpectedly, or strain not only the organization but the entire community. An organization cannot mitigate risks, plan thoroughly, and sustain an effective response and recovery without preparing its staff and collaborating with the community, suppliers and external response partners. Such an approach will aid the organization in developing a scalable response capability, and in defining the timing and criteria for decisions involving sheltering in place, patient transfer, facility closings, or evacuation.

- EC.4.14: The organization establishes strategies for managing resources and assets during emergencies.

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

The organization establishes processes to collaborate with health care organizations outside of the community in the event of a regional or prolonged disaster that requires resources and assets from outside the immediate geographic area.

The organization establishes processes to receive and care for evacuees from other communities consistent with the organization's role in the state or local emergency operations plan.

2.4 Surge Capacity Strategies

According to a report by Health Systems Research Inc., *Altered Standards of Care in Mass Casualty Events;* an AHRQ Publication, April 2005 and The Recommendations of the state Expert Panel on Inpatient and Outpatient Surge Capacity, *Guidelines for Managing Inpatient and Outpatient Surge Capacity*, state of Wisconsin, November 2005, if a facility determines they are experiencing a healthcare surge they are to use the following guidelines to assess and prepare for the need to increase patient care capacity:

- Rapid discharge of emergency department (ED) and other outpatients who can continue their care at home safely
- Cancellation of elective surgeries and procedures, with reassignment of surgical staff members and space
- Reduction of the usual use of imaging, laboratory testing, and other ancillary services
- Transfer of patients to other institutions in the state, interstate region, or nationally.

- Facilitation of home-based care for patients in cooperation with public health and home care agencies
- Facilities should consider cohorting surge capacity patients rather than spread them out. This cohorting will also be necessary for pediatric and adolescent patients.
- Specifically for hospitals:
  - Expansion of critical care capacity by placing select ventilated patients on monitored or step-down beds; using pulse oximetry (with high/low rate alarms) in lieu of cardiac monitors; or relying on ventilator alarms (which should alert for disconnect, high pressure, and apnea) for ventilated patients, with spot oximetry checks
  - Conversion of single rooms to double rooms or double rooms to triple rooms if possible
  - Designation of 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 of these areas to cohort those health care providers caring for contagious patients to minimize disease transmission to uninfected patients
  - Use of cots and beds in flat space areas (e.g., classrooms, gymnasiums, lobbies) within the hospital for non-critical patient care
  - Avert elective admissions at tertiary hospitals and discharge patients to rehab or a SNF or to home healthcare.
  - Obstetrics (OB) is to be considered as a “clean” unit (no infectious patients should be placed in OB), but may be filled with other “clean” patients only as a last resort.
  - Any unit that is used for immuno-suppressed patients should be treated in the same way as the OB unit and thus should not be counted as inpatient surge capacity beds.
  - Nursery beds are not to be considered as potential inpatient surge capacity beds even for infants, since these beds are used only for neonates <28 days. If an infant with an infectious disease or with trauma is brought in, the infant is to be placed in pediatrics (PEDS).

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

- Waiting Rooms
- Wings previously used as inpatient areas that can be reopened
- Conference Rooms
- Physical Therapy Gyms
- Medical Office Buildings
- Parking Lots
- Temporary shelters on facility premises (including cots in tents)

Obviously, there is a hierarchy among these rooms as to which would best and first be used as patient/inpatient surge capacity treatment areas. This selection of areas to be used for surge capacity can best take place when the facility has an understanding of the intensity of the incident and the resulting number of surge patients that it may receive. Collaboration and the establishment of alert protocols with Emergency Medical Services, First Responders and the Emergency Operations Center (EOC) will provide facilities with the necessary information to implement the appropriate number of patient/inpatient surge capacity.

2.5 Surge Capacity and Triage

There are two planning aspects that can augment surge capacity, the "what" and the "where". The "what" relates to the pre-event planning of sorting patient care capacity based on triage color codes (red, yellow, green or black). Thus, a facility's surge capacity plan should consider identifying which

patient care areas can best serve the needs of a type of patient. Whereas the "where" enables employing the right amount and types of resources based on the needs of the victims.

2.5.1 The What

The "what" relates to the pre-event planning of sorting patient care capacity based on triage color codes (red, yellow, green or black). Thus, a facility's surge capacity plan should consider identifying which patient care areas can best serve the needs of a type of patient.

Surge capacity could be initially designated by the following triage color codes. **Note the triage color codes are not the same as the surge color codes and are to be used as independent color codes for their respective context**:

- RED patient care areas are to be designated for the care of patients in need of immediate care. These RED patient care areas, which need to be similar to ED rooms with the required gases and equipment. Examples of such rooms are Post Anesthesia Care Unit PACU and Intensive Care Unit (ICU) rooms or, if necessary, a medical/surgical room.
- YELLOW patient care areas are to be designated for the care of patients, whose treatment can be delayed. These are medical/surgical areas that are in close proximity to existing medical/surgical rooms and also in close proximity to ancillary services and supplies.
- GREEN patient care areas are to be designated for care of patients that are ambulatory and thus their injuries may be of a minor nature. GREEN patients could be directly transported to outpatient treatment centers
- BLACK patient care areas are to be designated for the palliative or comfort care of patients and may be rooms that are more distant from the core acute care service areas.

Note, as in the field, all these patients will need to be constantly re-triaged. The color designation may change several times for these patients[161].

2.5.2 The Where

The "where" enables employing the right amount and types of resources based on the needs of the victims. An applicable model to look at would be the one used by military medical departments. The Health Service Support on Battlefield doctrine employs Echelons of Care. The term echelon is used to describe the phased system of health care delivery in the Theater of Operations (such as from the forward line of troops (FLOT) Echelon I, back to the continental United states (CONUS) Echelon V). Each higher echelon reflects an increase in medical capability while it retains the capabilities found in the lower echelons. At Echelon I, the medic makes medically substantiated decisions on the field (including triage decisions) as well as provides emergency medical treatment, while at Echelon V, facilities are staffed and equipped to provide care for all categories of casualties.

Employing Echelons of care, to field triage would ensure that victims are routed to the right types of care areas, from field to community clinics, surgery centers, acute care hospitals or even to hospice care centers and thus employing only appropriate level and amounts of scarce resources. A detailed discussion of Echelons of Care can be found at:
https://ccc.apgea.army.mil/sarea/products/textbook/Web_Version/chapters/chapter_13.htm#Unit%20level

2.6 Role of Clinics and other Outpatient Facilities

Community clinics, including Indian health clinics operated by tribal government entities, have a significant role in providing medical care to underserved urban and rural communities. While their capabilities are limited, they are likely to be significant points of convergence for ambulatory patients seeking care because:

- “Victims often seek medical care in settings they are familiar with, such as a personal physician’s office;
- When medical surge demands severely challenge hospitals, patients may seek care at other healthcare facilities;
- Some victims’ treatment requirements may be adequately managed in these smaller settings; and
- Certain events, such as a biological agent release, may be prolonged in duration and generate patients that can be safely evaluated in these settings, thus relieving some of the burden on larger healthcare facilities". (The CNA Corporation, *Medical Surge Capacity and Capability: A Management System for Integrating Medical and Health Resources During Large-Scale Emergencies*, August 2004)

According to California Emergency Medical Services Authority, *California Disaster Medical Response Plan*, January 24, 2007, the use of off site facilities, such as freestanding Outpatient Surgery Centers, for treatment of specified injuries (orthopedic or abrasion/lacerations which require more than first aid) will free up necessary resources at the hospital. Increasingly, licensing, accreditation, and funding agencies require community clinics to develop disaster response plans and perform hazard vulnerability assessments.

Urgent care centers, dialysis clinics, and other non-hospital facilities also provide essential medical services. Following a catastrophic disaster these facilities, along with community clinics, have several potential response roles and responsibilities:

- Protection of staff and patients.
- Stabilization of casualties who are injured on site or converge to the facility.
- Maintaining continuity of care to ambulatory patient base
- Creating a surge capacity resource for the treatment of stable, low priority incident and/or non-incident patients
- Creating a venue to establish specialty disaster services, such as blood donation stations, worried well centers, and mental health services.
- Participation, consistent with the organization’s mission, capability and role as planned and provided for in the local system, in the OA’s medical and health response.
- If unable to provide services, referring both usual patients and disaster victims to appropriate alternative sources of medical care.
- In addition to keeping the facility open, provide assistance with recruiting medical personnel or volunteers to augment staff at other health care facilities or service sites.
- Supporting OA medical response through language services and outreach and information dissemination to limited-English proficient and isolated communities.
- Rapid restoration of function to provide services to its usual patient population.

To meet these responsibilities, non-hospital facilities should:

- Develop and exercise disaster plans for internal and external emergencies both separately and simultaneously.
- Train staff in disaster operations including operating under Incident Command System (ICS).
- Establish communication and coordination links with their MHOAC and as specified in local plans.
- Prepare their facilities by mitigating non-structural hazards

California Primary Care Association's The Community Clinic & Health Center Emergency Operations Plan Template, 2004, provides extensive guidance to community clinics in the development of their emergency management plans and programs. The template contains sections for mitigation, preparedness, response and recovery. The appendix section contains extensive tools that enable

planners to develop their emergency operations plan. The document can be accessed at: http://www.emsa.ca.gov/hbppc/hbppc.asp. The next update to the plans is expected to include Pandemic Influenza planning and an MOU template (see the draft version of the MOU template in Appendix SC 3).

3 The Workforce

The recommended guidelines and operational tools identified in this chapter can be used by non-licensed healthcare facility managers and planners to begin developing or adapting surge and disaster response plans as necessary to ensure appropriate and adequate personnel coverage during a surge. The primary goal of this content is to enable surge response through analysis of current standards and identification of waivers. To accomplish this, the content in this section covers the following areas:

- **Management and Organization of Personnel:** outlines how existing staffing regulations and staffing plans are affected once personnel are deployed to a facility, and what facilities' obligations are for their workforce. This section specifically addresses facilities' responsibility to develop plans to address key issues such as staffing regulations, staff assignments, and training, as well as to safeguard the health and safety of the workforce, provide support services such as dependent care, and ensure workforce resiliency.
- **Credentialing / Personnel Verification:** provides an overview of the current standards for the credentialing and privileging processes, how these may be streamlined during a surge, and what it entails for healthcare professionals.
- **Scope of Practice and Professional Liability:** provides analysis for standards and guidelines related to professional liability and scope of practice as they pertain to personnel working during surge. This section specifically covers the liability issues associated with caregivers delivering care outside of their licensed scope of practice in order to ensure an optimal population outcome and identifies waivers and potential flexing of current standards that will enable staff members to work during surge with reduced liability. Additionally, this section provides staff coordinators with the ability to utilize staff in non-traditional roles that provide for the optimal outcome in an emergency.

3.1 Augmenting Workforce

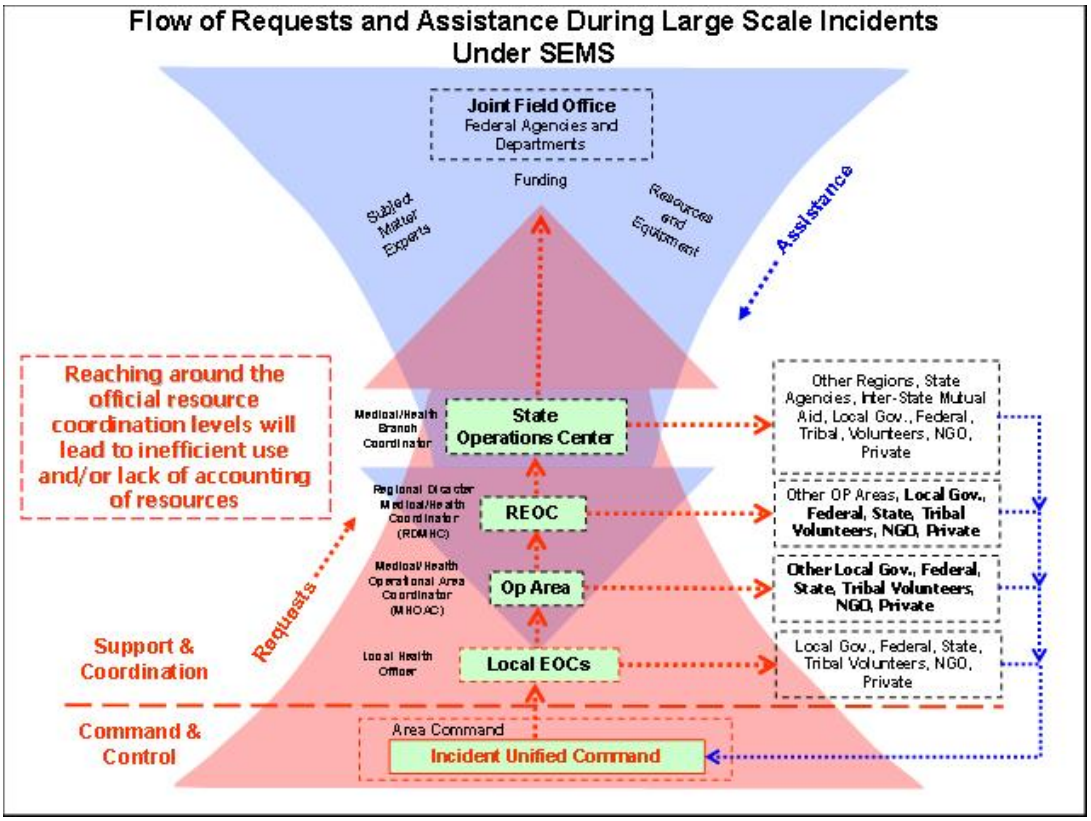
During a surge, non-licensed healthcare facilities may need to build a new workforce to adequately respond to the event. This section outlines the role of the Standardized Emergency Management System (SEMS) in acquiring personnel, how to identify additional personnel through various sources including registries such as ESAR-VHP and MRC and how to register personnel and assign them to job duties. This section also includes tools to help in the planning for augmenting the workforce.

3.1.1 Role of SEMS in Acquiring Personnel

The Standardized Emergency Management System (SEMS) is the system required by Government Code § 8607 (a) for managing response to multi-agency and multi-jurisdiction emergencies in California. SEMS consists of five organizational levels that are activated as necessary: field response which includes the on-scene responders, local government which includes county, city or special districts, operational area (OA) which includes the responsible jurisdictions within the boundary of a country, region includes operational areas and state which includes coordination integrated with federal agencies. The five SEMS organization levels, together with the private sector, represent all resources available within the State that may be applied in disaster response and recovery phases.

According to SEMS, resource requests for response and recovery originate at the level of government where the needs are unmet and are progressively forwarded to the next higher level until filled. All public health functions should be incorporated into SEMS system through the Mutual Aid System concept. The CDHS Emergency Response Plan defines mutual aid as voluntary assistance provided by agencies, local governments, and the State in the form of additional resources, facilities and other support whenever jurisdictions' resources prove to be inadequate to cope with a given situation.

The following diagram, sourced from the CDHS Emergency Response Plan, illustrates the mutual aid system concept and the general flow of requests and resources.



Medical and health coordination, at the OA level, is accomplished through the designated Medical/Health Operational Area Coordinator (MHOAC). Each California OA appoints a MHOAC to provide a 24-hour, seven day a week single point of contact for disaster medical and health operations. The local health officer of the LEMSA administrator (or designee) is usually assigned the position of the MHOAC. The MHOAC is responsible for coordinating mutual aid support for both the public and private sector within the OA, and responding to mutual aid resource requests. Mutual aid works on the premise that health facilities will exhaust their normal access points for personnel prior to making a formal request via the SEMS system. During a disaster the MHOAC directs the medical/health branch of the OA EOC, establishes priorities for medical and health related requests, responses and resources.

3.1.1.1 Pre-Surge Planning Recommendations

During planning, it is recommended that non-licensed healthcare facilities perform two preparatory activities: 1. Identify an Incident Commander and 2. Identify the relevant access point to the SEMS system in their respective OA.

1. An Incident Commander function should be established that will be responsible for compiling, analyzing and relaying mutual aid requests to the SEMS system during a disaster. The Incident Commander could represent an individual facility or multiple facilities within an OA that have Memorandum of Understanding (MOU) in place. The Incident Commander function should have 24-7 coverage and should be filled by personnel who are trained in the SEMS system and have working knowledge of their facility's emergency response plan. This function should not be viewed as a new position and could be merged with other existing

emergency preparedness roles already in existence at facilities.

2. One of the first tasks of the Incident Commander should be the identification of his or her SEMS contacts. It is recommended the following roles should be identified and their names and contact information should be maintained in the respective facility's emergency response plans:

    a. Local Health Department & Officer
    b. MHOAC
    c. Local EMS Agency Administrator and Medical Director
    d. OA Emergency Operations Center (EOC)

It is recommended that the Incident Commander set up an introductory meeting with his or her MHOAC and LHO. The purpose of the meeting will be to begin a working collaborative relationship with active sharing of relevant personnel information. It is important that the Incident Commander understand the staffing (including emergency credentialing) for his or her facility.

Non-licensed healthcare facilities should consider familiarizing themselves with the various “pools” by which they may acquire staff. They may opt to collaborate with (through the development of MOUs/MOAs) neighboring healthcare facilities or to acquire staff through volunteer agencies such as Emergency System for Advanced Registration of Volunteer Healthcare Professionals (ESAR-VHP), Medical Reserve Corps (MRC), and the Disaster Service Worker Volunteer Program (DSWVP). Upon acquiring staff, facilities need a mechanism by which to (1) register augmented personnel and (2) assign and track job duties.

Information and guidance related to these recommendations are presented in the next section. Along with a process flow diagram depicting the process by which facilities may accept and deploy augmented staff during surge is included as well.

3.1.2 Tool - Mutual Aid Memorandum of Understanding (MOU) – Staffing Component

The "Mutual Aid Memorandum of Understanding (MOU) – Staffing Component" Considerations is shown below. The complete tool can be found in the Operational Tools Manual.

In the event of a mass medical emergency in the State of California, 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. Resources from the state, federal, and private sector will be mobilized and deployed to augment local medical and health resources as requested and available. In order to support the delivery of care during a surge, it will be necessary to establish Memoranda of Understanding (MOUs) with neighboring healthcare facilities and create partnerships with local volunteer staffing organizations (MRCs, Community Emergency Response Teams (CERTs), etc.). MOUs between non-licensed healthcare facilities and other organizations will contain sections including, but not limited to: patient transfer, supplies, equipment and pharmaceuticals, and personnel.

Specific Principles of Understanding
A. 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. Request will follow the format as defined in Region IV Manual 3 – Medical Health Mutual Aid. 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 donated personnel will be required to present their donor 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 arriving donated 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 donated personnel.

3. Staff Support: The recipient hospital shall provide food, housing and/or transportation for donor healthcare facility 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 ninety days following receipt of the invoice.

   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.

5. Demobilization procedures: The recipient healthcare facility will provide and coordinate any necessary demobilization procedures and post-event stress debriefing.

3.1.3 Tool - List of Potential Staffing Sources during Surge – Background and Activation Information

The information contained in the following table is designed to provide surge planners and other appropriate facility representatives with a list of available resources to investigate as potential sources for augmented staffing and develop MOUs/MOAs as deemed necessary.

The "List of Potential Staffing Sources during Surge – Background and Activation Information " is shown below. The complete tool can be found in the Operational Tools Manual.

Volunteer Organization Brief Background & History	Who Is Eligible to Volunteer?	Who May Activate?	Additional Information May Be Found at:
American Red Cross (ARC) The mission of American Red Cross Disaster Services is to ensure nationwide disaster planning, preparedness, community disaster education, mitigation, and response that will provide the American people with quality services delivered in a uniform, consistent, and responsive manner. The American Red Cross responds to disasters such as hurricanes, floods, earthquakes, and fires, or other situations that cause human suffering or create human needs that those affected cannot alleviate without assistance. It is an independent, humanitarian, voluntary organization, not a government agency. All Red Cross assistance is given free of charge, made possible by the generous contribution of people's time, money, and skills. The most visible and well-known of Red Cross disaster relief activities are sheltering and feeding.	Various skills and backgrounds	The more than 750 Red Cross chapters across the country are required to respond with services to an incident within two hours of being notified.	http://www.redcross.org Information is available for both the national chapter as well as links to local chapters.

Volunteer Organization Brief Background & History	Who Is Eligible to Volunteer?	Who May Activate?	Additional Information May Be Found at:
California Medical Assistance Team (CalMAT) Three 120 person California Medical Assistance Teams (CalMATs) have been under state control to respond to catastrophic disasters. Each CalMAT consists of volunteers drawn from the private, not-for-profit, and existing State and local government health care delivery sector. The CalMATs will maintain caches that contain medical supplies, medical equipment, tents, pharmaceuticals, and interoperable (compatible) communications. The CalMAT program will be supported on-site by an EMS Authority lead Mission Support Team (MST) for administrative direction and logistical direction and re-supply.	Medical, nursing and other health care providers and logistic support staff will be recruited, trained and hired as temporary workers under this first-ever statewide medical response program.	The teams will be geographically located to serve the entire state. CalMATs would be part of the state disaster medical mutual aid system and would respond to catastrophic disasters, augment medical care, and re-establish medical care in areas of the State where hospitals or medical care systems have been damaged or overwhelmed.	http://www.emsa.ca.gov/def_comm/viii092706_d.asp CalMATs are to be fully deployable by June 30, 2007.
Community Emergency Response Teams (CERT) / Neighborhood Emergency Response Team (NERT) The Community Emergency Response Team (CERT) 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,	Various backgrounds	Battalion Call-out Teams respond to local incidents when they are requested by Incident Commanders.	http://www.citizencorps.gov/cert Information is available for both the national chapter as well as links to local chapters.

Volunteer Organization Brief Background & History	Who Is Eligible to Volunteer?	Who May Activate?	Additional Information May Be Found at:
CERT members can assist others in their neighborhood or workplace following an event when professional responders are not immediately available to help. CERT members also are encouraged to support emergency response agencies by taking a more active role in emergency preparedness projects in their community. The CERT concept was developed and implemented by the Los Angeles Fire Department (LAFD) in 1985. The Whittier Narrows earthquake in 1987 underscored the area-wide threat of a major disaster in California. Further, it confirmed the need for training civilians to meet their immediate needs. As a result, the LAFD created the Disaster Preparedness Division with the purpose of training citizens and private and government employees.			
Disaster Medical Assistance Team (DMAT) DMAT 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, non-profit, public or private organization that signs a Memorandum of Agreement (MOA) with	Doctors, Nurses, PAs, NPs, Pharmacists and Pharmacy Assistants, Paramedics, EMTs, Respiratory Techs, Lab Techs,	In addition to their federal role, DMATs can be mobilized and deployed by the EMS Authority as a medical mutual aid resource for local mass casualty incidents within the State.	http://www.ndms.dhhs.gov/teams/dmat.html California DMAT http://www.emsa.ca.gov/Dms2/dmatinfo.asp

Volunteer Organization Brief Background & History	Who Is Eligible to Volunteer?	Who May Activate?	Additional Information May Be Found at:
the DHS. DMATs 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. DMATs deploy to disaster sites with sufficient supplies and equipment to sustain themselves for a period of 72 hours while providing medical care at a fixed or temporary medical care site. In mass casualty 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. DMATs 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. Under the rare circumstance that disaster victims are evacuated to a different locale to receive definitive medical care, DMATs may be activated to support patient reception and disposition of patients to hospitals. DMATs are principally a community resource available to support local, regional, and State requirements. However, as a National resource they can be federalized	Communication Experts, and Logistical/Support Personnel interested in participating in disaster response		

Volunteer Organization Brief Background & History	Who Is Eligible to Volunteer?	Who May Activate?	Additional Information May Be Found at:
Disaster Service Worker (DSW) The State of California Disaster Service Worker Volunteer Program (DSWVP) includes public employees, and can include any unregistered person impressed 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.	There are 13 classifications of DSW volunteers including: Animal Rescue, Care & Shelter Laborer Communications Law Enforcement Community Emergency Response Logistics Team Member Medical & Environmental Health Finance & Administrative Staff Safety Assessment Inspector Human Services Search & Rescue Fire Utilities	All registered DSW volunteers should wait for official activation from their supervising authority before carrying out volunteer work. Official activation ensures the DSW volunteer the benefits and protections of the Disaster Service Worker Volunteer Program. Activation of DSW volunteers should be documented by the authorizing agency or organization.	http://www.oes.ca.gov/Operational/OESHome.nsf/PDF/Disaster%20Service%20Worker%20Volunteer%20Program%20(DSWVP)%20Guidance/$file/DSWguide.pdf
Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) ESAR-VHP is an electronic database of health	California's ESAR-VHP system currently accepts	During a State or national disaster, this system will be accessed by	http://www.hrsa.gov/esarvhp/guidelines/default.htm California ESAR-VHP

Volunteer Organization Brief Background & History	Who Is Eligible to Volunteer?	Who May Activate?	Additional Information May Be Found at:
care personnel who volunteer to provide aid in an emergency. The ESAR –VHP system can: (1) register health volunteers, (2) apply emergency credentialing standards to registered volunteers, and (3) allow for the verification of the identity, credentials, and qualifications of registered volunteers in an emergency. Implementation of California's ESAR-VHP system is currently underway. Remaining activities include: codification of policies and procedures; limited-scope exercises to test operational concepts; extensive marketing, recruitment and outreach efforts; pilots with key hospital/health care system partners; resolution of additional legal and regulatory issues; pursuit of funds for future operations; and training of system administrators. Registration is currently open.	registration from licensed nurses, physicians, pharmacists and paramedics.	authorized medical/health officials at the State Emergency Operations Center.	https://medicalvolunteer.ca.gov/ (currently serves as a volunteer registration site) Los Angeles ESAR-VHP http://www.vcla.net/esar
Medical Reserve Corps (MRC) The Medical Reserve Corps (MRC) 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 MRC is comprised of organized medical and public health professionals who serve as volunteers to respond to natural	Practicing, retired, or otherwise employed medical professionals, such as doctors, nurses, emergency medical	Activation is based on the local MRC unit.	http://www.medicalreservecorps.gov/HomePage

Volunteer Organization Brief Background & History	Who Is Eligible to Volunteer?	Who May Activate?	Additional Information May Be Found at:
disasters and emergencies. These volunteers assist communities nationwide during emergencies and for ongoing efforts in public health. There is no "typical" MRC unit. Each unit organizes in response to their area's specific needs. At the local level, each MRC unit is led by an MRC 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.	technicians, pharmacists, nurses' assistants, public health professionals, and community members without medical training (can assist with administrative and other essential support functions)		

3.1.4 Tool - Volunteer Sign-In Form[162]

This form is to serve as a sign-in sheet during a surge. It is initiated by the Labor Pool & Credentialing Unit Leader (designation under HICS) and copies are to be shared with additional stakeholders within the facility.

The "Volunteer Registration Form" is shown below. The complete tool can be found in the Operational Tools Manual.

Instructions for Use:

1. FROM DATE/TIME Indicate starting date/time of period covered by this form. 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.

2. TO DATE/TIME Indicate ending date/time of period covered by this form.

3. SECTION Indicate the Section for which this Sign-In Form is being prepared.

4. TEAM LEADER Use proper name to identify the supervisor of the personnel listed.

5. REGISTRATION Use proper name, listing last name first, of volunteers, and record complete address, Social Security number, telephone number, and certification/licensure and number. Indicate work start and end times in the Time IN and Time OUT columns. Have volunteer sign the form.

6. CERTIFYING OFFICER Use proper name to identify who verified the information on the registration form.

7. DATE/TIME SUBMITTED Indicate date and time that the form is submitted to the Time Unit Leader.

8. HOSPITAL NAME Use when transmitting the form outside of the hospital.

WHEN TO COMPLETE: Throughout activation.

HELPFUL TIPS: Data on this form may be summarized at the end of each operational period. This form is suitable for duplication using carbonless copy paper.

Volunteer Registration						
1. From Date/Time:	**2. To Date/Time:**	**3. Section/ Location:**	**4. Team Leader:**	**5. Registration:**		
Name (Last, First)	**Social Security #**	**Telephone #**	**Certification/ Licensure #**	**Time In:**	**Time Out:**	**Signature:**
6. Certifying Officer:		**7. Date/Time Submitted:**		**8. Facility Name:**		

3.1.5 Tool - Job-Action-Sheets Overview[162]

The following information reflects HICS approach to assignment of roles and activities (Job Action Sheets - JAS) to staff for a surge event. The benefit of such a framework is that tasks and responsibilities are pre-identified and augmented staff and volunteers can be assigned critical roles during surge. This HICS excerpt provides an overview of JAS design and function. Job Action Sheets are different than job descriptions, in that JAS provide an overview and checklist of the responsibilities for a given position (role) during a surge, while job descriptions provide a detailed outline of how to perform the assigned tasks of a given position.

The "Job-Action-Sheets Overview" is shown below. The complete tool can be found in the Operational Tools Manual.

Surge Staff Planning Recommended Approach - Using the Job Action Sheets
The Job Action Sheet (JAS) is an incident management tool designed to familiarize the user with critical aspects of the command position he or she is assuming. Information provided on a JAS includes a radio identification title, purpose, to whom they report, and critical action considerations. These tasks are intended to "prompt" the incident management team members to take needed actions related to their roles and responsibilities. The Job Action Sheets included with HICS have been extensively revised and include more action steps listed by time periods; a new Demobilization and System Recovery time period has also been added. The JAS format allows for personnel to document each action undertaken and record decision timeframes. The new JAS also graphically depicts the position within the incident management team and highlights reporting relationships. The information below provides an overview of JAS purpose and format, which will assist the reader in understanding the value of implementing such tools.

Purpose: To provide the user with a series of action options to consider when serving in a particular command role.

Use: The Hospital Incident Command System currently provides 78 Job Action Sheets (JAS) for addressing all types of healthcare facility needs. However, in most cases only a portion of these positions will be necessary for a successful response. The items listed are minimum considerations for developing a JAS. A variety of other considerations may be included, based on healthcare facility size, available resources, or response needs. Thus, each healthcare facility can take the prepared JAS and use them as written, modify them as needed, or craft their own, unique JAS using the HICS model as a template.

Format: The key format considerations for each JAS are the same and include the following information:

- Command Title – the name of the position
- Mission – a brief statement summarizing the basic purpose of the job
- Fundamental Information Box – details information pertaining to who is assigned the position, where they are physically located, and basic contact information
- Action Considerations – suggested action steps listed by operational periods; the time periods are listed as:
  - Immediate 0–2 hours
  - Intermediate 2–12 hours
  - Extended Beyond 12 hours
  - Demobilization/System Recovery
- Documents/Tools – a listing of pertinent HICS forms this position is responsible for using, along with other tools that will help them fulfill their role and responsibilities.

The JASs are designed to be customized, but healthcare facilities are encouraged to maintain the prescribed format and terminology as a means of ensuring the standardization benefit of NIMS. Each healthcare facility should look closely at the items listed in the Documents/Tools Section and make

modifications appropriate for their facility and community. The format also allows for the JASs to be used to preliminarily document actions taken during the incident and assist in developing a chronology of events, problems encountered, and decisions made.

When each JAS review is complete, it is recommended that one set be laminated and multiple paper copies duplicated for use and documentation during response. The JASs should be kept with the Incident Command identification (vest) for the position, along with needed administrative items such as pens and paper.

All personnel assigned to an incident command role should wear identification that correctly communicates his or her role. Many healthcare facilities use a vest for this purpose. Each vest should clearly identify the HICS position title on the front and back in both normal and low-light conditions. The vests may also be color-coded to the HICS incident management team chart (grey/black – Command Staff; red – Operations; blue – Planning; yellow – Logistics; and green – Finance/ Administration). They should contain large pockets for holding a portable radio, tablet, pens, markers, and a Job Action Sheet (JAS). The vests should be readily available from a secure location and regularly checked to make sure they have the required items

3.1.6 Tool - Job-Action-Sheet for Personnel Staging Team Leader[162]

The HICS job action sheet (JAS) below identifies the role and responsibilities for the personnel staging team leader. This particular JAS represents the lead position of the staffing coordinator. This JAS is intended to provide the reader with an example. There are 78 JASs in HICS and as indicated earlier, planning for and adopting these JASs and identified positions will depend on the needs and capabilities of each facility responding during a surge.

The "Job-Action-Sheet for Personnel Staging Team Leader Tool" is shown below. The complete tool can be found in the Operational Tools Manual.

PERSONNEL STAGING TEAM LEADER

Mission: Organize and manage the deployment of supplementary personnel resources.

Date: _____ Start: _____ End: _____ Position Assigned to: _____
Initial: _____ **Position Reports to: Staging Manager**
Signature: _____
Hospital Command Center (HCC) Location: _____
Telephone: _____ Fax: _____
Other Contact Info: _____ Radio Title: _____

Instructions for Use:

For each action item identified for the individual designated as the Personnel Staging Team Leader, the time it was completed as well as the individual's initials will be documented.

Immediate (Operational Period 0-2 Hours)	Time	Initial
Receive appointment and briefing from Staging Manager. Read the Job Action Sheet and put on position identification.		
Develop initial action plan with other Staging Team Leaders. Designate time for follow-up meeting.		
Notify your usual supervisor of your HICS assignment.		

Appoint Personnel Staging Team members and complete the Branch Assignment List (HICS Form 204).		
Document all key activities, actions, and decisions in an Operational Log (HICS Form 214) on a continual basis.		
Coordinate delivery of needed personnel resources to requesting areas in coordination with Labor Pool & Credentialing Unit and Transportation Unit Leader.		
Brief Team on current situation. Designate time for follow-up meeting.		
Establish and maintain contact with Planning Section's Personnel Tracking Manager and Logistics Section's Labor Pool & Credentialing Unit Leader to share information and personnel status.		
Instruct all Team members to evaluate personnel needs; report status to Staging Manager and Labor Pool & Credentialing Unit Leader.		
Assess problems and needs in each unit area; coordinate resource management.		
Establish regular meetings with Staging Manager to discuss plan of action, critical issues and staffing.		
Document all communications (internal and external) on an Incident Message Form (HICS Form 213). Provide a copy of the Incident Message Form to the Documentation Unit.		

Intermediate (Operational Period 2-12 Hours)	**Time**	**Initial**
Continue coordinating delivery of needed personnel, working with the Logistics Section.		
Ensure prioritization of problems when multiple issues are presented.		
Ensure documentation is done correctly and collected.		
Report resource problems and issues Logistics Section.		
Coordinate use of external resources.		
Continue to meet regularly with Staging Manager for status reports, and relay important information.		
Ensure your physical readiness through proper nutrition, water intake, rest, and stress management techniques.		
Advise Staging Manager immediately of any operational issue you are not able to correct or resolve.		
Ensure staff health and safety issues being addressed; resolve with Safety Officer, Staging Manager and Employee Health & Well-Being Unit, as appropriate.		

Extended (Operational Period Beyond 12 Hours)	**Time**	**Initial**
Continue to monitor Personnel Staging Team members' ability to meet workload demands, staff health and safety, resource needs, and documentation practices.		
Coordinate assignment and orientation of external personnel assigned to Staging Team.		
Work with Staging Manager and Logistics Section on the assignment of external resources.		

Observe all staff and volunteers for signs of stress and inappropriate behavior. Report concerns to Staging Manager and Employee Health & Well-Being Unit.		
Rotate staff on a regular basis.		
Continue to document actions and decisions on an Operational Log (HICS Form 214) and submit to the Staging Manager at assigned intervals and as needed.		
Continue to provide Staging Manager with periodic situation updates.		
Request mental health assistance for staff from Employee Health & Well-Being Unit as needed.		

Demobilization/System Recovery	Time	Initial
As needs for Personnel Staging Team staff decrease, return staff to their normal jobs and combine or deactivate positions in a phased manner.		
Continue to participate in briefings and meetings as requested.		
Assist Staging Manager, Operations Section Chief and Team members with restoring healthcare facility resources to normal operating condition.		
Ensure return/retrieval of equipment and supplies and return all assigned incident command equipment.		

3.1.7 Tool - Staff Assignment Tracking Sheet

As part of the staffing plan to be outlined for coordination of staff, this tracking sheet allows staff coordinators at non-licensed healthcare facilities the ability to assign roles and responsibilities (Job-Action-Sheets) prior to and during surge. Pre-assigned surge team members of a facility will have explicit roles during surge. In addition, for non-licensed healthcare facilities that have pre-determined agreements (MOUs/MOAs) with neighboring healthcare facilities or volunteer organizations, this sheet will allow augmented staff to be assigned roles as well prior to a surge. In the event that augmented staff do not arrive from pre-determined sources, or additional staff arrive as walk-in volunteers, this sheet, in conjunction with the surge staffing plan and job actions sheets will allow staff coordinators to assign and track responsibilities for all such augmented staff.

The "Staff Assignment Tracking Sheet" is shown below. The complete tool can be found in the Operational Tools Manual.

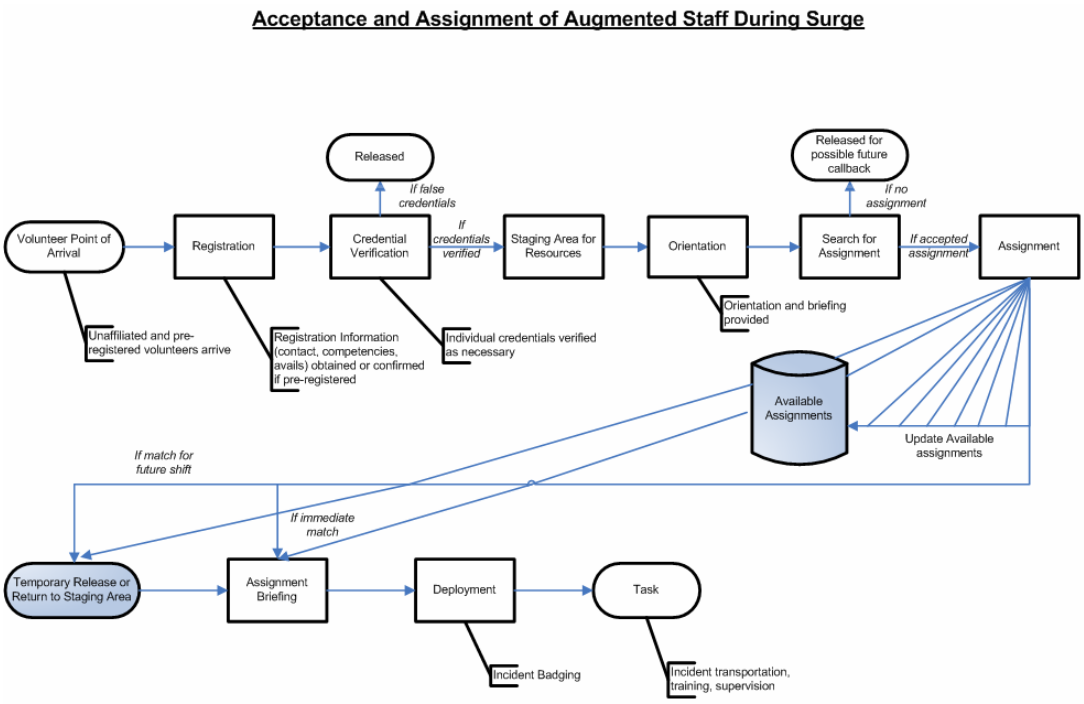
Instructions for Use: For each staff person assigned to a facility, the staffing coordinator of designated individual will document their: name, assigned staff ID#, their assigned Job-Action-Sheet (JAS) title, their assigned roles and responsibilities, the name of the individual who has oversight responsibility, and the date the staff person's training and orientation were completed.

Staff Assignment Tracking Sheet					
Name (Last, First)	**Staff ID #**	**JAS Title**	**Surge Roles & Responsibilities**	**Supervisor/Oversight**	**Date Training/Orientation Completed**

3.1.8 Tool - Process Flow for Acceptance and Assignment of Augmented Staff during Surge[163]

3.1.9

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



The "Acceptance and Assignment of Augmented Staff during Surge" Process Flow is shown above. The complete tool can also be found in the Operational Tools Manual.

3.2 Organizing Personnel

This section addresses facilities' need to develop plans to address key issues such as staffing regulations, staff assignments and training. During a surge existing standards and regulations for these issues may be compromised and non-licensed healthcare facilities must be prepared to respond in not only an effective manner but also a timely one. Several tools are included in this section to facilitate the efficient organizing of personnel at a non-licensed healthcare facility.

3.2.1 Current Standards and Analysis

During a surge, there are two types of staffing regulations to be considered:

> (1) A healthcare emergency may cause a significant volume change; therefore the clinic must demonstrate that prompt efforts were made to maintain required staffing levels.
>
> (2) Business & Professions Code §3516 states that no physician shall supervise more than two physician assistants at any time. Additionally, Business & Professions Code §3502.5 allows for physician assistants, during a state of war emergency, state of emergency, or state of local emergency, to provide patient care regardless of whether the physician assistant's approved supervising physician is available so long as a licensed physician is available to render the appropriate supervision.

Government Code §8571 states that during a state of war emergency or state of emergency the Governor may suspend any regulatory statute, or statute prescribing the procedure for conduct of state business, or the orders, rules or regulations of any state agency, including subdivision (d) of Section 1253 of the Unemployment Insurance Code, where the Governor determines and declares that strict compliance with any statute, order, rule or regulation would in any way prevent, hinder, or delay the mitigation of the effects of the emergency.

3.2.2 Guidelines and Recommendations

It is recommended that non-licensed healthcare facilities should plan for staffing for the first 72 hours of a mass casualty incident. During this time period, especially if other facilities are involved, there may not be the ability to call upon other organizations for assistance or to begin to recruit volunteers to assist, given the time necessary to implement these processes.

As such, it is recommended:

- Staffing plans should encompass not only clinical roles such as RNs and how they may be assigned to different duties based on the designated patient care levels, but also ancillary support staff.
- Matrices should be developed to assist staffing supervisors to identify specific staff types.

In preparing these staffing plans and matrices, it should be noted however, that "fewer ancillary staff would necessitate more nursing staff to accomplish tasks normally the responsibility of ancillary staff."[164]

The following tools present non-licensed healthcare facilities with various options in terms of surge staffing strategies and plans, staff utilization matrices (both for nursing and for ancillary support staff) as well as recommended medical staff bylaw language allowing licensed healthcare practitioners to provide care without supervision during a surge.

3.2.2.1 Tool - Staffing Strategy for RNs during Surge[165]

Outlined in the Guidelines for Managing Inpatient and Outpatient Surge Capacity, the Wisconsin State Expert Panel has developed the following staffing strategy to be used as a best practice for planning for surge staffing. As the most current guidance on this topic the Wisconsin Guidelines is referenced here as a model or sample for both existing facilities and ACSs.

The "Staffing Strategy for RNs during Surge Tool" is shown below. The complete tool can be found in the Operational Tools Manual.

In the first 72 hours of a surge, there will be limited additional staff therefore, the following staffing strategies have been identified to extend the staff capacity of a healthcare facility:

- **Strategy One**: Staffing ratios will need to be adapted to the need. Each of the designated patient care levels (Critical, Complex/Critical, Basic, and Supportive) will require different staffing ratios.
- **Strategy Two**: 8 hour shifts may be changed to 12 hour shifts.
- **Strategy Three**: Work tasks are to be prioritized so that only essential patient care tasks are provided by staff.
- **Strategy Four**: Healthcare facilities are to consider flexing scope of practice of staff to provide necessary care with available staff (when authorized by the Governor during a declared state of emergency to allow flexed scope of practice).
- **Strategy Five**: The healthcare facilities can use the media to contact volunteer health care workers or acquire staff through established MOUs and partnerships with other facilities and alternate labor sources such as MRCs, Community Emergency Response Teams (CERTS), etc.

<u>Assignment of Staff to Designated Patient Care Levels</u>
In a surge incident, it is most likely that the healthcare facility will not have the appropriate staffing complement of RNs and other staff. The organization will need to assign available staff and volunteers to the designated care levels, based on the staff level and scope of practice. The following minimum skill sets that staff should have in order to provide patient care, based on the care level designation of the patient are recommended below:

1. Staff skills necessary to care for Critical patients: These are to be staff or volunteers, who are acute care RNs and Residents, who can perform primary and secondary assessment of critical care patients. The healthcare facility can also use acute care LVNs, technicians, PCAs and student nurses to assist these RNs and Residents; this will allow for increased productivity of these RNs and Residents.

2. Staff skills necessary to care for Complex/Critical patients: These are to be staff or volunteers, who are RNs and LVNs, who can perform initial and on-going assessment of patients and who are presently employed either in acute care settings or in non-healthcare facility work sites.

3. Staff skills necessary to care for Basic and Supportive patients: These are to be staff or volunteers, who are comfortable with death and dying, such as hospice volunteers, clergy, social workers, retired healthcare workers, healthcare facility volunteers, and members of service organizations such as the American Red Cross. It will be necessary to have a RN supervisor and Team Leader in each area to assess these staff, their skills and their stress and rehabilitation needs.

3.2.2.2 Tool - Sample Estimated Staffing Levels for Surge Facility Scenarios

Recommended by the Agency for Healthcare Research and Quality in its report on Reopening Shuttered Hospitals to Expand Surge Capacity[166], the following table is presented as a recommendation for staffing levels. It may be customized depending on the level of care provided at

each non-licensed healthcare facility but provides an overview of the different roles (both clinical and administrative) whose presence will be necessary.

The "Sample Estimated Staffing Levels for Surge Facility Scenarios Tool" is shown below. The complete tool can be found in the Operational Tools Manual.

Staff Type	Staff	Scenario 1: Medical/Surgical	Scenario 2: Infectious Disease	Discussion
Physician and Physician Extenders	Chief Medical Officer	1	1	One person responsible for medical care 24 hours per day/ 7 days per week. Physically onsite 8 hours/ day, M-F, available off-shift and weekends.
	Internist	3-7 FTEs/ 7AM-7PM 1 FTE/ 7PM – 7AM	3-7 FTEs/ 7AM-7PM 1 FTE/ 7PM-7AM	Each MD, assuming 10-15 minutes per patient, could see 48-72 patients over 12 hours (7A-7P) plus at least one person for night coverage (7P-7A).
	Radiologist	As needed	As needed	Adjust according to patient acuity. May be an increased need with an infectious disease population.
	Infectious Disease Specialist	As needed	As needed	Likely only needed for infectious disease population.
	Nurse Practitioner/ Physician Asst	As needed to supplement internists or nurses	As needed to supplement internists or nurses	Must work under the supervision of an MD, could supplement internist coverage if adequate number of physicians not available or supplement nursing coverage (supervisor or RN).
Nursing	Nursing Director	1 RN	1 RN	One person responsible for nursing care 24 hours per day/ 7 days per week. Physically onsite 8 hours/ day, M-F, available off-shift and weekends.
	Supervisor	1 RN per shift	1 RN per shift	Prefer RN supervisor, but if none available, an experienced LPN would suffice.
	RN	1:5-1:15 RN to	1:5-1:15 RN to	Could go as high as

Staff Type	Staff	Scenario 1: Medical/Surgical	Scenario 2: Infectious Disease	Discussion
		patient ratios	patient ratios	1:40 with adequate LPN, nurse aide and ancillary staff coverage, but highly dependent on patient acuity. Precaution procedures in an infectious disease scenario would require increased staffing levels to accommodate the additional time needed for gowning, disposal of medical waste, etc.
	LPN	1:5-1:15 RN to patient ratios	1:5-1:15 RN to patient ratios	Could go as high as 1:40 with adequate LPN, nurse aide and ancillary staff coverage, but highly dependent on patient acuity. Precaution procedures in an infectious disease scenario would require increased staffing levels to accommodate the additional time needed for gowning, disposal of medical waste, etc.
	Nurse Aide	1:6 (day shift) 1:8 (eve shift) 1:15 (night shift) NA to patient ratios	1:6 (day shift) 1:8 (eve shift) 1:15 (night shift) NA to patient ratios	Adjust nurses up or down according to licensed nurse coverage and ancillary staff support. Precaution procedures in an infectious disease scenario would require increased staffing levels to accommodate the additional time needed for gowning, disposal of medical waste, etc.
Allied Health	Dietitian	1 FTE RD	1 FTE RD	Dependent on the level of supervision needed in Dietary Department, number of admissions and discharges, level of patient acuity.
	Discharge Planner	2-4 FTEs (M-F normal business hours) Discharge planners or social	2-4 FTEs (M-F normal business hours) Discharge planners or social	Adjust as needed according to number of admissions and discharges. Assumed one SW per two units

Staff Type	Staff	Scenario 1: Medical/Surgical	Scenario 2: Infectious Disease	Discussion
		workers	workers	(80 beds).
	EKG Technician	1 FTE to cover 7AM-3PM, M-F	1 FTE to cover 7AM-3PM, M-F	In no EKG tech available, EKGs may be done by nurses, NP/PAs, physicians, EMTs. Interpretation done by physician or interpretive software program if available.
	Laboratory Technician	2.1 FTEs (7AM-7PM, 7 days/week) One person to run basic haematology, chemistry, urinalysis, bacteriology tests. Assume no blood bank, no type and x-match needed.	2.1 FTEs (7AM-7PM, 7 days/ week) One person to run basic haematology, chemistry, urinalysis, bacteriology tests. Assume no blood bank, no type and x-match needed.	Adjust up according to the number of specimens processed. May not be needed if specimens are sent out. Nursing able to perform certain screens (e.g., dipstick urine, hemoccult) on the unit.
	Medical Records	1 FTE	1 FTE	Adjust up according to the number of admissions and discharges.
	Mental Health Worker/ Social Worker	2-4 FTEs (M-F, 8AM-4PM)	2-4 FTEs (M-F, 8AM-4PM)	Adjust up according to patient, family and staff needs. Assumed one SW per two units (80 beds).
	Pharmacist	2.1 FTEs RPh (7AM-7PM, 7 days/week)	2.1 FTEs RPh (7AM-7PM, 7 days/week)	Adjust up according to patient needs. If drugs were supplied from another location, would not be needed.
	Pharmacy Technician	1-2 FTEs CPhTs	1-2 FTEs CPhTs	Adjust up according to patient needs. Must be supervised by pharmacist.
	Phlebotomist	1 FTE able to perform venipuncture 7AM-3PM, M-F	1 FTE able to perform venipuncture 7AM-3PM, M-F	If not available, some nurses, NP/PAs, physicians and EMTs would be able to draw blood.
	Respiratory Therapist	1 FTE RT needed primarily to set up, monitor and troubleshoot problems with ventilators	1 FTE RT needed primarily to set up, monitor and troubleshoot problems with ventilators	Adjust according to patient needs. Nurses/ physicians/ NP/PAs, and EMTs are able to assess lung sounds, provide chest physical therapy.
	X-Ray Technician	1 FTE	1 FTE	May not be needed on a daily basis, but

Staff Type	Staff	Scenario 1: Medical/Surgical	Scenario 2: Infectious Disease	Discussion
				requires specialized skills. It's likely that coverage would not be available from other staff types.
All Other Types of Staff	Administrative Support	3-6 FTEs (8AM-4PM, M-F)	3-6 FTEs (8AM-4PM, M-F)	Includes payroll (1 person), billing (1 person) and 1-4 people to assist with unit clerk-level work
	Biomedical Engineering	1 FTE 7AM-3PM, M-F and on-call	1 FTE 7AM-3PM, M-F and on-call	As needed to deal with problems associated with medical monitoring equipment
	Central Supply/ Materials Management	2-4 FTEs 1-2 people covering 7AM-7PM, 7 days/week	2-4 FTEs 1-2 people covering 7AM-7PM, 7 days/week	To oversee ordering, distribution of supplies. Adjust up as needed based on acuity of patients.
	Food Service Supervisor	1 FTE (M-F, 8AM-4PM)	1 FTE (M-F, 8AM-4PM)	To oversee the dietary department, order food and supplies, schedule dietary staff.
	Cook	2-4 per meal	2-4 per meal	Food Service Supervisor may also act as cook.
	Food Service Workers	4-6 per meal	4-6 per meal	Increased staff needed at peak meal times.
	Housekeeping	5-9 people 7AM-7PM 1-2 people 7PM-7AM	5-9 people 7AM-7PM 1-2 people 7PM-7AM	Assuming one person per unit (40 beds) plus one person for common areas, trash from 7AM-7PM. 1-2 people 7PM-7AM.
	Human Resources	1 FTE (M-F, 8AM-4PM)	1 FTE (M-F, 8AM-4PM)	Assist with staff support/ dependent care. May need to recruit dependent care staff/volunteers to cover all shifts as needed.
	Laundry			Adjust depending on equipment available and acuity of patients Assuming three complete bed changes per day.
	Maintenance	3-4 FTEs (1-3 people, 8AM-4PM, 7 days per week)	3-4 FTEs (1-3 people, 8AM-4PM, 7 days per week)	May assist with housekeeping, safety and security as needed.
	Morgue Worker	1 FTE	1 FTE	As needed.
	Public	1 FTE	1-2 FTEs	An infectious disease

Staff Type	Staff	Scenario 1: Medical/Surgical	Scenario 2: Infectious Disease	Discussion
	Information Specialist			scenario would likely require more communication with media, families, etc.
	Safety Manager	1 FTE	1 FTE	May have maintenance responsibilities also.
	Security	8-12 FTEs (1-3 people per shift, 7 days per week, 24 hours per day)	8-12 FTEs (1-3 people per shift, 7 days per week, 24 hours per day)	Adjust according to scenario, number of entrances, facility location
	Transport	1.5-3 FTEs (1-2 people covering M-F, 7AM-7PM)	1.5-3 FTEs (1-2 people covering M-F, 7AM-7PM)	Adjust according to staff availability. All staff capable of transport.
	Volunteers	As available	As available	Assist with transport, delivery of supplies and meals, administrative/clerical functions, dependent care, etc.

3.2.2.3 Tool - Ancillary Support Matrix

The following sample staff utilization matrix, is adapted from another example[167] set forth by the Wisconsin State Expert Panel in its guidance on surge capacity. It provides non-licensed healthcare facilities with a template and guidelines for Ancillary staffing needs for a facility operating in surge. This document provides recommendations for maintenance of ancillary staff during a surge to maintain day-to-day operations as well as meet the expanded needs; sample matrices are provided. Ancillary staffing recommendations follow the matrices provided below.

The "Ancillary Support Matrix" is shown below. The complete tool can be found in the Operational Tools Manual.

Instructions for Use

Ancillary 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 or ACS with the surge of patients. The following ancillary departments are to complete their staffing plans (based on the template above) and strategies:

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

- Dialysis

Each department is to complete its own staff utilization matrix but is to collaborate to determine which staff can be pulled from other departments to assist with these functions so that departments do not identify and depend upon the same staff.

Ancillary 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			

3.3 Credentialing/ Personnel Verification

This section of the document provides an overview of the current standards for credentialing and the verification of qualifications of personnel ("personnel verification") as well as an analysis of how, or the extent to which, these standards may be flexed during a surge. Specific guidelines and processes (in the form of operational tools) as to how these processes may be streamlined during a surge are also provided, as appropriate.

3.3.1 Streamlined Credentialing and Privileging during Surge (Licensed Independent Practitioner)

3.3.1.1 Current Standards and Analysis

During a surge, healthcare professionals may opt to volunteer their services at a location other than that which they normally work. If a physician chooses to volunteer at a hospital at which he/she is not credentialed or privileged, that physician will have to undergo a process known as "emergency credentialing" and be granted temporary disaster privileges, per Joint Commission. These same standards do no apply to physicians volunteering at a non-licensed healthcare facility; however, these facilities may choose to follow the same procedures. The following section outlines these standards and the information required so that physicians can familiarize themselves with the process.

Standard MS.4.110 in the Joint Commission Comprehensive Accreditation Manual for Hospitals (2007) states that an organization may grant disaster privileges to volunteers eligible to be licensed independent practitioners. The Rationale for this standard further states that the organization may implement a modified credentialing and privileging process for eligible volunteer practitioners (in this case, licensed independent practitioners) when the disaster plan has been implemented and the immediate needs of the patients cannot be met. The usual process to credential and privilege practitioners would not allow a volunteer practitioner to provide immediate care, treatment and services in the event of a disaster due to the length of time it would take to complete the process.

While this standard allows for a method to streamline the credentialing and privileging process, safeguards must be in place to assure that volunteer practitioners are competent to provide safe and adequate care, treatment, and services. Even in a disaster, the integrity of two parts of the usual credentialing and privileging process must be maintained:

- Verification of licensure
- Oversight of the care, treatment, and services provided

Joint Commission does not provide any formal procedure for carrying out this process, nor does it make any commitment to suspend accreditation requirements during a disaster. Healthcare providers retain the obligation to verify competency and maintain oversight of the practitioners and care delivered. If primary source verification cannot be obtained within 72 hours from the practitioner presenting to the facility, the provider must keep records of why it could not under the circumstances do the required verification check.

In order to implement this standard, organizations are held to the following criteria or performance expectations:

- Disaster privileges are granted only when the following two conditions are present: the emergency management plan has been activated, and the organization is unable to meet immediate patient needs.
- The individual(s) responsible for granting disaster privileges is identified.

- The medical staff describes in writing a mechanism (for example, direct observation, mentoring, and clinical record review) to oversee the professional performance of volunteer practitioners who receive disaster privileges.
- The organization has a mechanism to readily identify volunteer practitioners who have been granted disaster privileges.
- In order for volunteers to be considered eligible to act as licensed independent practitioners, the organization obtains for each volunteer practitioner at a minimum, a valid government-issued photo identification issued by a state or federal agency (e.g., driver's license or passport) and at least one of the following:
    - A current picture hospital or clinic ID card that clearly identifies professional designation
    - A current license to practice
    - Primary source verification of the license
    - Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), or Medical Reserve Corps (MRC), Emergency System for the Advanced Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal organizations or groups.
    - Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity)
    - Identification by current facility or medical staff member(s) who possesses personal knowledge regarding volunteer's ability to act as a licensed independent practitioner during a disaster.
- Primary source verification of licensure begins as soon as the immediate situation is under control, and is completed within 72 hours from the time the volunteer practitioner presents to the organization. **Note**: *In the extraordinary circumstance that primary source verification cannot be completed in 72 hours (e.g., no means of communication or a lack of resources), it is expected that it be done as soon as possible. In this extraordinary circumstance, there must be documentation of the following: why primary source verification could not be performed in the required time frame; evidence of a demonstrated ability to continue to provide adequate care, treatment, and services; and an attempt to rectify the situation as soon as possible.*
- The medical staff oversees the professional practice of volunteer licensed independent practitioners.
- The organization makes a decision (based on information obtained regarding the professional practice of the volunteer) within 72 hours related to the continuation of the disaster privileges initially granted.

3.3.1.2 Guideline and Recommendation

An alternative to non-licensed healthcare facilities conducting their own credentialing process is the use of volunteers from ESAR-VHP and MRC. The credentials of volunteers registered with ESAR-VHP are validated prior to an emergency so that they may be deployed quickly to facilities in need. Similarly practitioners who are registered with MRCs may also have completed the credentialing process prior to the emergency; however the determination to offer this process is made at the local MRC Unit level. Since there is a fee associated with credential verification, it may be cost-prohibitive for some of the small Units.

Calling upon these volunteers may be a more feasible solution for facilities which do not conduct this process. Should a non-licensed healthcare facility decide to independently complete this process, certain considerations should be made. Additionally current policies and procedures should be updated to reflect that under a declared state of emergency the Governor has the authority to waive certain requirements that would then allow facilities to call upon otherwise unavailable practitioners (e.g., physicians with inactive or retired licenses).

It is recommended that non-licensed healthcare facilities that do not have a standardized system to credential providers, such as non-hospital affiliated clinics, use the following operational tools as

templates to streamline their credentialing and privileging process. The tools that have been drafted include:

- A recommended emergency credentialing policy
- Volunteer application form for healthcare practitioners (to be used as a credentialing form)
- A recommended credentialing matrix log to verify that all required identification has been obtained; and

3.3.1.3 Tool - Recommended Policy for Emergency Credentialing and Privileging (Licensed Independent Practitioners)[168]

The "Recommended Policy for Emergency Credentialing and Privileging" is shown below. The complete tool can be found in the Operational Tools Manual.

Although these policies are more applicable to a physician volunteering at a licensed facility or Alternate Care Site, the following policy may be adapted at non-licensed healthcare facility utilizing volunteer physicians during a surge.

Licensed independent practitioners (such as physicians, advanced practice nurses, and registered nurses) who request temporary disaster privileges during a period of officially declared emergency must be currently licensed.

Non-licensed healthcare facility medical staff bylaws/rules that address disaster credentialing should specify identification requirements for those practitioners requesting disaster privileging. At a minimum, identification should include a valid government-issued photo identification issued by a state or federal agency (e.g., driver's license or passport) and at least one of the following:

- A clinic or hospital identification card with current picture.
- A current license to practice and a valid picture identification issued by a state, federal, or regulatory agency.
- Identification indicating that the individual is a member of the California Medical Assistance Team (CalMAT) or of a Disaster Medical Assistance Team (DMAT).
- Documentation indicating that the individual has been granted authority to render patient care in disaster circumstances, such authority having been granted by a federal, state, or municipal entity.
- Presentation by current clinic or hospital or medical staff member(s) with personal knowledge regarding the practitioner's identity.

Immediate temporary disaster privileges may be granted in accordance with the bylaws/rules of the medical staff. The individual responsible for granting such privileges must be delineated in writing in the medical staff bylaws/rules and referenced in the facility's disaster (emergency preparedness) plan. The bylaws/rules should specify that this individual is not required to grant privileges to any requestor and is expected to make such decisions on a case-by-case basis at his or her discretion. The privileges should be effective immediately and continue through the completion of the patient care needs or until the orderly transfer of the patient's care to another properly credentialed practitioner can be accomplished.

Following disaster credentialing, the practitioner should be provided and maintain on his or her person written verification of said privileges. The medical staff bylaws, rules and regulations should require that his or her notations in the medical record reflect that the practitioner is working under disaster privileges. For quality review purposes, a list of all patient encounters should be kept, if practical.

Allied Health Professionals (AHP) may be similarly considered for temporary privileges, and shall be subject to the same general conditions of supervision except that supervision may be performed by an AHP with current like privileges.

Emergency temporary privileges may be rescinded at any time, and there shall be no rights to any hearing or review, regardless of the reason for such termination.

Temporary disaster privileges are terminated at the end of the declared disaster.

A Volunteer Application for each practitioner must be completed and maintained on file at the facility.

3.3.1.4 Tool - Volunteer Application for Healthcare Practitioners

The "'Volunteer Application for Healthcare Practitioners" is shown below. The complete tool can be found in the Operational Tools Manual.

Upon presenting at a non-licensed healthcare facility to provide services during a surge, healthcare professionals will be requested to complete an application form similar to the sample shown below. Its purpose is to give facilities a mechanism by which to collect the minimum necessary information to verify a practitioner's competency. This tool may serve as the Emergency Credentialing and Privileging form for non-licensed healthcare facilities if one has not already been developed.

Instructions for Use:

1. For each licensed independent practitioner (MD, DO, APN, or PA) who presents at a hospital to apply for emergency credentials, the Medical Staff office representative will provide him/her with the following application form.
2. Each licensed independent practitioner must present to the Medical Staff office representative with proper identification including a valid government-issued photo identification issued by a state or federal agency (e.g., driver's license or passport) and at least one of the following:

    - A current picture hospital identification card.
    - A current license to practice and a valid picture identification issued by a state, federal, or regulatory agency.
    - Identification indicating that the individual is a member of the California Medical Assistance Team (CalMAT) or of a Disaster Medical Assistance Team (DMAT).
    - Documentation indicating that the individual has been granted authority to render patient care in disaster circumstances, such authority having been granted by a federal, state, or municipal entity.
    - Presentation by current hospital or medical staff member(s) with personal knowledge regarding the practitioner's identity.

3. Completed application form is then given to the Medical Staff Director or other designated individual for review and determination of the practitioner's duties and area of assignment.
4. Concurrently, the Medical Staff Office representative will initiate the primary source verification process. This process must be completed within 72 hours from the time the practitioner presented to the organization.

VOLUNTEER APPLICATION (Licensed/Certified/Registered Professional)

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*, please explain:

Current Address: Street: City: State: Zip:	Previous Address: Street: City: State: Zip:
Phone number: ( )	Pager/ Cell Phone: ( )
Are you 18 years or older? ☐ No ☐ Yes	Social Security number:
Birth Date (mm/dd/yyyy):	Birth Place (City, State):

NEXT OF KIN & EMERGENCY CONTACT

Give name, telephone number and relationship of two individuals who we may contact in the event of an emergency.

Name	Telephone Number	Relationship
1.	( )	
2.	( )	

DEPENDENTS

Please list any dependents for which you are responsible.

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

LICENSURE/ CERTIFICATION/ REGISTRATION INFORMATION

Do you now have or have you previously had a health care 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

Please 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, please select below:

☐ ESAR-VHP ☐ Medical Reserve Corps (MRC) ☐ California Medical Assistance Team (CalMAT)
☐ Disaster Medical Assistance Team (DMAT) ☐ Other. Please 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*, please specify.

Age Specific Practice Criteria:
Please 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+)

Initials	
	Proper identification was verified and copied. ☐ Government issued photo identification (All Applicants) ☐ Clinical License (Licensed Personnel only) If applicant unable to present license, 2 witnesses from applicants current place of practice may attest to applicant's qualifications to practice. 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:** / /

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

If *Yes*, please 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

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.

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

3.3.1.5

3.3.2 Streamlined Personnel Verification (Licensed/ Certified/ Registered Professionals and All Other Volunteers)

3.3.2.1 Current Standards and Analysis

For all other healthcare providers – other licensed, certified, or registered practitioners – and all other volunteers, processes should be in place to verify their qualifications and experience as well. To differentiate this process from that of credentialing, it will be referred to as "personnel verification". The (Office of Inspector General) OIG Compliance Program Guidance for Hospitals states that facilities should conduct a reasonable and prudent background investigation, including a reference check, as part of every such employment application. This is recommended as a best practice for all types of facilities.

3.3.2.2 Guideline and Recommendation

Similar to the recommendation made for credentialing above, non-licensed healthcare facilities are encouraged to consider the use of volunteer registries such as ESAR-VHP and volunteer organizations such as MRC and benefit from their pre-registration process which not only encompasses credentialing of licensed independent practitioners but may also fulfil requirements for personnel verification.

In order to assist non-licensed healthcare facilities in planning, the following tools and templates are included to address the process for personnel verification. Just as the credentialing tools may be customized, these personnel verification tools may be revised as well to best fit the needs of the non-licensed healthcare facility.

Operational tools to implement a streamlined personnel verification process include:

- Recommended Policy for Personnel Verification (Other Licensed/ Certified/ Registered Practitioners and All Other Volunteers)
- Volunteer Application for Licensed/Certified/Registered Professionals and All Other Volunteers
- Personnel Verification Matrix for Other Licensed/ Certified/ Registered Practitioners and All Other Volunteers

3.3.2.3 Tool - Recommended Policy for Personnel Verification (Other Licensed/ Certified/ Registered Practitioners and All Other Volunteers)[169]

The "Recommended Policy for Personnel Verification (Other Licensed / Certified / Registered Practitioners and all Other Volunteers)" is shown below. The complete tool can be found in the Operational Tools Manual.

3.3.2.4

The following policy is recommended for non-licensed healthcare facilities to adopt to verify the licensure of health care professional and volunteers:

During a local emergency (as declared by local, state, or national officials) in which the emergency management plan has been activated and the organization is unable to meet immediate patient needs, licensed or certified personnel, who are not current employees of [Facility Name], [City, County] may be granted temporary working privileges as needed to assist in staffing during the emergency. The Administrator or Human Resource Director/Manager or their designees, (as identified under the Facility's Emergency Management Plan) will designate these non-employees to work at [Facility Name], [City, County].

Volunteers considered eligible to act as a licensed or certified personnel may also be considered upon approval from the Administrator, Human Resource Director/Manager or their designees.

Each non-employee and/or volunteer must present a valid government issued 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 current picture hospital ID card that clearly identifies professional designation
- A current license and/or certification to work
- Identification indicating that the individual is a member of the California Medical Assistance Team (CalMAT) or of a Disaster Medical Assessment Team (DMAT) or MRC, ESAR-VHP or other recognized state or federal organization or groups
- Documentation indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (if applicable)
- Identification by current hospital employee(s) who possesses personal knowledge regarding the non-employee/volunteer's ability to act as a licensed independent practitioner during a disaster (if applicable)

The Human Resource department will conduct a primary source verification of licensure (if applicable) as soon as the immediate situation is under control and is completed within 72 hours from the time the non-employee or volunteer presents to the organization.

The Labor Pool Unit Leader* shall determine the duties and area of assignment of those with emergency privileges.

The employee or volunteer will wear an [Facility Name] issued ID badges that indicate they have are a disaster volunteer. The Labor Pool Unit Leader will have the temporary badges and be responsible for distributing them to the identified personnel.

The Labor Pool Leader or designee will make a decision (based on information obtained regarding the license and/or certification of the non-employee/volunteer) within 72 hours related to the continuation of the disaster.

** - The Labor Pool Unit Leader is a designation under the Hospital Incident Command System (HICS). For the hospital to respond effectively to the demands associated with a disaster, support requirements will be coordinated by the Logistics Section. Under the Service Branch of the Logistics Section, the Labor Pool & Credentialing Unit is charged with acquiring and credentialing additional personnel. When activated, this unit is represented by the Labor Pool Unit Leader.*[170]

3.3.2.5 Tool - Volunteer Application for Licensed/Certified/Registered Professionals and All Other Volunteers

Upon presenting at anon-licensed healthcare facility to provide services during a surge, all other healthcare professionals (not licensed independent practitioners) and volunteers will be requested to complete an application form similar to the sample shown below. Its purpose is to give facilities a mechanism by which to collect the minimum necessary information to verify a practitioner's competency.

The "Volunteer Application for Licensed/Certified/Registered Professionals and All Other Volunteers" is shown below. The complete tool can be found in the Operational Tools Manual.

Instructions for Use:

1. For all other licensed, certified, or registered professionals and all other volunteer who present at a hospital to provide service, the Human Resources department representative will 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 government issued 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 current picture hospital ID card that clearly identifies professional designation
   - A current license and/or certification to work
   - Identification indicating that the individual is a member of the California Medical Assistance Team (CalMAT) or of a Disaster Medical Assessment Team (DMAT) or MRC, ESAR-VHP or other recognized state or federal organization or groups
   - Documentation indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (if applicable)
   - Identification by current hospital employee(s) who possesses personal knowledge regarding the non-employee/volunteer's ability to act as a licensed independent practitioner 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 practitioner's duties and area of assignment.

VOLUNTEER APPLICATION (General 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*, please explain:	
Current Address: Street: City: State: Zip:	Previous Address: Street: City: State: Zip:
Phone number: ( )	Pager/ Cell Phone: ( )
Are you 18 years or older? ☐ No ☐ Yes	Social Security number:
Birth Date (mm/dd/yyyy):	Birth Place (City, State):
NEXT OF KIN & EMERGENCY CONTACT	
Give name, telephone number and relationship of two individuals who we may contact in the event of an emergency.	

Name	Telephone Number	Relationship
1.	( )	
2.	( )	

DEPENDENTS

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

AVAILABILITY, AFFILIATION, & EXPERIENCE

Please 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, please select below:

☐ ESAR-VHP ☐ Medical Reserve Corps (MRC) ☐ California Medical Assistance Team (CalMAT)
☐ Disaster Medical Assistance Team (DMAT) ☐ Other. Please specify _____

Please 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 – please 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*, please identify which other language(s) and rate your proficiency in these languages:

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

VERIFICATION OF TRUTHFULNESS AND UNDERSTANDING REGARDING VOLUNTEER AGREEMENT

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

3.3.2.6 Tool - Personnel Verification Matrix for Other Licensed/ Certified/ Registered Practitioners and All Other Volunteers

The "Personnel Verification Matrix for Other Licensed/ Certified/ Registered Practitioners and All Other Volunteers" is shown below. The complete tool can be found in the Operational Tools Manual.

This table is meant to provide non-licensed healthcare facilities who do not already have a tracking mechanism with a template to use to verify that non-employed licensed practitioners, as well as all other volunteers, have provided the appropriate, and required, documentation.

Instructions for Use

For each licensed, certified, or registered practitioner, or any other volunteer, who presents at a hospital to provide service, the Human Resources department representative intakes the following information:

- The practitioner's/volunteer's full name
- The presence (by checking off the applicable box) of the identification requirements. A government-issued photo ID (e.g., a Drivers License) is required in order to qualify for emergency credentials.
    - If the practitioner 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 ESAR-VHP) or presentation by current hospital or medical staff member(s) with personal knowledge regarding the practitioner's identity, these should be specified in the box labeled "Other".

Once the practitioner's identity and ability to practice has been verified, and the Labor Pool Leader determines the duties and area of assignment for each practitioner or volunteer, this information should be documented in the column labeled "Allowed Scope of Work/ Job Classification."

Sample Job Classification types includes but is not limited to: Housekeeping, Security, Food Services, Facilities Management, Laundry, Medical Records and Admissions.

Qualification Requirements during Surge						
Individual Name	**Proposed Minimum Identification Requirements during Surge (Please select all applicable)**					**Allowed Scope of Practice**
	Govt-Issued Photo ID (Required)	Hospital ID	Current License & Picture	Volunteer (e.g., CalMAT, DMAT) ID	Other - Please specify	

3.4 Maintaining Personnel

This section of the document focuses on maintaining staff through the period of surge, including taking the necessary precautions to safeguard their health and safety, providing support services such as dependent care, and addressing issues surrounding workforce resiliency. Specific guidelines are outlined in this section along with recommended tools and templates to enable effective planning.

3.4.1 Workforce Health & Safety and Workers Rights - Current Standards and Analysis

Per the Occupational Safety Health (OSH) Act of 1970, Section 5, "each employer shall furnish to each of his employees employment and a place of employment which are free from recognized hazards that are causing or are likely to cause death or serious physical harm to his employees." Known as the "general duty clause" it very simply states employers' basic obligation to keep employees safe – a concept that could not be any more applicable than in a time of surge. State-specific CalOSHA regulations further detail this obligation, under Labor Code §6400. One of non-licensed healthcare facilities' main priorities in planning for, and responding to a surge, is their overarching duty to safeguard the health and safety of their workforce. Without the workforce, there can be no response.

One of the methods by which non-licensed healthcare facilities protect the health and safety of their workforce is in the provision of personal protective equipment (PPE). Under Labor Code §6401, "every employer shall furnish and use safety devices and safeguards, and shall adopt and use practices, means, methods, operations, and processes which are reasonably adequate to render such employment and place of employment safe and healthful." Additional specific guidance for the provision of PPE are outlined in CCR 8 §3380. CalOSHA requirements may not be waived, but in the event that a non-licensed healthcare facility is unable to meet this requirement, CalOSHA's response would be to assist the non-licensed healthcare facility in meeting the standard under alternate means. Enforcement of CalOSHA requirements during the surge is handled through ICS, under which the focus is not on citation (or the issuance of tickets or violations) but in resolving the issue.

In conjunction with employers' obligation to safeguard the health and safety of their workforce is their responsibility to honor employees' rights. A healthcare surge would affect the way in which non-licensed healthcare facilities would be able to address workers' rights, for example requiring staff and administrators to remain at a non-licensed healthcare facility or report to work (after leave) during a disaster. The California Industrial Welfare Commission Order No. 4-2001, 3(B)(9)-(10) outline the number of hours that healthcare personnel may work during a healthcare emergency and allows, after overall operational status has been considered, certain provisions to be made to extend overtime to staff during a disaster. Per CDHS Legal Counsel analysis, this order is subject to modification or waiver under the Governor's executive powers during a state of emergency.

To address employers' ability to have employees' return to work (from a leave) during a disaster, CCR 8 §9776.1 is referenced which discusses employers' general requirement of a return to work release with limitations and/or accommodations before returning an employee to work. This can be obtained from the workers compensation approved physician. In order to respond to a surge, this standard may be waived by authority of the Governor under the Emergency Services Act. Doing so would allow non-licensed healthcare facilities to potentially return certain staff members to work in an expedited manner, thereby increasing the workforce pool.

3.4.2 Workforce Health & Safety - Guidelines and Recommendations

Based on the review of the above standards and the ability to flex these regulations and requirements during a surge, it was identified that mandates can be made for staff to comply with certain requirements as a condition of their employment. It is recommended that the standards discussed above, as well as the accompanying analysis, be incorporated into a Workforce Resiliency Policy.

3.4.2.1 Tool - Policy for Workforce Resilience during Disaster[171]

The "Policy for Workforce Resilience during Disaster" is shown below. The complete tool can be found in the Operational Tools Manual.

This policy offers guidelines for dealing with needs and training to optimize workforce resilience in the event of a disaster. This policy provides minimum standards for non-licensed healthcare facilities to incorporate into current workforce resiliency policies. The term worker is used to refer to non-licensed healthcare facility personnel during a time of surge, which could consist of paid employees or volunteers.

Purpose:
This policy offers guidelines for dealing with needs and training to optimize workforce resilience in the event of a disaster. This policy 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 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, however, 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 we 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 worker too sick to be at work)

Personal:

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

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

Emotional:

- Management will provide all workers with regular updates of status of disaster in community 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 stigmata that workers may face for working with victims. Stress control teams will be trained in infection control precautions.

Training

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

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

2. Department specific training will be developed by department managers as appropriate to the type of services provided.

3. If there are not enough behavioral health specialists available for response to staff needs in a disaster, __(Affiliate name)___ will provide basic counseling training to selected individuals to assist in meeting worker emotional needs.

4. ___(Affiliate name)___ has developed information packages 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 to 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 that 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

3.4.3 Support Provisions for Staff - Current Standards and Analysis

Although there are no legal requirements for the provision of support to staff or dependents during an emergency, Joint Commission standards under Environment of Care (EC) 4.10 state that organizations must address emergency management. In order to fulfil this standard, the organization's emergency plan must provide processes for managing the following elements under emergency conditions[172]:

- Activities related to care, treatment, and services (for example, scheduling, modifying, or discontinuing services; controlling information about patients; referrals; transporting patients)
- Staff support activities (for example, housing, transportation, incident stress debriefing)
- Staff family support activities
- Logistics relating to critical supplies (for example, pharmaceuticals, supplies, food, linen, water)
- Security (for example, access, crowd control, traffic control)
- Communication with news media

3.4.4 Support Provisions for Staff - Guidelines and Recommendation

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

It is recommended that non-licensed healthcare facilities consider specific elements in developing a staff support provision plan – elements that include critical stress management and workforce health and safety. It is also recommended that facilities develop and implement a dependent care policy.

3.4.4.1 Tool - Considerations for Staff Support Provisions[167]

The "Considerations for Staff Support Provisions" is shown below. The complete tool can be found in the Operational Tools Manual.

As a starting point for planning, surge planners are encouraged to consider certain issues or components to providing support provisions for staff. The healthcare facility should consider the formation of Staff Disaster Support Committee or have its Human Resources Department pre-plan for the following (the list is not intended to be inclusive): Some of these issues include:

1. Some staff will not be able to report to work due to the fact that they or their loved ones may have been directly involved in the incident. In the absence of existing policies, it is recommended that a policy be developed or incorporated into current leave (sick time, medical leave, etc.) policies.

2. Some staff will refuse to report to work due to concerns about their own and their family members' safety and health. In the case of a biological incident, they may have fear of contracting the disease or bringing the disease home. In the absence of existing policies, it is recommended that a policy be developed or incorporated into current leave (sick time, medical leave, etc.) policies.

3. Many staff will have concerns about childcare. The normal childcare provider may not be able to provide these services in an incident. These same concerns apply to staff, who may be caring for their parents or others. There should be options available for childcare/eldercare so that staff are free to report to work. Title 42 - Termination if employees chose to volunteer for disaster work (Policy or guideline for protection of work, possibly consider waiver).

4. Some staff may have concerns about the shelter and care of their pets. Considerations should be made to plan for pet care during surge. Designated kennel or housing provisions should be part of the disaster preparedness plan and individual staff member plan.

5. The facility is to consider the provision of rooms for staff for rest and sleep and for personal hygiene needs (blankets, pillows, sheets, showers, towels, soap, shampoo, etc.). In the case of a biological incident, there may be the implementation of work quarantine in addition to staff working longer shifts or not being able to go home. The healthcare facility may also want to consider what is available in local hotels, churches, and other such organizations for sleeping accommodations and showers.

6. The facility is to consider areas for staff to eat and have refreshments.

7. Staff may be away from home for extended shifts and need to communicate with family members and other loved ones. The facility is to consider the availability of telephones to call home and computer access for email.

8. 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 so that this "Kit" is readily available.

9. Staff are to also have a "Family Plan" so that everyone in the family knows what will need to happen and who is responsible for various duties if a family member, who works at the facility, needs to work longer shifts or is quarantined at the facility.

10. The facility should also give consideration for back-up of essential services such as food services, laundry, housekeeping and other services, especially if these services are out-sourced and the incident affects the ability of the contractor to continue to provide these services and if the surge of patients and visitors overwhelms the capacity of these contractors.

11. Most facilities use "calling trees" to notify staff. The facility is to consider a back-up system for notifying staff should the telephone lines be down or the circuits busy.

12. The facility is to consider pre-identifying staff persons, who will manage and supervise volunteers and in which areas or departments the facility is likely to utilize volunteers.

13. The facility is also to consider that there may not be sufficient managers to supervise the staff in the surge capacity areas.

14. With staff being asked to work in the surge capacity areas, work in these areas may not necessarily involve their normal work responsibilities (duties as assigned). It is suggested that job descriptions be available for all positions so that staff can receive "just-in-time" training by reading the job descriptions.

Based on these recommendations, the following support provisions have been identified and should be considered by surge planners:

- Behavioral/Mental Healthcare care 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 Rest/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, etc.) staff store at the place of works
- Family Emergency Plan

3.4.4.2 Tool - Sample Policy for Dependent Care[173]

To address one of the issues regarding the provision of staff support services, it is recommended that non-licensed healthcare facilities implement a policy for dependent care. Such a policy should address facilities' commitment to shelter and feed staff and volunteer dependents during a surge.

3.4.4.3 The "Sample Policy for Dependent Care" is shown below. The complete tool can be found in the Operational Tools Manual.

3.4.4.4

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 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.

Responsibilities:
The Dependent Care Unit Leader shall 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 of 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
   a. The Dependent Care Unit Leader will oversee other staff or volunteers requested from the Labor Pool, two clerical staff for registration, and a nurse to administer medications as needed.
   b. Staff and volunteers shall sign in and out when reporting to assist.
   c. Staff shall monitor the area continuously for safety issues and to respond to dependents' needs.
   d. 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
   a. Post signs indicating "Dependent Care Area – Responsible Adult Must Register Dependent."
   b. Assign each family a Family Number.
   c. 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.
   d. Apply and armband to each dependent upon arrival with name and Department Number.
   e. Take a picture of each dependent with person responsible for them, and attach to Dependent Care Registration form.
   f. Special sign-in and sign-out procedures shall be provided for minor or incompetent dependents.
      i. Implement a positive ID system for all children cared for under 10 years of age.
      ii. Provide matching ID for retrieving guardian to show upon release of child.
   g. Tag medications, bottles, food and other belongings with dependent's name and Dependent Number and store appropriately.
   h. Assign each dependent to a dependent care provider and record on form.

G. Medications
   a. Assure that dependents taking medications have a supply to last during the estimated length of stay.
   b. 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 responding to specific incidents or individual needs.

I. Documentation

a. Document all care provided to individual dependents, such as medications, psychological services, toileting or dressing.
b. Document all other actions and decisions and report routinely to the Dependent Care Unit Leader.

J. Checking Out of Dependent Care Area
   a. When dependent leaves area, compare picture with dependent and responsible person.
   b. Check ID, verify name and obtain signature of responsible person picking up dependent.
   c. Retrieve and send all medications and personal items with dependent.
   d. Collect arm bands.

The following form (Form 1) allows healthcare facilities to track the individuals for whom they provide dependent care during a surge and Form 2 serves as a tracking form to monitor the healthcare services provided to individuals while they are under dependent care.

Form 1

Check In Date	**Time**	
Check Out Date	**Time**	
Staff Name	**Relationship to Dependent**	**Family Number**
Dependent Name	**Age**	**Dependent Number**
Staff's Department	**Extension**	
Other Family, Relative, etc we can call in an emergency		
Name	**Phone Number**	
Name	**Phone Number**	
Special Needs **Allergies** **Food** **Toileting** **Medical Conditions**		
Medications you brought:		
Name	**Dose**	**Times to be given**
Name	**Dose**	**Times to be given**
People who may pick up dependent		
Name	**Relationship**	
Name	**Relationship**	

Name	**Relationship**
For Dependent Care Area Staff Only:	
Dependent Care Staff: • Apply armband with name and registration number on each dependent. • Tag all medications, bottles, food and other belongings and store appropriately. • Photograph dependent with person responsible and attach photo to this form. • Use reverse side of this form to document care provided to this dependent. • Retain forms in Dependent Care Area until “All Clear” is announced, then route to Incident Command Center.	
Dependent Care Providers Assigned	
Name of person picking up dependent	
Signature of person picking up dependent	

Form 2

Dependent Name		Dependent Number
Date/ Time	**Type of Care Given**	**Notes**

3.4.4.5

3.5 Scope of Practice and Professional Liability

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

To the extent that flexibility is limited, or explicitly prohibited, professional liability, for both employed professionals and volunteers, needs to be clearly defined. Although this section focuses specifically on the practitioner's liability, the knowledge is essential to non-licensed healthcare facilities in determining the way in which they staff their facilities.

3.5.1 Scope of Practice - Current Standards and Analysis

To date, there is only one type of practitioner who is specifically allowed to provide services outside their licensed scope of practice during a surge: pharmacists.

Per Business & Professions Code §4062(b), under a declared emergency, the pharmacy board has the authority to waive the application of the act if it will aid in the protection of public health or the provision of patient care.

3.5.2 Scope of Practice - Guidelines / Recommendation

The recommendation has been made that the Licensing Boards of each of the following practitioners be contacted to determine if flexibility currently exists within their scope of practice or could be drafted for approval.

- Physicians
- Registered Nurses
- Advanced Practice Nurses
- Physician Assistants
- Dentists
- Emergency Medical Technicians (EMTs) and Paramedics
- Pharmacists
- Respiratory Care Practitioner
- Respiratory Therapy Technician
- Cardiovascular Technologists and Technicians
- Radiologic Technologists and Technicians
- Surgical Technologists
- Medical and Clinical Laboratory Technologists
- Medical and Clinical Laboratory Technicians (Phlebotomists)
- Diagnostic Medical Sonographers
- Veterinarians
- Marriage and Family Therapists
- Medical and Public Health Social Workers
- Psychologists
- Mental Health Counselors
- Behavioral Health Professionals

This endeavour is currently underway as the California Department of Health Services has reached out to each of the Licensing Boards to obtain the information. The following table includes initial responses from the Licensing Boards identifying expected flexed scope of practice for various

professional types that could be used to assign personnel during a surge to meet patient needs with the available staff.

3.5.2.1 Tool - California Healing Arts – Licensing Board Responses

The "California Healing Arts – Licensing Board Responses" is shown below. The complete tool can be found in the Operational Tools Manual.

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	It is recommended by the Legal Office of the California Board of Podiatric Medicine that §2397(d) be amended or sunsetted.

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

3.5.2.2 Tool - Flexed Scope of Practice Plan

The "Flexed Scope of Practice Plan" is shown below. The complete tool can be found in the Operational Tools Manual.

In order to provide essential services to patients and maintain facility daily operations, it may be necessary to flex the scope of practice for personnel to meet clinical and non-clinical needs. The following matrix is designed to assist staffing coordinators at non-licensed healthcare facilities in planning and allocation of personnel resources during surge. Examples of positions are provided to illustrate classification of staff.

Flexed Scope of Practice Plan		
Position	**Competencies/ Skill Sets (Non-Surge)**	**Allowed Skill Sets (Surge)**
Credentialed Staff		
Dentist		
Non Credentialed Staff		
Nurse Practitioner		
In-State Volunteers (Other Facility, Registered Volunteer, Walk-In)		
Out-of-State Credentialed Volunteer*		
Psychiatrist		
Out-of-State Non-Credentialed Volunteers		
Certified Registered Nurse Anesthetist (CRNA)		

3.5.3 Professional Liability - Current Standards and Analysis

A resounding concern in planning for a surge response is that of professional liability, even more so when the discussion of flexing providers' scope of practice is involved. Protections for employed personnel as well as available protections for volunteers – under normal conditions - must be clarified as well as the extent to which they may be expanded during a surge.

Several statutes apply to the liability of healthcare professionals. It should be noted, however, that those listed below only address the providers' liability while they are within the bounds of their "normal" scope of practice. To date, there are no statutes specific to liability and professional malpractice coverage if an injury occurs to a patient receiving care from a provider whose care is outside his or her scope.

- Government Code §8659, under the California Emergency Services Act states that any physician or surgeon (whether licensed in this state or any other state), hospital, pharmacist, nurse, or dentist who renders services during any state of war emergency, a state of emergency, or local emergency at the express or implied request of any responsible state or local official or agency shall have no liability for any injury sustained by any person by reason of such services, regardless of how or under what circumstances or by what cause such injuries are sustained; provided, however, that the immunity herein granted shall not apply in the event of a wilful act or omission.

Certain statutes and practices specifically address the liability of practitioners providing service outside the state by which they are licensed:

- Government Code §178, Article 5 provides that "no party state or its officers or employees rendering aid in another state pursuant to this compact shall be liable on account of any act or omission in good faith on the part of such forces while so engaged", the Governor's suspension authority runs only to "statutes" not parts of statutes. Additionally, this provision of the Interstate Civil Defense and Disaster Compact applies to the liability of out-of-state disaster workers and is not a regulatory statute or one for the conduct of state business.

Certain statutes specifically address the liability of volunteers while providing uncompensated care:

- The Volunteer Protection Act of 1997, Section 4(a) provides that a volunteer of a non-profit organization or government generally will be relieved of liability for harm if the volunteer was acting within the scope of his responsibilities if he was properly licensed, certified, or authorized for the activities (whenever such licensing, certification or authorization is appropriate or required).

  The Act preempts state law, but allows a State to apply its own law exclusively in any case that does not involve out-of-State parties. It does not protect volunteer organizations. And as it is a federal provision, it cannot be suspended or flexed by the Governor.

- The Good Samaritan Statutes under Business & Professions Codes §2395, 2395.5, 2396 and 2398 state that no licensee, who in good faith renders emergency care at the scene of an emergency, shall be liable for any civil damages as a result of any acts or omissions by such person in rendering the emergency care. "The scene of an emergency" as used in this section shall include, but not be limited to, the emergency rooms of hospitals in the event of a medical disaster. "Medical disaster" means a duly proclaimed state of emergency or local emergency declared pursuant to California Emergency Services Act.

  As the Good Samaritan statutes are neither regulatory statutes nor statutes for the conduct of state business, they cannot be suspended.

- Per the Disaster Service Worker Volunteer Program Guidance[174], the Emergency Services Act (Government Code §8657) provides DSW volunteers with limited immunity from liability while providing disaster service as it is defined CCR 19 §§2570.2 and 2572.2. Additionally, the Volunteer Protection Act of 1997 also provides them with limited protection. Immunity from liability protects the political subdivision or political entity, and the DSW volunteer in any civil litigation resulting from acts of good faith made by the political subdivision or political entity, or the DSW volunteer, while providing disaster service (e.g., damage or destruction of property; injury or death of an individual). Immunity from liability does not apply in cases of wilful intent, unreasonable acts beyond the scope of DSW training, or if a criminal act is committed.

  Convergent volunteers (those who have not pre-registered, or been impressed into service) not listed as DSW volunteers, have some liability protection for disaster service under the Good Samaritan statutes. They are not, however, provided immunities to the extent as registered DSW volunteers and are not covered for workers' compensation insurance through the DSW Volunteer Program.

3.5.4 Professional Liability - Guidelines/ Recommendation

It is recommended that non-licensed healthcare facilities be provided with, and review, a list of qualified immunities to: (1) be aware of the liability protections that exist for various personnel and (2) to apply this knowledge in developing staffing plans and policies and procedures.

Additionally it is recommended that education of these liability protections be provided for personnel at all levels (e.g., management, practitioners, and support staff), hand-in-hand with education about the flexibility to provide "out of scope" services.

3.5.4.1 List of Qualified Immunities

To some extent, the Legislature has already recognized liability in an emergency. There are several statutes providing qualified immunity to persons rending aid during an emergency. These immunity provisions instruct the courts not to impose liability in specified emergency circumstances. Thus, if the immunity applies, there can be no liability. This, in turn, may reduce the need for a suspension of regulatory requirements, because the immunity already contemplates that the standard of care is altered in emergency circumstances.

Qualified immunities refer to the immunity from civil liability that is afforded within a certain range of circumstances, as by a requirement of good faith or due care. Below are the qualified immunities that would be applicable to volunteer and contracted personnel.

Qualified Immunities for Volunteer Personnel - The Volunteer Protection Act of 1997 states that no volunteer of a nonprofit organization or governmental entity shall be liable for harm caused by an act or omission of the volunteer on behalf of the organization or entity if: (1) the volunteer was acting within the scope of the volunteer's responsibilities...etc. (2) if appropriate or required, the volunteer was properly licensed, certified, or authorized by the appropriate authorities...etc. This statute is very broad and may apply in broad circumstances, so long as summoned by a proper authority, and possesses the required first aid and emergency care training; immunity from liability appears to exist for providing any service that could fall within the definition of emergency services. For the purposes of this statute, emergency services includes but is not limited to first aid and medical services, rescue procedures, and transportation or other related activities necessary to insure the safety of the victim who is the object of a search or rescue operation.

California Civil Code §§ 1714.2 and 1714.21 states that if trained in basic CPR by the AHA or ARC and in good faith renders CPR at the scene of an emergency is not liable for any civil damages unless grossly negligent. Not applicable to those expecting compensation (e.g., staff/volunteers trained in CPR who renders aid during duty hours). A person is not liable for any civil damages if

rendered AED (defibrillator) at the scene of an emergency, if complied with applicable requirements of Health and Safety Code §1797.196.

Qualified Immunities for Contracted Services - Good Samaritan Statutes outline qualified immunities for contracted healthcare personnel providing services in an emergency situation. California Business & Professional Code § 1627.5 applies to dentists and states that no person licensed under this chapter **[dentists]**, who in good faith renders emergency care at the scene of an emergency occurring outside the place of that person's practice, or who, upon the request of another person so licensed, renders emergency care to a person for a complication arising from prior care of another person so licensed, shall be liable for any civil damages as a result of any acts or omissions by that person in rendering the emergency care.

California Business & Professional Code § 2395 applies to physicians and surgeons and states that no licensee, who in good faith renders emergency care at the scene of an emergency or during a medical disaster, shall be liable for any civil damages as a result of any acts or omissions by such person in rendering the emergency care. "The scene of an emergency" as used in this section shall include, but not be limited to, the emergency rooms of hospitals in the event of a medical disaster. "Medical disaster" means a duly proclaimed state of emergency or local emergency declared pursuant to the California Emergency Services Act (Chapter 7 (commencing with Section 8550) of Division 1 of Title 2 of the Government Code). Acts or omissions exempted from liability pursuant to this section shall include those acts or omissions which occur after the declaration of a medical disaster and those which occurred prior to such declaration but after the commencement of such medical disaster. The immunity granted in this section shall not apply in the event of a willful act or omission.

California Business & Professional Code § 2727.5 applies to nurses and states that a person licensed under this chapter **[nurse]** who in good faith renders emergency care at the scene of an emergency which occurs outside both the place and the course of that person's employment shall not be liable for any civil damages as the result of acts or omissions by that person in rendering the emergency care. This section shall not grant immunity from civil damages when the person is grossly negligent.

California Business & Professional Code § 2861.5 applies to licensed vocational nurses and states that a person licensed under this chapter **[licensed vocational nurse]** who in good faith renders emergency care at the scene of an emergency which occurs outside both the place and the course of his employment shall not be liable for any civil damages as the result of acts or omissions in rendering the emergency care. This section shall not be construed to grant immunity from civil damage to any person whose conduct in rendering emergency care is grossly negligent.

California Business & Professional Code § 3503.5 applies to physician's assistants and states that a person licensed under this chapter **[physician's assistant]** who in good faith renders emergency care at the scene of an emergency that occurs outside both the place and course of that person's employment shall not be liable for any civil damage as a result of any acts or omissions by that person in rendering the emergency care. This section shall not be construed to grant immunity from civil damages to any person whose conduct in rendering emergency care is grossly negligent. In addition to the immunity specified in subdivision (a), the provisions of Article 17 (commencing with Section 2395) of Chapter 5 shall apply to a person licensed under this chapter when acting pursuant to delegated authority from an approved supervising physician.

Qualified Immunities for Paid Personnel - Immunities for paid personnel would fall under the authority of the employer. Paid personnel are subject to the terms and conditions of the employment agreement between an employer and the employee.

4 Supplies, Pharmaceuticals and Equipment

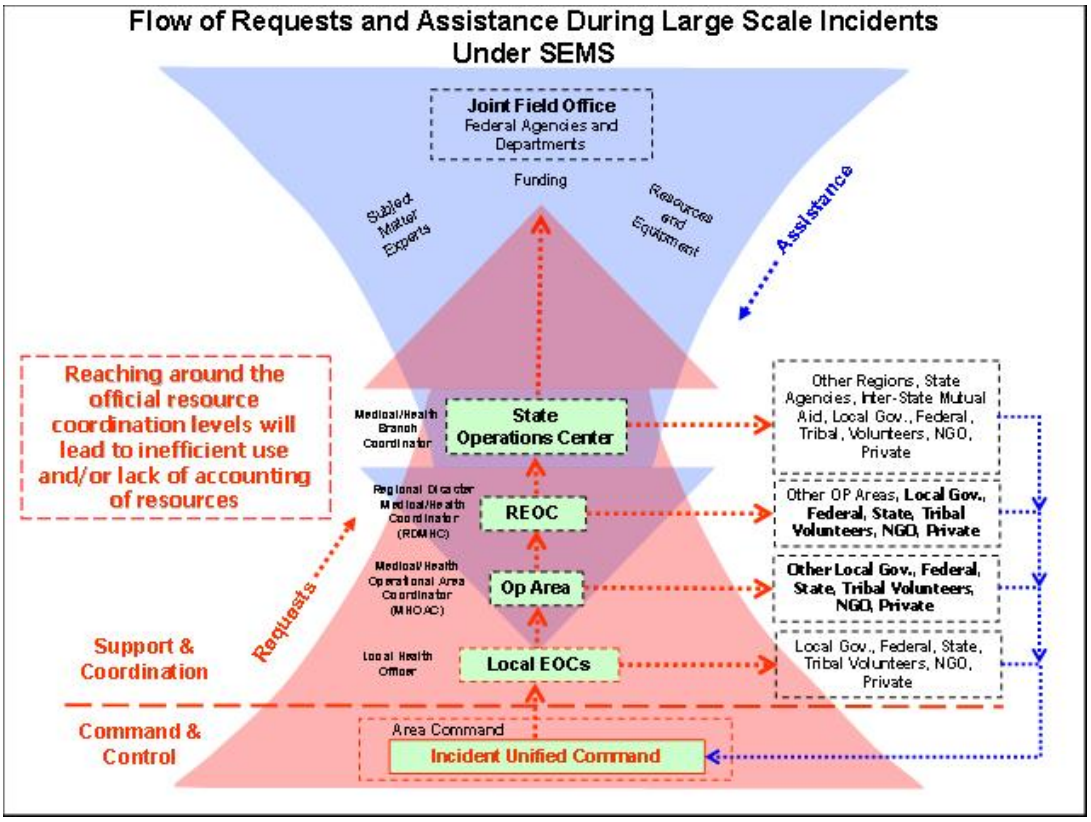
Under non-surge conditions, there are existing processes for healthcare facilities to access, procure, store and distribute supplies, pharmaceuticals, and equipment. During a surge, these processes may be altered and new processes needed to ensure that each operational level can obtain potentially scarce resources in a timely manner. This chapter outlines processes for acquiring supplies, pharmaceuticals, and equipment pre-surge and during a surge, as well as the liability, licensing and regulatory implications for their distribution and deployment.

Key definitions for the purposes of this chapter are:

- Supplies are defined as durable and consumable goods which are essential in carrying out the treatment of a patient's illness or injury.
- Pharmaceuticals are any prescription medications, over the counter drugs and/or nutraceuticals administered to persons to diagnose, treat, or prevent disease or other abnormal conditions.
- Equipment is fixed or portable equipment used for diagnosis, treatment, monitoring and direct care of individuals.
- Acquisition is defined as the process of acquiring supplies, pharmaceuticals, and equipment from various sources via procurement, stockpiles, caches, and other sources.
- Procurement is the process of obtaining supplies, pharmaceuticals, and equipment via contracts, government requests, and mutual aid that includes an arrangement of payment. Procurement is considered a subset of access.

4.1 Understanding how the SEMS Structure Affects Acquisition of Supplies, Pharmaceuticals and Equipment

It is important to understand the process of how supplies, pharmaceuticals, and equipment (SPE), referenced throughout this section as "clinical resources", can be accessed through SEMS. According to SEMS, resource requests for response and recovery originate at the level of government where needs are unmet and are progressively forwarded to the next level until the needs are filled. All public health functions should be integrated into the appropriate level of the SEMS structure and its systems of state-wide mutual aid. The California Department of Health Service's (CDHS) Emergency Response Plan defines mutual aid as voluntary assistance provided by agencies, local governments, and the State in the form of additional resources, hospitals and other support whenever jurisdictions' resources prove to be inadequate to cope with a given situation[175]. The following diagram, from the CDHS Emergency Response Plan, illustrates the mutual aid system concept and the general flow of requests and resources.



The SEMS system is designed to foster coordination of both public and private sector resources at all levels of its structure. Mutual aid works on the premise that health facilities will exhaust their normal access points for supplies, pharmaceuticals and equipment prior to making a formal request via the SEMS system. Some health facilities, such as hospitals, have multiple access points given existing supply chains with established retailers and wholesalers relationships.

4.1.1 Acquisition Overview

In surge planning with respect to supplies, pharmaceuticals, and equipment the overall goal is self sufficiency. "The term 'sustainability' describes the ability of a local health care system to tolerate an extreme event until significant outside assistance arrives.[176]" Research supports that after a disaster; outside assistance arrives from a range of 24 to 96 hours with peak demand time occurring within 24 hours.[176]

The overall goal of surge planning is to have enough inventories on hand to maintain existing operations, as well as respond to acute, incremental acute needs until stock is replenished, either through routine supply chain channels or existing caches. In preparation for a surge, the following recommendations, based on HRSA guidelines and professional experience, provide guidance to hospitals for ordering the appropriate types and quantities of equipment to assist in sustaining clinical resources.

4.1.2 Maximizing Sustainability

Below are recommendations on how to make non-licensed healthcare facilities as self-sufficient as possible. Non-licensed healthcare facilities should use these recommendations to guide the types

and quantities of supplies, pharmaceuticals, and equipment they have in current inventory as well as where to acquire these resources (e.g. vendor, mutual aid, MOU, stockpiles).

1. Non-licensed healthcare facilities should have enough supplies, pharmaceuticals, and equipment at their facility to be self sufficient for 72 hours.
2. When considering the type of events that may occur, non-licensed healthcare facilities may need to rely on the available market supply (e.g. MOUs, retailers or wholesalers) and State stockpiles for specific resources.

Below is an example of a Natural Disaster type HVA which attempts to identify the risk of the event by quantifying the probability of the event occurring and its potential severity.

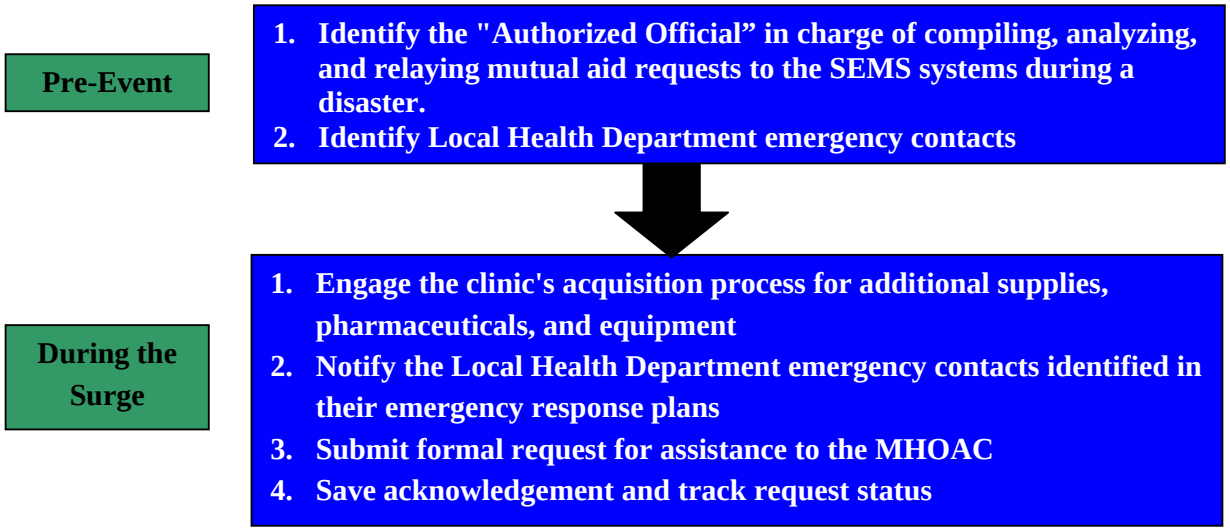
EVENT	PROBABILITY	SEVERITY = (MAGNITUDE - MITIGATION)						AMMC RISK
		HUMAN IMPACT	PROPERTY IMPACT	BUSINESS IMPACT	PREPARED-NESS	INTERNAL RESPONSE	EXTERNAL RESPONSE	
	Likelihood this will occur	*Possibility of death or injury*	*Physical losses and damages*	*Interuption of services*	*Preplanning*	*Time, 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	2	1	2	2	1	1	2	**33%**
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	0	2	1	2	1	1	**13%**
Volcano	0	0	0	0	0	0	0	**0%**
Epidemic	2	2	0	1	1	1	1	**22%**
AVERAGE SCORE	**0.69**	**0.38**	**0.44**	**0.44**	**0.75**	**0.63**	**0.69**	**4%**

**Threat increases with percentage.*

RISK =	PROBABILITY *	SEVERITY
0.04	0.23	0.18

4.1.3 Acquisition Process

The following diagram is a summary that illustrates at a high-level the pre-disaster and response activities that need to be performed in the acquisition process with guidance below on how to achieve these steps. For details on the SEMS process, please refer to the Declarations and Triggers section of this document under the Emergency Preparedness and Response in California" segment:



The following steps should be performed at the non-licensed healthcare facility during **pre-event:**

1. Identify the "authorized official" who is in charge of compiling, analyzing, and relaying mutual aid requests to the Local Health Department systems during a disaster.
2. This authorized official should set up an introductory meeting with his or her MHOAC and LHO. The purpose of the meeting will be to begin a working collaborative relationship with active sharing of relevant supplies, pharmaceuticals and equipment information.
3. Contact should also be established with non-medical disciplines within the SEMS structure (e.g. transport vendors), especially at the local and OA levels. This will provide assistance in the transportation, handling, storage, or management of clinical resources.

Effective planning for "**during surge**" processes will help to mitigate the effects of limited clinical resource availability. Successful implementation of the acquisition of clinical resources can only be accomplished if the following steps are performed during a surge:

1. Engage the facility's acquisition process for additional supplies, pharmaceuticals, and equipment. Working with the relevant functional areas at his or her facility, the authorized official should compile information regarding:
    i. Patient volume and acuity.
    ii. Impact on existing quantities of supplies, pharmaceuticals, and equipment over time.
    iii. The duration of the surge

2. Notify the SEMS emergency contacts identified in their emergency response plans in the following order :
    i. Local Health Department
    ii. MHOAC
    iii. Local EMS Agency
    iv. Or as guided by local policy

3. Complete a status report and a formal request for assistance when the resources at his or her

facility prove to be inadequate to cope with the surge.

i. This formal request should be submitted to the MHOAC and should be **specific** and **quantifiable**. The submission of the request for assistance from the authorized official to the MHOAC is the **formal entry point for the facility into the SEMS system.**

4. Ensure that when acknowledgement of the request is received, it is saved and used to track request status. The acknowledgement should contain:
   i. Confirmation of the specific request that was made.
   ii. The anticipated response time.
   iii. Any additional information on the scope and impact of the disaster and its effect on mutual aid requests.
5. Prepare to reconfirm a response time of request if the request is not fulfilled as anticipated.

4.1.4 Questions to Consider When Planning for a Surge

The following questions represent issues/challenges that may arise during a surge followed by recommendations on how to properly prepare.

1. Is the surge created by a disaster that has impacted transportation and routing capabilities?
   Recommendation: If so, alternate routes and means of transportation need to be identified and non-licensed healthcare facilities should contact the State Department of Transportation for specific information regarding the condition of roads.
2. If requesting equipment, does the facility have the appropriate personnel trained to operate that equipment?
   Recommendation: If not, it should be considered what facility can better utilize the equipment with appropriately trained personnel or determine if training can be done at the facility in need.
3. If requesting pharmaceuticals, does the facility have the appropriate licensing or licensed personnel to accept receipt of the shipment?
   Recommendation: A decision needs to be made on the need of medications vs. the legal licensing issue. As noted in the California Board of Pharmacy rules and regulations, Article 3, Section 4059.5.(a), drugs may only be ordered by a licensed pharmacy and delivered to the licensed premises, and must be signed for by a pharmacist.[177] In the event that non-licensed healthcare facilities would be required to function as pharmaceutical dispensing sites, they need to work with the Board of Pharmacy in order to expedite approval for acceptance of pharmaceutical shipments.
4. Does the facility have the appropriate security protocols and resources to manage the requested shipment?
   Recommendation: A facility should consider:
   i. Current personnel resources they have to assist.
   ii. Relationships with the local security officials they can leverage.
   iii. Relationships with private security entities they can leverage.

4.1.5 Planning for the Acquisition of Clinical Resources Pre-Surge and During Surge

In determining the process of how to acquire clinical resources pre-surge and during a surge the following options exist:

1. Conventional vendors / suppliers → Normal supply chain process
2. Local Government including EMS Disaster Coordinator
3. Mutual Aid / MOU → Unconventional supply chain process
4. Non-Governmental Organizations (NGOs) → Unconventional supply chain process
5. Wholesalers and Retailers – e.g. Grainger, Walmart, Costco → Unconventional supply chain process

4.1.5.1 Vendors, Suppliers, and Local Government

During a surge, non-licensed healthcare facilities should use their conventional vendors and suppliers as well as utilize the SEMS structure (local government) when resources are or are anticipated to be scarce. Below, unconventional options (MOUs, NGOs, Manufacturers, Wholesalers, and Retailers) are described as additional options.

4.1.5.2 Memorandum of Understanding

Stockpiling should be the primary method of being prepared for a surge. MOUs may be an effective method in sustaining operations in a hospital if clinical resources are scarce. The process of developing an MOU, while time and effort intensive provides direct benefits to the parties involved. The benefits of MOUs include an increased level of awareness and understanding of a community's needs and capabilities; and an environment of trust and collaboration during a disaster. In many ways, MOUs are collaborative building tools whereby the process of developing an MOU becomes more crucial and beneficial than the resulting document. MOUs could provide the basis for counties and OAs to perform realistic emergency preparedness planning and needs assessments.

4.1.5.3 Working with NGOs, Manufacturers, Wholesalers, and Retailers

Donations received from Non-Governmental Organizations (NGOs), manufacturers, wholesalers and retailers are another way of increasing the pool of supplies, pharmaceuticals and equipment during a surge. Also, potential options may include corporations and faith based organizations that may have stockpiles of supplies and equipment. This is recommended **only** if the non-licensed healthcare facilityl has the adequate infrastructure, personnel and processes in place to manage the receipt, storage, maintenance, security and deployment of the donated supplies, pharmaceuticals and equipment. Instead, it is recommended that the NGO and the manufacturer engagement take place at the OA level coordinated through the OA EOC. This will enable the entry of additional resources at a level where it can be part of the overall system supply base and be made available for the communities that may be in most need.

4.1.5.4 Acquisition of Pharmaceuticals

The following section on Pharmaceuticals offers two tools that non-licensed healthcare facilities can use when preparing for pharmaceutical needs during a surge.

Pharmacy inventory levels are closely scrutinized and the challenge is often to move as close as possible to just-in-time (JIT) to enhance financial performance. The pharmacy wholesalers support these JIT efforts by providing deliveries five to six days per week. Additionally, wholesalers provide pharmacies access to historical purchase data and software tools to easily establish par levels, reorder points and reorder quantities. “Par Levels are the maximum desirable number of pharmaceuticals determined. The reorder quantity equals the number of units below this predetermined number.”[178] Despite the frequency of deliveries, pharmacies must plan for the gaps in delivery service, e.g., 24-48 hours at a minimum, and establish par levels accordingly, therefore creating a barrier to a true JIT system.

A limitation often seen with the calculation of par levels is that they are established using "averages", and therefore do not account for significant variations in utilization that are sometimes seen in hospitals, e.g., a sudden increase in the use of an antimicrobial due to seasonality changes. To compensate for the gaps in delivery service and the limitations of par level calculations, pharmacies identify key pharmaceuticals that are critical to patient care and adjust par levels on these products accordingly.

It will depend on the function of each Non-Licensed Healthcare Facility to determine what specific pharmaceuticals are needed. There are certain surge scenarios such as a pandemic outbreak that may warrant a Non-Licensed Healthcare Facility operating for an extended period of time. If that is the case, the ordering of types of pharmaceuticals at a Non-Licensed Healthcare Facility may have to

be accomplished. A good reference for Non-Licensed Healthcare Facilities to utilize when ordering types of drugs is the Disaster Medical Assistance Team (DMAT) Rx list. DMAT caches were utilized in Hurricane Katrina and the comprehensive nature assumes that the Non-Licensed Healthcare Facility is starting with no resources. Due to the extensive nature of this list, existing facilities and public health officials can gain access to this list through their Local Health Officer (LHO).

The decision to utilize these tools is site dependent, based on the existing complexity of services offered, volume expectations during a surge, and the needs of the community. Due to the financial impact, the decision to increase existing inventories and/or cache a supply a pharmaceuticals to accommodate a surge event should be made in conjunction with hospital leadership with consideration give to the specific risks that the hospital has identified in its HVA.

When resources allow, or are available within the community, strong consideration should be given to involving key stakeholders in the planning process. The following list is not comprehensive.

- Clinical Pharmacists
- Disaster Coordinators
- Emergency Department Directors
- Emergency Department Physicians
- Respiratory Therapists
- Pulmonologists
- Critical Care Director
- Infectious Disease Physicians
- Poison Control Specialists
- Drug Information Specialists
- Radiologists
- Radiation Safety Officers
- Hospital Administrators
- Pediatric Specialists (Pediatric Critical/ Emergency Medicine Physicians)
- Vendors and Distributors

4.1.5.5 Tool - Basic Inventory Approach - Pharmaceuticals

The Basic Inventory Approach is designed to build upon **existing** practices within pharmacy operations and develop a systematic approach to establishing baseline inventory levels to sustain normal operations for 72-96 hours. Because of existing gaps in delivery, many pharmacies may currently be operating at or near these levels. This approach helps create a baseline inventory for normal operations for 72-96 hours. The use of an “80/20 report” is recommended if possible. An 80/20 report is a commonly used report provided by pharmacy wholesalers. This report is often used to identify which of the top dollar volume drugs are driving changes in the drug expenses for the institution. The intent of the "80/20 report" is that 200-300 lines of drugs represent 80-90% of the total dollars expended. To use this approach, simply refer to the process flow below and refer to an 80/20 report for guidance.

Basic Inventory Approach

Steps to consider when determining pharmaceuticals needed during a surge at a facility

Step 1

Obtain an “80/20” report from the pharmacy wholesaler

DISTRIBUTION CENTER	NDC	ITEM #	DESCRIPTION	FORM	STR	GENERIC GROUP	NET QTY	NET SALES	CUM SALES	CUM % of Total Sales
RALEIGH (B)	00075062040	270884	LOVENOX 40MG PFS 10X0.4ML	PFS	40	ENOXAPARIN SODIUM S.C.	384	$71,527.91	$71,527.91	6%
RALEIGH (B)	00173044202	453928	ZOFRAN 2MG/ML SDV 5X2ML	SDV	2	ONDANSETRON HCL	818	$68,507.50	$140,035.41	11%
RALEIGH (B)	00004196401	098772	ROCEPHIN 1GM VL 10X10ML	VL	1	CEFTRIAXONE SODIUM	309	$67,924.36	$207,959.77	16%
RALEIGH (B)	00075062300	533844	LOVENOX 100MG PFS 10X1ML	PFS	100	ENOXAPARIN SODIUM	71	$33,148.09	$241,107.86	19%
RALEIGH (B)	55513082310	445890	EPOGEN S40 40M UN/ML VL 10X1ML	VL		EPOETIN ALFA	6	$26,983.08	$268,090.94	21%
RALEIGH (B)	00075062280	532770	LOVENOX 80MG PFS 10X0.8ML	PFS	80	ENOXAPARIN SODIUM	68	$25,239.31	$293,330.25	23%
RALEIGH (B)	57894004002	595579	RETAVASE HALF KIT	KIT		RETEPLASE	21	$23,859.53	$317,189.78	25%
RALEIGH (B)	00310030022	748897	DIPRIVAN 10MG/ML VL 25X20ML	VL	10	PROPOFOL	83	$22,845.54	$340,035.32	27%
RALEIGH (B)	08290094110	934861	NORMAL SALINE 0.9% W/CANN SYG 30X10ML	SYG		SODIUM CHLORIDE	1,457	$22,013.42	$362,048.74	28%
RALEIGH (B)	00074445604	232207	ULTANE PEN BTL LIQ 250ML	LIQ		SEVOFLURANE	97	$21,482.84	$383,531.58	30%

Step 2 — **Identify the items on the "80/20" report that the organization believes would be impacted during a surge**

Step 3 — **Based on historical data, establish 72-96 hours par levels for these items**

Step 4 — **If sterile solutions are on the list (e.g. Lactated Ringers, are obtained from a different vendor) identify the items that the organization believes would be impacted during a surge**

Step 5 — **Based on Historical Data and vendor lead time, establish 72-96 hour par levels for these items**

4.1.5.6

Beyond this tool, Non-Licensed Healthcare Facilities should make sure to consider clinical resources that may be needed in larger supplies during a surge. For example, saline solution will be in high demand during a surge because ensuring adequate hydration is vital both during a disaster and post-disaster. Planning should consider the potential volume of patients that may require hydration for a 72 hour period. Dehydration may result post-disaster due to diarrhea because of a lack of clean drinking water and sanitary facilities. . Planning should also consider the potential volume of patients that may require oral hydration for the post-disaster period.

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

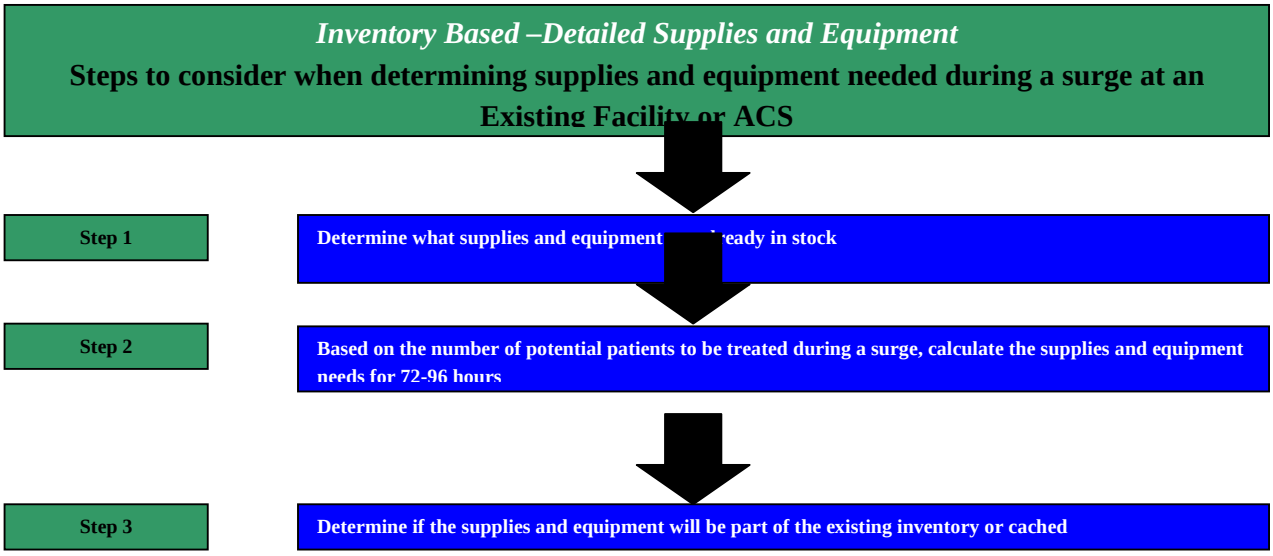
4.1.6 Planning for the Acquisition of Supplies and Equipment

The stockpiling of supplies and medical equipment will be paramount in the ability to function in a disaster. Similar to pharmaceuticals, the decision as to which methodology to use is site dependent based on the existing complexity of services offered and volume expected during a surge. Information from the Hazards Vulnerability Assessment should be utilized to assist in understanding site specific needs. When resources allow, or are available within the community, strong consideration should be given to involving key stakeholders in the planning process such as:

- Materials Manager / Procurement
- Disaster Coordinator
- Emergency Department Director
- Respiratory Therapists
- Facilities / Logistics
- Medical-Surge Coordinator
- Critical Care Coordinator
- Pediatric Specialists (Pediatric Critical / Emergency Medicine Physicians)
- Vendors and Distributors

4.1.6.1 Tool - Inventory Based - Detailed Supplies and Equipment List

This tool encourages planners to utilize a detailed list to guide the ordering of specific supplies and equipment. It allows organizations the flexibility to define the classes of supplies and equipment and determine whether caches are better suited for their organization, or if increasing par levels of existing inventory is a better strategy. The contents and quantities of the Disaster Resource Center (DRC) caches were originally developed by the Los Angeles County EMS Agency. The State EMS Authority developed a recommendation for Casualty Collection Points in the 1990's. This information was used as the starting point for the medical cache contents. Subsequently, the DRC Coordinator group has worked with the EMS Agency to refine these caches and address the perceived needs that would arise in a disaster. The number of patients that could be treated varies based on the type and mix of patients[179]. 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 surge scenario.



The "Detailed Supplies and Equipment List" is shown below. The complete tool can be found in the Operational Tools Manual.

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 non-licensed healthcare facility'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 non-licensed healthcare facility, what is the quantity that may be part of the non-licensed healthcare facility's cache either on-site or nearby.

Development of Standards and Guidelines for Healthcare Surge During Emergencies
Supplies and Equipment that May Be Required During a Surge

BANDAGES AND DRESSINGS	Current Supply	Total Potential Requiring Treatment	Package Size (if applicable)	Quantity / Cache
Adhesive strip, 1” X 3”				
Alcohol pads				
Bandage elastic (Ace wrap) 2”				
Bandage elastic (Ace wrap) 4”				
Bandage elastic (Ace wrap) 6”				
Bandage, gauze non sterile (kerlix) 4” X 10’				
Bandage, gauze non sterile 4X4				
Bandage 4X4 sterile				
Bandage 2X2 sterile				
Eye pad, oval sterile				
Eye Shields				
Morgan Lens				
Petroleum Gauze 5” X 9” (Xeroform)				
Vaseline gauze				
Gauze Pad 5” X 9” sterile				
Tape 1” transparent				
SURGICAL SUPPLIES	**Current Supply**	**Total Potential Requiring Treatment**	**Package Size (if applicable)**	**Quantity / Cache**
Scalpel with blade, disposable #10				
Scalpel with blade, disposable #15				
Sterile gloves, sizes 6.5, 7.0, 7.5, and 8.0				

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

Syringe, 5 ml				
Syringe, 10 ml				
Syringe, 20 ml				
Syringe, 35cc, for wound irrigation				
Syringe/needle, 3 ml, 22gauge X 1 ½”				
Syringe/needle, 1 ml, 25 gauge X 5/8”				
Syringe/needle 1 ml, 29 gauge X ½”				
Sharps container				
AIRWAY MANAGEMENT SUPPLIES	**Current Supply**	**Total Potential Requiring Treatment**	**Package Size (if applicable)**	**Quantity / Cache**
Bag-valve-mask, adult				
Bag-valve-mask, pediatric				
Airway adjunct, OP Airway				
Airway adjunct, NP Airway				
Cricothyrotomy / Shiley 4				
Endotracheal tube, cuffed 8mm				
Endotracheal tube, cuffed, 7.5mm				
Endotracheal tube, cuffed 7mm				
Endotracheal tube, cuffed, 6mm				
Endotracheal tube, cuffed 2.5mm				
Endotracheal tube, cuffed 3mm				
Endotracheal tube, cuffed, 4mm				
Endotracheal tube, cuffed, 4.5mm				
Endotracheal tube, cuffed, 5mm				
Endotracheal tube, cuffed, 5.5mm				
Endotracheal tube, non-cuffed, 2.5mm				
Endotracheal tube, non-cuffed, 3mm				
Endotracheal tube, non-cuffed, 4mm				
Endotracheal tube, non-cuffed, 5mm				
ETT Holders				

Intubation kit, incl. Blades, medium handle, stylet and case – including magill forceps				
Intubation kit (Pediatrics) , incl. Blades, medium handle, stylet and case – including magill forceps				
Nasal cannula, adult				
Nasal cannula, pediatric				
02 mask with tubing, pediatric				
02 mask with tubing, adult				
02 mask - non-rebreather, adult				
Nebulizers – hand held				
Nebulizers – masks				
Ventilator circuits				
Suction machine, portable				
Suction catheters 10 french				
Suction catheters 12 french				
Suction catheters 14 french				
Yankauer suction				
Suction tubing				
Suction Canisters				
NG Tubes				
Thoracostomy Tubes, assorted sizes				
Pleurivac & Heimlich valves				
INFECTION CONTROL SUPPLIES	**Current Supply**	**Total Potential Requiring Treatment**	**Package Size (if applicable)**	**Quantity / Cache**
Cover/Isolation gowns				
Splash guard for wound irrigation				
Masks surgical				
Face shield with eye shield				
Masks N-95				
Patient exam gloves, small				
Patient exam gloves, medium				

Patient exam gloves, large				
Shoe covers				
Surgical caps				
Wipes, disposable				
MISCELLANEOUS SUPPLIES	**Current Supply**	**Total Potential Requiring Treatment**	**Package Size (if applicable)**	**Quantity / Cache**
Bags, plastic 30 gallon, 8 mil				
Batteries, C for laryngoscope handle				
Batteries, D for flashlights				
Blankets lightweight				
Clipboards				
Diapers, disposable large				
Diapers, disposable medium				
Diapers, disposable small				
Diapers, disposable, large, peds				
Diapers, disposable, medium, peds				
Diapers, disposable, small, peds				
Emesis basins, plastic				
Facial tissues				
Flashlights				
Gloves work type leather/canvas				
OB kits, disposable				
Paper towels				
Patient ID bands				
Styrofoam cups				
Tongue depressors, non sterile				
NON-DISPOSABLE MEDICAL SUPPLIES	**Current Supply**	**Total Potential Requiring Treatment**	**Package Size (if applicable)**	**Quantity / Cache**
Blood Pressure multi-cuff kit with adult, pediatric, infant and thigh cuff				

Glucometer kit with lancets, test strips and battery				
Portable Otoscope/Ophthalmoscope set with batteries				
Pulse Oximetry, portable				
Stethoscope				
Tourniquets 1”				
Trauma/paramedic scissors				
MISCELLANEOUS Equipment	**Current Supply**	**Total Potential Requiring Treatment**	**Package Size (if applicable)**	**Quantity / Cache**
Ventilators - dual use Adult/Pediatric				
Portable/disposable vents				
Equipment Trailer				
18 X 24 Tent				
10 X 10 Tent				
Temps Beds				
Simpler Life Cots				
Junkin Cots				
Blankets/Sleeping Bags/Linen				
Tables				
Chairs				
Lights				
Portable Generator				
Heating System/Fan				
HEPA Filtration System				
Staff Noticiation/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 handwashing				
Outdoor Lighting				
EZ Up Shades				
Security Upgrades and hardening				
Post Decontamination clothing sets				
Pharmacy Cache				
CHEMPACK location site				
Medical/Surgical Supply Cache				
Prime Mover (tow vehicle)				

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 radiatin injury within a 24-hour period.

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

There are specific supplies and equipment to be considered that are specific to the pediatric population. In the specific tool for this section, the pediatric population is referenced, but to find more detailed information on the emergency care of the pediatric population, please refer to http://www.emsa.ca.gov/def_comm/vii032807_a.asp.

4.1.7 Planning for the Acquisition of Personal Protective Equipment (PPE)

When considering PPE, the primary use will be by personnel who require a certain degree of protection. This includes proper equipment and training to sustain an all-hazard event response. This section concentrates on the first receiver component of PPE. The Occupational Safety and Health Administration (OSHA) provides guidelines that many facilities currently use. Employers are required by OSHA to use PPE to limit employee exposure to hazards and employers must determine if PPE should be used for the protection of the employees. Under Cal/OSHA Labor Code 6401, every employer must furnish protective equipment, use safety devices and safeguards and provide training.

There are two major situations when PPE may be required which will determine the appropriate action to be taken: (1) Natural Disaster/ Biological Event, (2) First Receiver Operations:

Natural Disaster/ Biological Event

- This is an infection control/ epidemiology issue (e.g., Pandemic Flu outbreak).
- Requires universal precautions.
- Respiratory protection may be required depending on the situation (e.g., N-95/N-100).
- Infection Control practices should be followed.

First Receiver Operations (Chemical, Biological, Radiological, Nuclear, Explosive/ CBRNE)

- This type of operation involves receiving victims from an incident with the release of hazardous substances.
- The 1995 OSHA manual, "Best Practices for Hospital Based First Receivers" should be used as a guide for handling these types of scenarios. Training, personnel, and storage are addressed in detail in this manual.

Some of the many challenges that hospitals face around selecting, acquiring, managing/storing, and training staff on their PPE are described below.

Guidance on the Selection and Acquisition of PPE:

- Facilities should be at least prepared for levels C and D, but equipment selection should be site specific → This should guide facilities on the general types of PPE that may be needed during a surge.
- Use a HVA to consider suspected hazards that may impact a facility and the specific potential hazard to employees (skin, ingestion, eye contact). This is site specific guidance on the types of PPE needed on hand.
- Facilities should work with other hospitals and healthcare facilities, their county, and the state of California to increase mutual aid interoperability. This would set up a network pre-surge to allow for sharing of scarce resources.
- Consider standardizing PPE within a community/region.

Managing/Storing PPE Considerations include:

- Equipment is often outdated and must be current for appropriate use.
- Storage space.
- Body types and physical requirements.
- Employee mix.
- The environment of employees to anticipate specific PPE needs.
- Maintenance.
- Training.
- Durability of PPE materials (e.g. strength of materials) such as heat, cold, etc.
- Multiple types of equipment –cross-trained on different brands of equipment.

General Training Recommendations for Biological Events and/or First Receiver Operations

- Training should occur quarterly with demonstrable annual competency for OSHA Level C.

- Follow competency requirements by OSHA as a standard.
- Decontamination exercises should be included in the training.
- Training should be targeted to non-clinical staff for OSHA Level C operations and include:
    - Just-in-Time (JIT) training for those who are not knowledgeable in using PPE and show up to a hospital during the surge (e.g. clinical staff).
    - Just-in-Case (JIC) training in for scenario planning in preparation for the surge. (e.g. security, housekeeping and ancillary staff).
- Clinics should work with their local field representatives from their vendors and suppliers for formalized training.

*In preparation for a Surge, there are suppliers that can provide guidance in determining the appropriate amount of supplies and equipment, including personal protective equipment (PPE). It will be vital to work with suppliers to consider each facility's unique characteristics such as patient population, surge capacity, and probability of the various types of events that may occur due to location (e.g. nuclear power plant). Suppliers and Manufacturers such as Grainger and 3M have tools available that are designed to facilitate critical decisions, using specific inputs, about the type and quantity of supplies needed to set-up care sites.

For further information on a sample tool go to Grainger's website:
http://www.grainger.com/Grainger/static.jsp?page=rc_emergency.html.

For more detail, please visit OSHA's website at:
http://www.osha.gov/SLTC/personalprotectiveequipment/index.html

4.2 Storage Considerations

This section breaks down storage into five areas including: Inventory Management, Environmental Management, Security, Transport, and Ease of Access.

4.2.1 Inventory Management

From a planning perspective, many non-licensed healthcare facilities and public health organizations will have a stock of supplies, pharmaceuticals, and equipment that must be maintained. As a general guideline, Non-Licensed Healthcare Facilities should identify local vendors and maintain up to date content information. Pharmaceuticals and supplies/equipment are addressed separately in the subsequent sections.

4.2.1.1 Pharmaceuticals – Inventory Management

The inventory must be managed so the drugs can be effective when used. Therefore, there must be a process to monitor expiration dates, storage dates, and a process for rotating stock from a cache into the general inventory to minimize pharmaceuticals that may expire.

4.2.1.2 Supplies and Equipment – Inventory Management

Items that require consistent maintenance need to be addressed. Equipment such as batteries for portable monitoring equipment and ventilators are a high priority because these items are used for life saving measures. Also, equipment that may be impacted by the environment such as ventilator seals, need to be maintained because they can become un-usable. Obsolescence is also essential to consider because supplies and equipment may become outdated due to technological advances or changes in ordering patterns. To help ensure that personnel can use the equipment stored, “Just-In-Time” training documents for the clinical resources should be in the storage area. Lastly, space is a very important consideration. Many non-licensed healthcare facilities have inadequate space to house their equipment and supplies and there needs to be a prioritization of what will be included in the storage space. Other options to space limitations include storing supplies and equipment at other facilities that may exist within their health system or using warehouse space either on or off site.

4.2.2 Environmental Management

Pharmaceuticals and Supplies/Equipment have similar considerations regarding environmental management. The chemical nature of pharmaceuticals puts it at risk of an altered state which may impact the efficacy of the drug and safety of the patient. Many pharmaceuticals are affected by temperature and have specific storage requirements such as “room temperature” or “refrigeration”. There must be a process to monitor the environment of pharmaceuticals to meet United States Pharmacopeia (USP). Supplies and Equipment items are also impacted by temperature as significant variations can affect the durability and quality of the material. Non-licensed healthcare facilities should ensure that manufacturer’s storage guidelines are met.

4.2.3 Security

Resources may be scarce and there should be pre-planning for heightened security in a disaster state.

A process for the security of pharmaceuticals and supplies and equipment at non-licensed healthcare facilities should be set up for the following:

- Ensuring the security of existing inventory and caches by utilizing personnel or security cameras.
- Controlling access into and within the building area.

- Identifying and tracking patients, staff, and visitors.
- Working with local authorities prior to a surge to address heightened security
- Working with private security entities prior to a surge to address heightened security.

4.2.4 Transport

It is essential to consider in the planning how supplies and equipment will get from the cache or stockpile to the desired location. A plan should be in place with options on what would be the primary mode of transport with secondary options. The inability to access roads and facilities must also be taken into account.

4.2.5 Ease of Access

Staging of supplies, pharmaceuticals, and equipment to ensure ease of access is vital to accessing what is needed first. This is addressed in further detail in the Staging Section of this document.

4.2.6 Tool - Pharmaceutical Storage Consideration Checklist

The "Pharmaceutical Storage Consideration Checklist" is shown below. The complete tool can be found in the Operational Tools Manual

This tool serves as a checklist to address the vital areas that need to be considered specifically around storing pharmaceuticals at a non-licensed healthcare facility and in a cache/warehouse.

Inventory Management

□ A process for monitoring the expirations dates.
□ A process for rotating stock from the cache into the general inventory to minimize outdates, if applicable.
□ A process for returning stock to the vendors for replacement or credit, if applicable.
□ Medications from large dispensing sites may come in unit dose (a single packaged pill) or in bulk bottles (a bottle containing 100 pills) that will require local repackaging.
□ Repacked pharmaceuticals require proper labeling.
□ These labels are important for lot number and patient tracking in the event of contamination, adverse reactions, or medication error.

Environmental Management

□ A process for monitoring the environment to meet United States Pharmacopeia (USP) standards, e.g., temperature, humidity, pests.
□ Most medications require adequate room temperature, as specified in the Strategic National Stockpile guidelines, to range between 68° and 77° F.
□ Local planning should ensure that manufacturer's storage guidelines are met.

Security

Facility (assuming a heightened state of security)

□ A process for ensuring the security of the caches.
□ A process for controlling access <u>into</u> the building or area.
□ A process for controlling access <u>within</u> the building.
□ A process for Identifying and tracking of patients, staff, and visitors.
□ Monitoring of facilities with security cameras.
□ Security locks on pharmaceuticals in place.
□ A process for working with <u>local</u> authorities prior to surge to address heightened security needs.
□ A process for working with <u>private</u> security entities prior to surge to address heightened security needs.

Caches *(external to a facility or ACS)*
□ 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 surge to address heightened security needs.
□ A process for working with private security entities prior to surge to address heightened security needs.

Licensing
□ Depending on the location of the cache, consider any licensing needs, e.g., Board of Pharmacy.
□ 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?

4.2.7 Tool - Supplies and Equipment Consideration Checklist

The "Supplies and Equipment Storage Consideration Checklist" is shown below. The complete tool can be found in the Operational Tools Manual.

This tool serves as a checklist to address the vital areas that need to be considered specifically around storing supplies and equipment at a non-licensed healthcare facility and in a cache/warehouse.

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

Environmental Management
□ A process for monitoring Personal Protective Equipment (PPE) 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 of patients, staff, and visitors.
□ Monitoring of facilities with security cameras.
□ A process for working with local authorities prior to surge to address heightened security needs.
□ A process for working with private security entities prior to surge to address heightened security needs.

Caches *(external to an existing facility or ACS)*
□ 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 surge to address heightened security needs.
□ A process for working with private security entities prior to surge to address heightened security needs.

Transport
□ A process for obtaining the caches and transporting 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? (see Staging section for an example)

4.2.8 Storage Vendor Considerations

This section examines the relationship between non-licensed healthcare facilities and their current and future vendors/suppliers. Considerations are highlighted for non-licensed healthcare facilities to use when working with vendors and suppliers.

Many organizations rely on vendors for maintenance of their supplies and equipment. As a result, they are strongly encouraged to consider the vendor or supplier from whom they acquire supplies, pharmaceuticals, and equipment to ensure proper maintenance during storage. This group may play a large role in ensuring that materials work correctly during a surge. Below is list of considerations:

1. "Disaster clauses" within the contract with the vendor to understand what they are responsible for during a surge situation.
2. Process for the rotation of stock and inventory (control management).
3. "Days on hand" inventory of the vendors. This may guide the organizations determination on how much supplies, pharmaceuticals, and equipment to keep in their own stock.
4. Process for material delivery during surge.

4.2.9 Tool - Storage Vendor Considerations

The "Vendor Considerations Checklist" is shown below. The complete tool can be found in the Operational Tools Manual.

This tool identifies specific considerations that should be addressed when working with vendors from a surge perspective.

□ Identify any "disaster clauses" within the contract and understanding the requirements of the vendor.
□ Understand the options of how supplies, pharmaceuticals, and equipment will be delivered during a surge.
□ Understand where supplies, pharmaceuticals, and equipment will be delivered during a surge (e.g. where at the facility they will be delivered to).
□ Understand who the supplies, pharmaceuticals, and equipment will be delivered to during a surge.
□ Identify the vendor lead time of critical supplies, pharmaceuticals and equipment.
□ The Rotation stock and inventory (control management) agreement.
□ Identify payment terms under a surge scenario.
□ Understand the "days on hand" inventory of the vendors.

4.3 Staging & Deployment

This section examines the most efficient ways for non-licensed healthcare facilities to stage their supplies, pharmaceuticals, and equipment pre-surge and in-surge. It also looks at how regulatory issues impact distribution. This section offers three tools that non-licensed healthcare facilities can use for guidance in the staging and distribution of clinical resources.

4.3.1 Staging Considerations

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

Non-licensed healthcare facilities often organize their disaster supplies similar to other clinical materials each item is stored with like items in the same location, e.g., cots are stored with cots, PAPR hoods are stored with PAPR hoods, medical supplies are stored with medical supplies, etc., and often different locations. This is an efficient means of monitoring and replenishing inventory under routine operating procedures; however it may not be optimal in a disaster response.

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

If space is sufficient, the “first push” supplies may be packaged in a cart or trailer to make deployment more rapid. Consideration should be given to the path of travel between the storage site and the destination, so that the chosen cart or trailer will successfully clear all obstacles. Further, a detailed inventory should accompany the first push of supplies, indicating "what" and "how many" of each item is immediately available, and where additional supplies are located so that they can be acquired by staff who may not be knowledgeable of how the supplies are organized and stored.[180]

4.3.1.1 Tool - Staging Recommendation Checklist

The "Staging Recommendation Checklist" is shown below. The complete tool can be found in the Operational Tools Manual

This tool serves as a checklist to identify considerations that organizations should assess when staging their resources. This tool can be utilized at non-licensed healthcare facilities where there are areas that items are stored with the potential need for immediate use.

□ A process for determining what items will be needed first → Concept of last in, first out.
□ Do not place one type of material all in one place (e.g. cots all in one area).
□ How the materials will be moved (e.g. deployable cart).
□ How items are 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.).
□ Space is often a limiting factor.
□ Consider alternate sites to stage supplies, pharmaceuticals, and equipment (e.g. off-site warehouses).

□ Pushcarts can be utilized for moving materials efficiently.
□ Pushcarts need to be labeled with all materials and expiration dates.
□ Accountability for property
□ Ownership of staging areas (state vs. local) and who is responsible for identifying Points of Distribution (PODS).
□ Pharmaceutical caches should be stored in secure containers that can be easily transported (e.g. plastic totes with tear away locks).
□ Non-expired medical supplies should be kept separate from medical supplies that have expiration dates.
□ Covering supplies, pharmaceuticals, and equipment for protection from the elements for purposes of reducing spoilage and the need to repackage materials.

4.3.2 Distribution / Deployment Consideration

4.3.2.1 Liability, Licensing, and Regulatory Implications

Once at the distribution point of supplies, pharmaceuticals, and equipment, there are many regulatory issues that are relevant during a surge. They include:

- Waivers.
- Expired medications.
- The liability for off-label drug usage.
- Determining what designated personnel are allowed to distribute and / or disperse mediations during a surge and what their liability is.
- The liability of pharmacists, intern pharmacists, or pharmacy technicians who are not licensed in California, but who are licensed in good standing in another state, including those presently serving military or civilian duty.
- The delivery of pharmaceuticals to licensed and un-licensed sites (e.g. delivery of medications to an un-licensed dispensing site).
- The liability of using supplies and equipment beyond the manufacturer's recommended use (e.g. PPE).
- The liability for Non-Governmental Organizations (NGOs) for the distribution of medical and health supplies.

The California State Board of Pharmacy Waiver

The California State Board of Pharmacy plays a large responsibility in the function of pharmacists who play an intricate role in patients receiving needed medications. In a recent response to the potential of a surge, the California State Board of Pharmacy created a Disaster Response Policy Statement in January 2007 to ensure proper preparation and an effective response to any local, state, or national disaster. The purpose of the policy statement and potential waivers as part of the California Business and Professions Code, section 4062, subdivision (b) is to encourage pharmacists to do everything possible to do the most good for the largest amount of people.

This policy highlights that in the event of declared disaster or emergency, the Board expects to utilize its authority under the California Business and Professions Code, including sections 4005(b) and 4062, to encourage and permit emergency provision of care to affected patients and areas, including by waiver of requirements that it may be implausible to meet under these circumstances.[181] This takes into account what would be otherwise normal operating procedures that may not be able to be addressed during a surge such as record-keeping requirements, labeling requirements, employee ratio requirements, consultation requirements and other standard pharmacy practices and duties that may interfere with the most efficient response to those affected.

How the Waiver is communicated

In the event of the waiver, the State of California Board of Pharmacy would communicate this information to the Office of Emergency Services (OES) for them to distribute the information.

Information would also be posted on their website at www.pharmacy.ca.gov and communicated via phone @ (916) 574-7900.

The Board expects licensees to apply their judgment and training to provide medication to patients in the best interests of the patients with circumstances on the ground dictating the extent to which regulatory requirements can be met in affected areas. The Board also expects that the highest standard of care possible will be provided, and once the emergency has dissipated, its licensees will return to practices conforming to state and federal requirements.[182]

4.3.2.2 Tool - California State Board of Pharmacy Disaster Policy Statement

The "California State Pharmacy Board Disaster Policy Statement" is shown below. The complete tool can be found in the Operational Tools Manual.

This tool can be used a reference to understand the purpose of the California State Pharmacy Board waiver and how it will be utilized in the event of a surge.

The California State Board of Pharmacy wishes to ensure complete preparation for, and effective response to, any local, state, or national disaster, state of emergency, or other circumstance requiring expedited health system and/or public response. Skills, training, and capacities of board licensees, including wholesalers, pharmacies, pharmacists, intern pharmacists, and pharmacy technicians, will be an invaluable resource to those affected and responding. The board also wishes to encourage an adequate response to any such circumstance affecting residents of California, by welcoming wholesalers, pharmacies, pharmacists, intern pharmacists, and pharmacy technicians licensed in October 25 and 26, 2006, Board Meeting Minutes - Page 13 of 52 pages good standing in other states to assist with health system and/or public response to residents of California.

The board encourages its licensees to volunteer and become involved in local, state, and national emergency and disaster preparedness efforts. City or county health departments, fire departments, or other first responders can provide information on local opportunities. The Emergency Preparedness Office of the California Department of Health Services is a lead agency overseeing emergency preparedness and response in California, particularly regarding health system response, drug distribution and dispensing, and/or immunization and prophylaxis in the event of an emergency. At the federal level, lead contact agencies include the Department of Health and Human Services, the Centers for Disease Control, and/or the Department of Homeland Security and its Federal Emergency Management Agency (FEMA). Potential volunteers are encouraged to register and get information at www.medicalvolunteer.ca.gov (California) and www.medicalreservecorps.gov (federal).

The board also continues to be actively involved in such planning efforts, at every level. The board further encourages its licensees to assist in any way they can in any emergency circumstance or disaster. Under such conditions, the priority must be protection of public health and provision of essential patient care by the most expeditious and efficient means. Where declared emergency conditions exist, the board recognizes that it may be difficult or impossible for licensees in affected areas to fully comply with regulatory requirements governing pharmacy practice or the distribution or dispensing of lifesaving medications.

In the event of a declared disaster or emergency, the board expects to utilize its authority under the California Business and Professions Code, including section 4062, subdivision (b) thereof, to encourage and permit emergency provision of care to affected patients and areas, including by waiver of requirements that it may be implausible to meet under these circumstances, such as prescription requirements, record-keeping requirements, labeling requirements, employee ratio requirements, consultation requirements, or other standard pharmacy practices and duties that may interfere with the most efficient response to those affected.1 The board encourages its licensees to assist, and follow directions from, local, state, and national health officials. The board expects licensees to apply their judgment and training to providing medication to patients in the best interests of the patients, with circumstances on the ground dictating the extent to which regulatory requirements can be met in

affected areas. The board further expects that during such emergency, the highest standard of care possible will be provided, and that once the emergency has dissipated, its licensees will return to practices conforming to state and federal requirements.

Furthermore, during a declared disaster or emergency affecting residents of California, the board hopes that persons outside of California will assist the residents of California. To facilitate such Expanded powers in the event of a disaster are also granted to the Governor and/or other chief executives or governing bodies within California by the California Emergency Services Act [Cal. Gov. Code, §§ 8550-8668] and the California Disaster Assistance Act [Cal. Gov. Code, §§ 8680-8690.7], among others. Section 8571 of the Government Code, for instance, permits the Governor to suspend any regulatory statute during a state of war or emergency where strict compliance therewith would prevent, hinder, or delay mitigation. October 25 and 26, 2006, Board Meeting Minutes - Page 14 of 52 pages assistance, in the event of a declared California disaster or emergency, the board expects to use its powers under the California Business and Professions Code, including section 900 and section 4062, subdivision (b) thereof, to allow any pharmacists, intern pharmacists, or pharmacy technicians, who are not licensed in California but who are licensed in good standing in another state, including those presently serving military or civilian duty, to provide emergency pharmacy services in California. The board also expects to allow nonresident pharmacies or wholesalers that are not licensed in California but that are licensed in good standing in another state to ship medications to pharmacies, health professionals or other wholesalers in California.

Finally, the board also expects to allow use of temporary facilities to facilitate drug distribution during a declared disaster or state of emergency. The board expects that its licensees will similarly respond outside of the state to disasters or emergencies affecting populations outside California, and will pursue whatever steps may be necessary to encourage that sort of licensee response.

[1]Expanded powers in the event of a disaster are also granted to the Governor and/or other chief executives or governing bodies within California by the California Emergency Services Act [Cal. Gov. Code, §§ 8550-8668] and the California Disaster Assistance Act [Cal. Gov. Code, §§ 8680-8690.7], among others. Section 8571 of the Government Code, for instance, permits the Governor to suspend any regulatory statute during a state of war or emergency where strict compliance therewith would prevent, hinder, or delay mitigation.
[2]See also the Interstate Civil Defense and Disaster Compact [Cal. Gov. Code, §§ 177-178], the Emergency Management Assistance Compact [Cal. Gov. Code, §§ 179-179.5], and the California Disaster and Civil Defense Master Mutual Aid Agreement [executed 1950], regarding cooperation among the states.

4.3.2.3 Use of Expired Medications

In a surge scenario, there is the potential for a shortage of appropriate medications. An example could be a pandemic flu outbreak. Specific virals and vaccines may be indicated and there may not be an adequate amount available for use. The government may prepare by stockpiling exactly for this type of situation and there is the possibility that the medications may become expired. This may become a dilemma if medical personnel have the indicated medication at their disposal, but question their liability in using the product and the efficacy of the medication to provide the desired results. Approved drugs are tested for stability and the expiration dates are based on those tests. Only the FDA can approve the use of expired medications. Restrictions on pharmacists dispensing expired drugs could be waived by the Pharmacy Board which will be situation dependent. An emergency proclamation changing the standard of care could also provide protection.

4.3.2.4 Off – Label Drug Use

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

There is no statutory or regulatory prohibition against off-label use of a drug by a physician. Consequently, pharmacists may dispense pharmaceuticals without being out of compliance. The only limitation on such off-label use is the law of medical malpractice. The more a drug is used for off-label purposes, the lower the likelihood that such use will be considered a breach of the standard of care owed to the patient. A proclamation of an emergency could include a provision making the standard of care the prevention of the greatest loss of life, which could allow some off label uses even if not generally accepted by the medical community, but consistent with the goal of saving a life.

4.3.2.5 Distribution and/or Dispensing of Pharmaceuticals by non-licensed Pharmacists

During a surge, there is a possibility that there may not be a licensed Pharmacist on-site to dispense pharmaceuticals or oversee the process from a liability perspective. The California Business and Professions Code, Section 4051 states that “it is unlawful for any person to manufacture, compound, furnish, sell, or dispense any dangerous device, or to dispense or compound any prescription pursuant to Section 4040 of a prescriber unless he or she is a pharmacist under this chapter.” California Business and Professions Code, Section 4051. Situations when a Pharmacist may authorize the initiation of a prescription to non-licensed pharmacists/healthcare providers other than pharmacist is when:

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

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

4.3.2.6 Licensing of Dispensing Sites and Sites External to Hospitals

As noted in the California Board of Pharmacy rules and regulations, Article 3, Section 4059.5.(a), drugs may be ordered by a licensed pharmacy and delivered to the licensed premises, and must be signed for by a pharmacist. California Business and Professions Code, Section 4059.5, Section 3, subdivision(a) To the extent possible, Non-Licensed Healthcare Facilities are encouraged to work with

the Board of Pharmacy to identify themselves as pharmaceutical dispensing sites if that is there purpose to expedite approval. This would minimize any potential delays in getting pharmaceuticals delivered to external sites in the event of a surge situation. A pharmacist's educational background and experience should be utilized in this situation to understand if the appropriate medications have been delivered in the correct quantities so they can then utilize the pharmaceuticals in the most efficient manner.

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

With the possibility for limited Pharmacy staff in a surge scenario, many volunteers may present to any location where care is being provided (e.g. hospital, ACS, clinic, dispensing site) to assist in providing services that a Pharmacist, Intern Pharmacist and/or Pharmacy Technician would provide under normal operating procedures. To effectively utilize this type of volunteer it is essential to prepare for this situation and understand their potential capacity and liability.

The California State Board of Pharmacy encourages that persons outside of California will assist the residents of California. In the event of a declared disaster or emergency, the Board expects to use it powers under the California Business and Professions Code, including section 900 and sections 4005(b) and 4062 to allow any pharmacists, intern pharmacists, or pharmacy technicians, who are not licensed in California, but who are licensed in good standing in another state, including those presently serving military or civilian duty, to provide emergency pharmacy services in California[183].

Nonresident pharmacies or wholesalers that are not licensed in California but that are licensed in good standing in another state are encouraged to ship medications to pharmacies, health professionals or other wholesalers in California.

4.3.2.8 Furnishing Medications without a Prescription

During a surge, there may be limited time to receive a prescription from a Physician. Therefore Section 4062, subdivision (a) states that a Pharmacist may in good faith, furnish a dangerous drug or dangerous device in reasonable quantities without a prescription during a federal, state or local emergency, to further the health and safety of the public.[184] This section states that a record containing the date, name, and address of the person to whom the drug or device is furnished, and the name, strength, and quantity of the drug or device furnished shall be maintained. The pharmacist shall communicate this information to the patient's attending physician as soon as possible.

4.3.2.9 The Use of Supplies and Equipment beyond the Manufacturers Recommended Use

In a surge scenario there is the possibility that medical supplies and equipment may be used in a different manner than its intended use which brings into consideration liability and reimbursement. An example is the use of an adult intubation kit on a pediatric patient.

The Federal Food, Drug & Cosmetic Act, Chapter V, Subchapter E, Sec. 564 [21 USC 360bbb-3] - Authorization for Medical Products for Use in Emergencies subdivision states that the Secretary may authorize the introduction into interstate commerce, during the effective period of a declaration under subsection (b), of a drug, device, or biological product intended for use in an actual or potential emergency (referred to in this section as an "emergency use").

4.3.2.10 Liability for Non-Governmental Organizations (NGOs) for the distribution of medical and health supplies

There is potential for the state, regional areas and local non-licensed healthcare facilities to have the need to utilize NGOs to access medical and health supplies. Because this may not be part of the normal process there can be concerns around liability. An NGO can be held liable in negligence just

as any other organization. The liabilities for the distribution of medical and health supplies can be either regulatory (i.e., criminal), or civil (e.g., for damages).

Civil liability for NGOs during a declared emergency would depend upon whether the NGO was functioning as a disaster service organization, i.e., all of its employees are functioning as disaster service workers. If so, the employee's would be immune to liability under Civil Code section 1714.5.

Also, the Governor could issue orders that require NGOs to carry out certain functions, and they would not have liability under Civil Code section 1714.6.

4.3.2.11 Recommendation on the Distribution/Deployment of Supplies, Pharmaceuticals, and Equipment

- These liability, licensing, and regulatory issues should become apart of a non-licensed healthcare facility's policies and pertinent staff need to be educated on the regulatory aspect of distribution so this information can be utilized in a surge.
- Staff needs to understand the regulatory implications so they can act to the best of their ability to save lives during a surge.

5 Operations

This chapter focuses on six primary areas with respect to healthcare professionals and how their practice, the way in which they provide care at a non-licensed healthcare facility, will be affected during a healthcare surge. Topics discussed include:

(1) Regulations and standards that may present barriers to timely and effective delivery of care during a surge and any applicable liability protections.
(2) The methods by which the way professionals will manage and prioritize patients differ, all in an effort to switch in focus from patient-based outcomes to population-based outcomes.
(3) The way in which healthcare professionals will have to alter the way they document information in the patient's medical record;
(4) Considerations healthcare professionals must take with regards to patient tracking, and how this becomes integral in the healthcare surge response;
(5) The impact of HIPAA;
(6) Decontamination and infection control strategies.

5.1 Regulations, Standards and Liability Protection

During a healthcare surge, patient care capacity will be expanded to set up care areas for an influx of a large number of patients. This will mean that facilities may be unable to comply with certain regulatory and standards requirements, including those for:

- Scope of Practice and Treatment Methods
- Using non-clinical areas for clinical purposes
- Patient Management
- Patient Restraints
- Clinical Laboratory Improvement Act
- Structural Safety
- CAL/OSHA

This section provides an overview of the current compliance requirements for these areas as well as a list of any applicable waivers and available liability protections that may be available to facilities during surge.

5.1.1 Scope of Practice and Treatment Methods

Healthcare providers will be faced with extenuating circumstances during which they may have to provide patient care services for which they may not be licensed or treat patients using "non-traditional" treatment means. As a result, non-licensed healthcare facilities may need the following scope of practice for personnel and scope of services at facilities requirement to be flexed during a surge:

- Primary care clinics (per CCR 22 §75026) are to provide only those services for which it is organized, staffed and equipped.

To address the scope of services and treatment means compliance requirement mentioned above, non-licensed healthcare facilities should be aware of the following waiver for scope of services:

- The Governor – under Government Code §8571 – has the authority during a state of war emergency or a state of emergency to suspend any regulatory statute, or statute prescribing the procedure for conduct of state business, or the orders, rules, or

regulations of any state agency, including subdivision (d) of Section 1253 of the Unemployment Insurance Code, where the Governor determines and declares that strict compliance with any statute, order, rule, or regulation would in any way prevent, hinder, or delay the mitigation of the effects of the emergency.

5.1.2 Using Non-Clinical Areas for Clinical Purposes

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

- The National Fire Protection Association (NFPA) standards (19.1.1.4.4) stipulate that for existing health care occupancies, a change from one health care occupancy sub-classification to another shall require compliance with the requirements for new construction. With respect to existing ambulatory health care facilities, sections of facilities shall be permitted to be classified as other occupancies, provided that they meet all of the following conditions: (1) they are not intended to serve ambulatory health care occupants for purposes of treatment or customary access by patients incapable of self-preservation and (2) they are separated from areas of ambulatory health care occupancies by construction having a fire resistance training of not less than 1 hour. (NFPA standards 21.1.2.1)

At this time, there is no known process to flex NFPA standards.

5.1.3 Patient Restraints

Certain circumstances could warrant the use of patient restraints for the safety of the patient, other patients and staff. Regulations that apply include:

- Welfare and Institutions Code, 5150: When any person, as a result of mental disorder, is a danger to others, or to himself or herself, or gravely disabled, a peace officer, member of the attending staff, as defined by regulation, of an evaluation facility designated by the county, designated members of a mobile crisis team provided by Section 5651.7, or other professional person designated by the county may, upon probable cause, take, or cause to be taken, the person into custody and place him or her in a facility designated by the county and approved by the state Department of Mental Health as a facility for 72-hour treatment and evaluation.

  Such facility shall require an application in writing stating the circumstances under which the person's condition was called to the attention of the officer, member of the attending staff, or professional person, and stating that the officer, member of the attending staff, or professional person has probable cause to believe that the person is, as a result of mental disorder, a danger to others, or to himself or herself, or gravely disabled. If the probable cause is based on the statement of a person other than the officer, member of the attending staff, or professional person, such person shall be liable in a civil action for intentionally giving a statement which he or she knows to be false.

- California Administrative Code, Title 13, Section 1103.2 - Ambulance Emergency Care Equipment and Supplies: Any equipment or supplies carried for use in providing emergency medical care must be maintained in clean condition and good working order. (a) Essential equipment and supplies to be carried shall include as a minimum: (2) Straps to secure the patient to the stretcher or ambulance cot, and means of securing the stretcher or ambulance cot in the vehicle.

- Health and Safety Code, Section 1798.6: (a) Authority for patient health care management in an emergency shall be vested in that licensed or certified health care professional, which may include any paramedic or other prehospital emergency personnel, at the scene of the emergency who is most medically qualified specific to the provision of

rendering emergency medical care. If no licensed or certified health care professional is available, the authority shall be vested in the most appropriate medically qualified representative of public safety agencies who may have responded to the scene of the emergency. (b) If any county desires to establish a unified command structure for patient management at the scene of an emergency within that county, a committee may be established in that county comprised of representatives of the agency responsible for county emergency medical services, the county sheriff's department, the California Highway Patrol, public pre-hospital-care provider agencies serving the county, and public fire, police, and other affected emergency service agencies within the county. The membership and duties of the committee shall be established by an agreement for the joint exercise of powers under Chapter 5 (commencing with Section 6500) of Division 7 of Title 1 of the Government Code. (c) Notwithstanding subdivision (a), authority for the management of the scene of an emergency shall be vested in the appropriate public safety agency having primary investigative authority. The scene of an emergency shall be managed in a manner designed to minimize the risk of death or health impairment to the patient and to other persons who may be exposed to the risks as a result of the emergency condition, and priority shall be placed upon the interests of those persons exposed to the more serious and immediate risks to life and health. Public safety officials shall consult emergency medical services personnel or other authoritative health care professionals at the scene in the determination of relevant risks.

- In addition to the above regulations, CCR, Title 22, Sections 1000075 & 1000159 apply.

- Guidance on policy and procedures associated with patient restraints can be obtained from San Diego County Division of Emergency Medical Services - Policy Procedure Protocol (Pg 48), July 2002. The document can be accessed via: http://www2.sdcounty.ca.gov/hhsa/documents/EMS-TreatmentProt2004Rev6_30_04Part3.pdf

5.1.4 Clinical Laboratory Improvement Act (CLIA)

Recognizing that not all non-licensed healthcare facilities will have the ability to setup a laboratory during a healthcare surge, the following guidance is included to assist those facilities that may be able to respond in this way during a surge.

- As it relates to a facility's ability to setup a laboratory during a healthcare surge, the CLIA statutes are very prescriptive and prohibit any facility from receiving or testing human specimens unless the facility is CLIA certified. Certification requirements include an application, assurances of compliance, and a site survey. A CLIA waiver requires pre-approval based on an application, and limited scope of testing (42 USC 263a(d)(2).) Since the effect of this necessitates pre-approval, it does not appear possible to secure a waiver prior to a declared emergency.

There are two suggested options that non-licensed healthcare facilities can utilize to prepare for a surge:

1. Have a CLIA waiver prepared and ready for submission in the event of a declared emergency. This would expedite things on the facility's end, but would still require time for federal processing to approve and issue the waiver.
2. Request via the Governor to the Secretary of Health and Human Services a temporary suspension of the requirements under CLIA to obtain a Certificate or a certificate of waiver to perform simple laboratory examinations and procedures. There is authority under 42 USC 247d for the Secretary to take appropriate action in the event of a public health emergency.

5.1.5 Structural Safety of Facilities: Compliance Requirements

- The California Building Standards Code (CCR 24, Part 2, Volume 1, Section 102) states that all buildings or structures that are regulated by this code that are structurally unsafe or not provided with adequate egress, or that constitute a fire hazard, or are otherwise dangerous to human life are, for the purpose of this section, unsafe. Any use of buildings or structures constituting a hazard to safety, health or public welfare by reason of inadequate maintenance, dilapidation, obsolescence, fire hazard, disaster, damage or abandonment is, for the purpose of this section, an unsafe use.

- Per Health and Safety Code §129990, the Office of statewide Health Planning and Development (OSHPD) has the authority to order the vacating of any building or structure found to have been in violation of the adopted regulations of the office and may order the use of the building or structure discontinued within the time prescribed by the office upon the service of notice to the owner or other person having control or charge of the building or structure. Any owner or person having control so served shall, upon request made within 15 days of the written notice, be entitled to a hearing pursuant to Section 11506 of the Government Code.

5.1.5.1 Facility Damage Report (Limited Assessment)

The "'Facility Damage Report (Limited Assessment)" is shown below. The complete tool can be found in the Operational Tools Manual.

This tool provides a Facility On Site Damage/Operability Report which is a comprehensive assessment performed by California Department of Public Health, Licensing and Certification Program officer onsite..

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 “partial” or “no” answer to any question, ask provider to describe their plan and include that info in report to headquarters. If facility is preparing to evacuate, ask for patient list and evacuation destination (s) and enter info on Facility Transfer Summary. Report a summary of findings to headquarters Disaster Preparedness Coordinator ans/or Field Branch Chief.

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

5.1.6 Cal/OSHA Guidance

Cal/OSHA provided the following guidance as it relates to healthcare personnel safety during a mass casualty event.

1. The #1 priority or one of the first priorities, in responding to a healthcare surge should be to protect the health and safety of the workforce. The underlying issues around safeguarding their safety must be addressed or else there won't be a workforce to respond to the surge.

2. Health and safety planning has to be an integral part of any disaster planning and preparedness else there may be a resulting, secondary catastrophe. Facilities should develop an employee health an safety checklist, which should be incorporated in the emergency management plans.

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

4. Although Cal/OSHA regulations are not waived, Cal/OSHA is flexible and aims to work with facilities. Enforcement of the requirements is handled through the Incident Command System (ICS), under which the focus is not on citation (or issuance of tickets for violations). Cal/OSHA would shift from enforcement to "compliance assistance mode". The key driving principle for Cal/OSHA is not the violation but the hazard involved with violating the standard.

5. Cal/OSHA expects that facilities have a health & safety plan that addresses the following:
    - Infection control
    - Life safety
    - Emergency action plan
    - Control of hazardous substances
    - Personal protective equipment (PPE)
    - Fatigue
    - Heat stress
    - Provision of sanitary facilities

5.1.6.1 OSHA and Cal/OSHA Requirements

As it relates specifically to facility's obligation to maintain a safe working environment for its employees and volunteers, CalOSHA regulations (Labor Code 6400(a) and 6401) state that every employer shall furnish employment and a place of employment that is safe and healthful for the employees therein; and that every employer shall furnish and use safety devices and safeguards, and shall adopt and use practices, means, methods, operations, and processes which are reasonably adequate to render such employment and place of employment safe and healthful. Every employer shall do every other thing reasonably necessary to protect the life, safety, and health of employees.

- Federal OSH Act of 1970, Section 5 – "A. Each employer – a. shall furnish to each of his employees employment and a place of employment which are free from recognized hazards that are causing or are likely to cause death or serious physical harm to his employees; b. shall comply with occupational safety and health standards promulgated under this Act. B. Each employee shall comply with occupational safety and health standards and all rules, regulations, and orders issued pursuant to this Act which are applicable to his own actions and conduct."

- Cal/OSHA CCR 8 §3203(a)(6). Effective July 1, 1991, every employer shall establish, implement and maintain an effective Injury and Illness Prevention Program (Program). The Program shall be in writing and, shall, at a minimum: (6) Include methods and/or procedures for correcting unsafe or unhealthy conditions, work practices and work procedures in a timely manner based on the severity of the hazard: (A) When observed or discovered; and, (B) When an imminent hazard exists which cannot be immediately abated without endangering

employee(s) and/or property, remove all exposed personnel from the area except those necessary to correct the existing condition. Employees necessary to correct the hazardous condition shall be provided the necessary safeguards.

- Labor Code 90.5. (a) It is the policy of this state to vigorously enforce minimum labor standards in order to ensure employees are not required or permitted to work under substandard unlawful conditions or for employers that have not secured the payment of compensation, and to protect employers who comply with the law from those who attempt to gain a competitive advantage at the expense of their workers by failing to comply with minimum labor standards.

- Labor Code 6307. The division [California Division of Occupational Safety and Health] has the power, jurisdiction, and supervision over every employment and place of employment in this state, which is necessary adequately to enforce and administer all laws and lawful standards and orders, or special orders requiring such employment and place of employment to be safe, and requiring the protection of the life, safety, and health of every employee in such employment or place of employment.

- Labor Code 6401. Every employer shall furnish and use safety devices and safeguards, and shall adopt and use practices, means, methods, operations, and processes which are reasonably adequate to render such employment and place of employment safe and healthful. Every employer shall do every other thing reasonably necessary to protect the life, safety, and health of employees.

- Labor Code 6400. (a) Every employer shall furnish employment and a place of employment that is safe and healthful for the employees therein. (b) On multiemployer worksites, both construction and non-construction, citations may be issued only to the following categories of employers when the division has evidence that an employee was exposed to a hazard in violation of any requirement enforceable by the division: (1) The employer whose employees were exposed to the hazard (the exposing employer). (2) The employer who actually created the hazard (the creating employer). (3) The employer who was responsible, by contract or through actual practice, for safety and health conditions on the worksite, which is the employer who had the authority for ensuring that the hazardous condition is corrected (the controlling employer). (4) The employer who had the responsibility for actually correcting the hazard (the correcting employer). The employers listed in paragraphs (2) to (4), inclusive, of this subdivision may be cited regardless of whether their own employees were exposed to the hazard. (c) It is the intent of the Legislature, in adding subdivision (b) to this section, to codify existing regulations with respect to the responsibility of employers at multiemployer worksites. Subdivision (b) of this section is declaratory of existing law and shall not be construed or interpreted as creating a new law or as modifying or changing an existing law.

5.1.7 Liability Protection

Current legislation provides facilities with liability protection, including:

- *Government Code §8659* states that any physician or surgeon (whether licensed in this state or any other state), hospital, pharmacist, nurse, or dentist who renders services during any state of war emergency, a state of emergency, or a local emergency at the express or implied request of any responsible state or local official or agency shall have no liability for any injury sustained by any person by reason of such services, regardless of how or under what circumstances or by what cause such injuries are sustained; provided, however, that the immunity herein granted shall not apply in the event of a willful act or omission.

- *Civil Code §1714.5* which deems that there shall be no liability on the part of one, including the state of California, county, city and county, city or any other political subdivision of the

state of California, who owns or maintains any building or premises which have been designated as a shelter from destructive operations or attacks by enemies of the United states by any disaster council or any public office, body, or officer of this state or of the United states, or which have been designated or are used as mass care centers, first aid stations, temporary hospital annexes, or other necessary facilities for mitigating the effects of a natural, manmade, or war-caused emergency, for any injuries arising out of the use thereof for such purposes sustained by any person while in or upon said building or premises as a result of the condition of said building or premises or as a result of any act or omission, or in any way arising from the designation of such premises as a shelter, or the designation or use thereof as a mass care center, first aid station, temporary hospital annex, or other necessary facility for emergency purposes, except a willful act, of such owner or occupant or his servants, agents or employees when such person has entered or gone upon or into said building or premises for the purpose of seeking refuge, treatment, care, or assistance therein during destructive operations or attacks by enemies of the United states or during tests ordered by lawful authority or during a natural or manmade emergency. No disaster service worker who is performing disaster services ordered by lawful authority during a state of war emergency, a state of emergency, or a local emergency, as such emergencies are defined in Section 8558 of the Government Code**,** shall be liable for civil damages on account of personal injury to or death of any person or damage to property resulting from any act or omission in the line of duty, except one that is willful.

- *Civil Code §1714.6* states that the violation of any statute or ordinance shall not establish negligence as a matter of law where the act or omission involved was required in order to comply with an order or proclamation of any military commander who is authorized to issue such orders or proclamations; nor when the act or omission involved is required in order to comply with any regulation, directive, or order of the Governor promulgated under the California Emergency Services Act. No person shall be prosecuted for a violation of any statute or ordinance when violation of such statute or ordinance is required in order to comply with an order or proclamation of any military commander who is authorized to issue such orders or proclamations; nor shall any person be prosecuted for a violation of any statute or ordinance when violation of such statute or ordinance is required in order to comply with any regulation, directive, or order of the Governor promulgated under the California Emergency Services Act. The provisions of this section shall apply to such acts or omissions whether occurring prior to or after the effective date of this section.

- On a state level, limited liability protection is available through Health and Safety Code §1317 which states that no health facility, its employees, physician, dentist, clinical psychologist or podiatrist shall be liable in any action arising from refusing to render emergency care if based on a determination, exercising reasonable care, the person is not suffering from an emergency medical condition, or the health facility does not have the appropriate facilities or qualified personnel available to render those services. The same applies to any “rescue team” if resuscitation efforts are attempted and in good faith.

These protections only provide relief at the state level and for state-run programs. Thus, it is recommended that similar protection be afforded at a federal level.

It is further recommended that regulatory and compliance framework be flexible so that in the event of a healthcare surge, declaration of waivers leads surge response and affords healthcare providers the required flexibility and compliance and liability protection to provide care. Specifically:

- Expanding *Government Code §8659* to include all existing facilities as defined in this guide.
- Expanding *Government Code §8659* to include liability protection for facilities where volunteers present at facilities through informal channels. For example, for volunteers that are not sourced through ESAR-VHP[185], instead those that directly present at facilities. Another option would be to federalize such volunteers, which means that such volunteers would be considered employees of the federal government sourced through Department of Health Services.

- During most healthcare surge events, facilities will experience surge before a formal emergency is declared. In order to protect facilities, waivers accompanying the declaration should be retroactive to experience of surge.
- Waivers should not be specific to a certain set of regulations (for example, Title 22), but should be broad, yet appropriate for the circumstances. Facilities require a mechanism by which they can determine what level of care should be provided and what regulations should be complied with based on the type of declaration.
- Governor's request for waiver of federal requirements must be initiated for local as well as state emergencies.
- Waiver should be for suspension of regulations as well as enforcement.
- Beyond the waivers discussed in this manual, state should make available a list of specific laws and regulations that can and cannot be waived during a healthcare surge (for example, list of sections of Title 22 that might not be waived). In addition, waiving certain regulations might not be sufficient since providing care during a healthcare surge is likely to violate other related regulations. Facilities require specific guidance that provides them the necessary means to operate outside of license.
- Counties need to establish a formal surge mechanism which will have a measure of presumption or automatic confirmation that facilities are free to provide care during healthcare surges. Another option to consider would be a stand-by prior program flex approval conditioned upon declaration of disaster and compliance with as much as possible under the circumstances
- To the extent that Government Code §8659 and Civil Codes §1714.5 and 1714.6 do not sufficiently protect hospitals from liability, the recommendation is that liability protections be developed, or current protections be expanded, to ensure that hospitals are not held liable so long as they can show reasonable efforts to preserve safety for both its patients and staff.
- Additionally, while a local office can declare a local emergency, Government Code 8571 (Government Code §8571 – has the authority during a state of war emergency or a state of emergency to suspend any regulatory statute, or statute prescribing the procedure for conduct of state business, or the orders, rules, or regulations of any state agency, including subdivision (d) of Section 1253 of the Unemployment Insurance Code, where the Governor determines and declares that strict compliance with any statute, order, rule, or regulation would in any way prevent, hinder, or delay the mitigation of the effects of the emergency) would not apply under such circumstances. Thus facilities must be provided permission ahead of time to flex patient care areas and move patients from licensed units to non-licensed part of organizational asset.

The occurrence of a healthcare surge will require significant changes in the way in which health and medical care is delivered. If the healthcare system is to optimize population outcomes, planning, education, and training efforts should be focused on the development and implementation of appropriate protocols for Standard of Care during a Healthcare Surge.

5.2 Non-licensed Healthcare Facility Operations

According Emergency Medical Services Authority of California, *Hospital Incident Command System Guidebook*, August 2006, an Emergency Management Program is defined as "a program that implements the organization's mission, vision, management framework, and strategic goals and objectives related to emergencies and disasters. It uses a comprehensive approach to emergency management as a conceptual framework, combining mitigation, preparedness, response, and recovery into a fully integrated set of activities. The "program" applies to all departments and organizational units within the organization that have roles in responding to a potential emergency. (Adapted from NFPA 1600, 2004 and the VHA Guidebook, 2004)

Community based capacity and capability planning includes participation of all of community's assets. This does not, however, preclude or diminish the need for individual non-licensed healthcare facilities to have a comprehensive emergency management plan that addresses mitigation, preparedness, response, and recovery activities.

Each non-licensed healthcare facility is expected to develop its own emergency management plan. While this section is not intended to serve as a template for an emergency management plan, it does provide guidelines and operational tools for key components of the preparedness and response phases. The section also reviews regulations, standards, waivers and liability protection for hospital operations and some of the key recommendations. Topics covered in this section include: emergency management standards, continuity of business operations, security planning, hazardous waste management, decontamination, medical waste management, infection control, and mass fatality management. The operational tools manual for this section contains several tools, specifically, list of emergency preparedness tools and access links, Incident Command System, business continuity plan template, standard operating procedure template for equipment, plant and utilities, standardized security assessment/vulnerability tool, lockdown policy and procedure sample, mass fatality factsheet, and hospital damage report (limited and comprehensive assessment).

5.2.1 Emergency Management Standards

Emergency management standards provide a structure for development of emergency management plans. Below is a review of emergency management standards that apply to healthcare facilities.

5.2.1.1 OSHA

29 CFR 1910.38 Emergency Action Plans; corresponding Cal/OSHA reference - CCR Title 8, Sec 3220

a. Application. An employer must have an emergency action plan whenever an OSHA standard in this part requires one. The requirements in this section apply to each such emergency action plan.
b. Written and oral emergency action plans. An emergency action plan must be in writing, kept in the workplace, and available to employees for review. However, an employer with 10 or fewer employees may communicate the plan orally to employees.
c. Minimum elements of an emergency action plan. An emergency action plan must include at a minimum:
    - c.1. Procedures for reporting a fire or other emergency;
    - c.2. Procedures for emergency evacuation, including type of evacuation and exit route assignments;
    - c.3. Procedures to be followed by employees who remain to operate critical plant operations before they evacuate;
    - c.4. Procedures to account for all employees after evacuation;
    - c.5. Procedures to be followed by employees performing rescue or medical duties;
    - c.6. The name or job title of every employee who may be contacted by employees who need more information about the plan or an explanation of their duties under the plan.
d. Employee alarm system. An employer must have and maintain an employee alarm system. The employee alarm system must use a distinctive signal for each purpose and comply with the requirements in 1910.165.
e. Training. An employer must designate and train employees to assist in a safe and orderly evacuation of other employees.
f. Review of emergency action plan. An employer must review the emergency action plan with each employee covered by the plan;
    - f.1. When the plan is developed or the employee is assigned initially to a job;
    - f.2. When the employee's responsibilities under the plan change; and
    - f.3. When the plan is changed.

5.2.1.2 Incident Command System

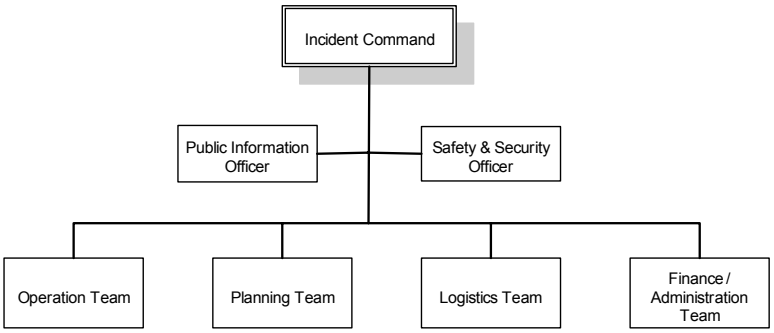
According to the California Governor's Office of Emergency Services (OES) website (http://acs.oes.ca.gov/Pages/acs_definitions.html), "The ICS (Incident Command System) is a long proven system of handling field response activities in emergencies. It provides essential management using these aspects: common terminology, modular organization, integrated communications, a unified command structure, consolidated action plans, manageable span-of-control, predesigned incident hospitals and comprehensive resource management."

Some non-licensed healthcare facilities may already utilize the Incident Command System version designed by Collaborating Agencies Responding to Disasters (CARD). It is recommended that all non-licensed healthcare facilities adopt an Incident Command System methodology for emergency organization structure and management such as the CARD version. It is also further recommended that non-licensed healthcare facilities become familiar with the Hospital Incident Command System (HICS) as part of their emergency management planning, and become more integrated with this system as part of their surge preparedness.

5.2.1.3 Tool - Version of Incident Command Collaborating Agencies Responding to Disasters (CARD)

The "Version of Incident Command Collaborating Agencies Responding to Disasters (CARD)"is shown below. The complete tool can be found in the Operational Tools Manual.

CARD version of Incident Command System



- Incident Command: Leads the response; appoints and empowers team leaders; sets tone and standards for response. Encourages teamwork and communications.
- Depending upon the situation the Incident Command might appoint Command Staff
  - Public Information Officer: Works with the media and distributes messages to the public and local community.
  - Safety and Security Officer: Focuses on the safety of all people responding to the incident.
- Management Functions
  - Operation Team: Handles key actions including first aid, search and rescue, fire suppression and securing the site.
  - Planning Team: Gathers information, thinks ahead and keeps all team members informed and communicating.
  - Logistics Team: Finds, distributes, and stores all necessary resources (supplies and people) to respond appropriately.
  - Finance/ Administration Team: Tracks all expenses, claims and activities and is the record keeper for the incident.

It is important to understand that ICS is a management system—not an organizational chart. Depending upon the size of the organization or the type of incident, one person may play more than one role.

Source: Collaborating Agencies Responding to Disasters (CARD), www.FirstVictims.org

While this manual refers to the Incident Command System as an emergency organization structure and management system so as to make it relevant for a larger audience (all hospitals), it is intended that the reader will apply the appropriate emergency management system that exists for their hospital/entity type.

5.3 Business Continuity Planning

Business Continuity Planning involves formulating an action-plan that enables an organization to perform its routine day-to-day operations in the event of an unforeseen incident. The Joint Commission's Environment of Care Standards requires organizations to address continuity of business operations as part of their emergency operations plan (EOP). National Fire Protection Association (NFPA) Standard 1600, Disaster/Emergency Management and Business Continuity Programs (http://www.nasttpo.org/NFPA1600.htm), has gained international recognition and consensus between the public and private sectors. The 9/11 Commission recommends that the NFPA 1600 Standard be adopted by the private sector. The 9/11 Commission further recommends that insurance and credit-rating industries look closely at a company's compliance with the NFPA Standard in assessing its insurability and creditworthiness. The Commission believes that compliance with the NFPA Standard should define the standard of care owed by a company to its employees and the public for legal purposes. NFPA standards are voluntary, open to public comment and are developed through consensus processes by technical committees.

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

The purpose of the Business Continuity function is to focus on certain aspects of non-licensed healthcare facility operations and service delivery that must not be interrupted. The continuity planning process should cover these main areas:

Business Planning - determines which aspects of the facility's operations are the most critical to its ability to provide care. This preliminary analysis phase assesses the potential risk and impact on the non-licensed healthcare facility operations, identifies recovery requirements and lists alternative strategies. The planning team must analyze the different departments that comprise the company's business. Identify and prioritize the departments and functions that are most critical to the business's survival.

Technical Support - determines the feasibility of the plan from a technical standpoint and ensures that the different departments, which may have been put at an off-premises site, have the equipment and technical support to provide care. Details of the functions that must be carried out must be provided, both prior to and following a disaster, to minimize the loss and improve the chances of quick recovery.

Implementation - ensures that non-licensed healthcare facility personnel will be able and willing to implement the plan. The plan should take personnel rotation into account, to avoid the situation where only one person knows about the equipment or other needs of the departments and their processes.

Maintenance and Testing - the Business Continuity Plan is a dynamic document that must reflect the continuing changes in daily operations of the non-licensed healthcare facility. Constant testing and adjusting are needed in order to ensure its continued viability.

When determining the necessity for a Business Continuity Plan, facility size should not be a factor, since business resumption is as critical to a medical office as it is to a large hospital.
The overall purpose of planning is to:

- Resume vital operations within a specified time after the incident occurs
- Return to normal operations as soon as practical and possible
- Train personnel and familiarize them with emergency operations.

The checklist below summarizes additional areas to consider when developing a Business Continuity Plan:

	Additional areas to consider when developing a Business Continuity Plan
☐	Clear definition of 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
☐	▪ Sanitary facilities
☐	▪ 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 facility .
☐	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, and procedures for catching up when systems are back in operation
☐	Evaluation of maximum outage tolerable for each major system and a restoration priority listing indicating the order in which to restore systems
☐	Verify that a copy of the Business Continuity Plan is stored off-site.

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

5.3.1 Tool - Sample Template for Business Continuity Plan

The "Sample Template for Business Continuity Planning" is shown below. The complete tool can be found in the Operational Tools Manual.

Section 1: Critical contact information

Critical Personnel and Entities*

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

Alternate:						
Critical Position #3:						
Alternate:						
Critical Position #4:						
Alternate:						

*Note, entities could include governmental agencies

Critical Vendors

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

Section 2: Functions and recovery objectives

Functions	Recovery Objectives
1. Function 1	
2. Function 2	
3.	
4.	
5.	

Section 3: Minimum Resource Requirements

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		

Section 4: All agencies, divisions and vendors upon which function is dependent

Function	Dependent Activity/Entity	BCP in place?	Comments
Function 1		Y/N	
Function 2		Y/N	
		Y/N	
		Y/N	
		Y/N	
		Y/N	

Section 5: Vital Records

Name/#	Description	Location

Section 6: Alternate Site for function

Special Alternate Facility Requirements:

Section 7: Emergency notification protocols (includes designee and communication mode)

1. During work hours
2. During non-work hours

Section 8: Security strategies for each function

Section 9: Designated Plan Coordinator

Name	Work Phone	Pager or Cell	Home Phone	Personal Email

Section 10: Review Date

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

In addition to continuity of business operations, development of standard operating procedures for key activities of Equipment, Plant and Utilities should be considered. It is essential to involve facility engineering personnel in the patient management planning processes in order to ensure maintenance of a safe non-licensed healthcare facility environment for both facility personnel and our patients. Areas within the expertise of engineering that must be included in the planning process are: alarm systems, electrical backup power, elevators-vertical transport, HVAC, 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. The standard operating procedure tool below can be used for Equipment, Plant and Utilities.

5.3.2 Tool - Standard Operating Procedure Tool for Equipment, Plant and Utilities

The "Standard Operating Procedure Template for Equipment, Plant and Utilities" is shown below. The complete tool can be found in the Operational Tools Manual.

1. Description of the Threat/Event

2. Impact on Mission Critical Systems

3. Operating Units and Key Personnel with Responsibility to Manage this Threat/Event.

4. Mitigation/Preparedness Activities of the Threat/Event.
    a. Hazard Reduction Strategies and Resource Issues
    b. Preparedness Strategies and Resource Issues.

5. Response/Recovery from the Threat/Event.
    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, 2002, provide extensive guidance around hazardous waste management (http://www1.va.gov/emshg/apps/emp/emp.htm).

Involving engineering in the planning and disaster management process will ensure that mission critical engineering systems essential to maintaining facility integrity will be properly monitored and preserved. The recommendation is that waivers for moving from an existing facility to another healthcare asset that doesn't meet the required standards (qualified immunity) be developed.

5.4 Security Planning

The Joint Commission's Environment of Care provides guidance on security planning. These standards will be effective January 1, 2008

EC.4.15 - The organization establishes strategies for managing safety and security during emergencies.

Controlling the movement of individuals into, throughout and out of the organization during an emergency is essential to the safety of patients and staff, and to the security of critical supplies, equipment and utilities. The organization 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. Factors influencing access and movement vary depending upon the type of emergency and local conditions (ie. the decision by the organization to shelter staff families, the allowance for or prohibition against firearms, mutual aid agreements with nearby hospitals or vendors, etc.)

During an emergency, the campus or immediate environment around the organization may be under the authority of the local police or sheriff serving the larger community. Access to and from the organization on local roads and interstates could be subject to local, state or even federal control. As an incident evolves, this responsibility and authority may shift from one agency to another. For this reason, it is important that the Emergency Operations Plan includes reference to any existing community command structure to provide for on-going communication and coordination with this structure. In the absence of such a command structure, the organization maintains direct contact with the agencies charged with community security.

Emergency Medical Services Authority of California, *Hospital Incident Command System Guidebook*, August 2006, provides guidance for security planning. Due to its applicability in the context of healthcare facilities, this section has been borrowed from the guidebook. Certain passages have been modified to provide appropriate context for this guide.

5.4.1 Lock-Down vs. Restricted Visitation

Each incident will have its own security-related issues. In the past, no consideration was given to the facility being a secondary or especially a primary target for a harm event. Facilities cannot afford that passive approach any longer. “Gang violence,” employee or patient-related violence, and terrorism are pressing reasons why facility security must be taken seriously and comprehensive planning and training conducted.

5.4.1.1 Tool - Standardized Security Assessment / Vulnerability

The "Standardized Security Assessment / Vulnerability Tool" is shown below. The complete tool can be found in the Operational Tools Manual.

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

The decision to restrict access must be made early into the event by the Incident Commander in conjunction with other senior personnel such as the Security Branch Director. If access is to be restricted, then implementing the decision should immediately be carried out according to the EOP. Announcing the security restrictions to the staff and public should be immediate, followed by assigned personnel rerouting pedestrian and vehicular traffic and doors being locked, either manually or electronically (Access Control Unit). Locked doors should ideally be monitored to ensure no

compromise occurs. Internal and external signage indicating the doors are NOT to be opened (and, where appropriate, redirecting would-be entrants) should be posted as soon as possible. Such signage can be created in advance and stored, ideally, by doors for rapid deployment. It is crucial to involve life-safety engineers/personnel in planning and response to ensure adequate egress in the event of a fire or other internal emergency.

Heightened surveillance procedures may need to be implemented including inspecting suspect packages; closer scrutiny of personnel at checkpoints, including verification that each individual, including staff, is wearing a proper identification badge; and assigning properly protected personnel at patient arrival points, including the decontamination sector if activated (Crowd Control Unit). Certain areas such as the emergency department, pharmacy, and Facility Incident Command Center (for example, Hospital Command Center) should receive enhanced security support. Steps may need to include restricting staff entry into certain areas because of security concerns, unsafe conditions, or because no additional staff is required.

5.4.1.2 Tool - Lockdown Policy and Procedure Sample

The "Lockdown Policy and Procedure Sample" is shown below. The complete tool can be found in the Operational Tools Manual.

I. PURPOSE

To provide procedures and guidance when the need to lockdown 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 lockdown 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 lockdown and will take measures to control access to and from the facility, whenever possible.

C. STAFF

Will separate themselves, if at all possible, from any involvement in a civil disturbance.

IV. PERSONNEL

All staff members

V. PROCEDURES

A. GENERAL – CIVIL DISTURBANCE

1. Regardless of how peaceful the intent or how righteous the cause of a civil disturbance, because of the strong emotional nature of the issues involved, these manifestations on many occasions end in rioting, violence, and destruction/looting of property.

2. Based on the nature of the disturbance, it will be managed by security staff until the decision is made that management of the situation requires the activation of the Facility Incident Command System.

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

B. MASS CONTAMINATION

1. Contaminated individuals/equipment entering the facility building may require the total closure of operations of all or part of the facility.

2. In a mass contamination situation, only individual or equipment which are KNOWN to be free of contamination will be allowed in the building

C. ACTIVATION/NOTIFICATION

1. The decision to initiate lockdown 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 lockdown 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 Lockdown>> "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 lockdown, the Incident Command Center and other designated portions of the Incident Command System organization will be activated. This will normally include as a minimum, a portion of the Planning Section and the Public Information Officer.

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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 if has already been initiated.

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, to include 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.

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 which are under guard 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. Inpatient 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 lockdown, 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.

LOCKDOWN CHECKSHEET

Mission: The primary goal in a lockdown situation is to isolate and control the situation while caring for the safety of the patients, visitors, staff, and property.

____ Personnel discovering the lockdown 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 individual 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 - Lockdown for Scripps Mercy Hospital.

5.4.2 Supplemental Security Staffing

Supplemental personnel may be needed to assist the on-duty Security staff, depending on the type and length of the incident. This need may be met by calling personnel in from home, reassigning other non-Security personnel to select tasks, and requesting help from local law enforcement (Law Enforcement Interface Unit). Planning should address when law enforcement will be able to assist and how they will be integrated into facility operations and the Incident Command System. Their deployment assignments and pertinent response procedures, including rules of engagement, should be discussed upon their arrival along with what support they will require (e.g., personal protective equipment, phone access). In addition to using local law enforcement to supplement staffing shortfalls, consideration should be given to having a contingency contract(s) with local or national private security firms to provide trained personnel during an emergency. Planning should address the deployment, supervision, and needed support for these personnel along with associated utilization expenses.

5.4.3 Traffic Control

Depending on the situation, victims will likely be arriving by private autos accompanied by quickly escalating numbers of family and friends. The media will also be arriving at some point and requesting special parking locations for their outside interviewing and “live shots.” The gravity of the situation may warrant inspecting all of these vehicles as they enter the campus; this will require additional personnel and the equipment needed to do the inspection (Traffic Control Unit). For non-licensed healthcare

facilities sharing campuses with other facilities, the decision-making associated with campus security should be done in a collaborative manner and employ optimal communication practices.

Traffic patterns may need to be revised to optimize EMS and other emergency vehicle arrivals. The area in front of the emergency department should be kept clear along with areas assigned for decontamination. All available parking areas should be opened and consideration given to suspending gate-entry systems and fee payments.

Planning should address situations such as abandoned vehicles, including those with possible chemical contamination, and how they should be removed from outside the emergency department and other critical locations. It should also be anticipated that law enforcement may request vehicle information (tag number make and model of the car, and location) for the patients being seen.

As time goes on, vendor deliveries may need special inspections, alternative routing, or cancellation. The implications of all of these actions should not be taken lightly and will require careful planning and coordination.

5.4.4 Chain of Custody Considerations

For suspicious incidents, specific chain-of-custody procedures must be followed. The EOP should outline a fundamental strategy of basic objectives and steps. These procedures ideally will address everything from handling a patient's personal effects to packaging and transfer of laboratory specimens. local law enforcement should be consulted when developing these procedures to ensure the outlined steps are consistent with accepted practice. During an incident it will be important for the Security Branch to identify what procedures are to be employed and to quickly disseminate easily understood instructions

5.5 Hazardous Waste Management

Veterans Health Administration Center for Engineering & Occupational Safety and Health in their *Emergency Management Program Guidebook*, 2002, provide extensive guidance around hazardous waste management (http://www1.va.gov/emshg/apps/emp/emp.htm). This section has been borrowed from the Emergency Management Program Guidebook.

Key OSHA Hazardous Materials Regulations

- Subpart H - Hazardous Materials (1910.101-.126)
    - 1910.120 - Hazardous Waste Operations and Emergency Response (HAZWOPER) and Appendices A-E.
- Subpart I - Personal Protective Equipment (1910.132-.139 and App. B)
    - 1910.132 - General Provisions
    - 1910.133 - Eye and Face Protection
    - 1910.134 - Respiratory Protection (and App. A-D)
    - 1910.136 - Occupational Foot Protection
    - 1910.138 - Hand Protection
- Subpart Z - Toxic & Hazardous Substances (1910.1000-.1450 App. B)
    - 1910.1200 - Hazard Communication (and App. A-E)

From California's perspective (Cal/OSHA), Subchapter7. General Industry Safety orders, Group 16. Control of Hazardous Substances will apply (Note, The General industry Safety Orders are generally applicable in health care). Emergency first responders , at the site of the release, are covered under OSHA's Standard on Hazardous Waste operations and Emergency Response (HAZWOPER), or the parallel Cal/OSHA state Plan standards (Title 8 CCR, Section 5192-E), and depending on their roles, some hospital employees also are covered by the standard.

OSHA 1910.120 - Hazardous Waste Operations and Emergency Response (HAZWOPER) regulation applies to facilities in at least three scenarios: when facilities have an internal release of a hazardous substance which requires an emergency response; when facilities respond as an integral unit in a community-wide emergency response to a release of hazardous substance; and, if a facility is a RCRA (Resource Conservation and Recovery Act)-permitted Treatment, Storage and Disposal Facility (OSHA, 1991).

The term "emergency" is dependent upon several factors, including the hazards associated with the substance, the exposure level, the potential for danger and the ability to contain the substance. OSHA does not require that facilities receive accident victims, but if the victim were part of an emergency involving hazardous substances and facility personnel needed to decontaminate, HAZWOPER would apply (OSHA, 1992).

The role of facility personnel in the safe decontamination of victims has been further clarified in the OSHA publication "Best Practices for Hospital-Based First Receivers of Victims from Mass Casualty Incidents Involving the Release of Hazardous Substances," released in January 2005 (http://www.osha.gov/dts/osta/bestpractices/html/hospital_firstreceivers.html). In this document OSHA outlines the minimal level of personal protective equipment recommended for healthcare employees decontaminating victims presenting to a non-contaminated medical facility.

The Environmental Protection Agency (EPA), as part of EPCRA, has stated that the agency will not pursue enforcement actions for environmental consequences of necessary and appropriate actions, such as decontamination, during the phase of an emergency response where an imminent threat to human health and life is present. However, once this phase passes, every attempt should be made to contain the runoff and dispose of it properly. All facilities implementing decontamination programs must include procedures for runoff containment and management in the facility decontamination plan. EPA's website has extensive guidelines for hazardous waste storage, disposal, transportation, and treatment. The guidance can be accessed at: http://www.epa.gov/epaoswer/osw/hazwaste.htm

Key aspects to consider in the development of the standard operating procedure for decontamination include event recognition, activation, management, primary triage, patient registry and collection of personal property, decontamination, secondary triage, logistics for treatment, public information and post-incident actions. Healthcare facility decontamination training programs should follow NFPA Standard 473, Professional Competence of EMS Personnel Responding to a Hazardous Materials Incident.

5.6 Decontamination

In addition to providing guidance on hazardous waste management, OSHA's publication "Best Practices for Hospital-Based First Receivers of Victims from Mass Casualty Incidents Involving the Release of Hazardous Substances" may also serve as the primary source for decontamination procedures. Additionally, the Hospital and Healthcare System Disaster Interest Group and The California Emergency Medical Services Authority, have developed *Patient Decontamination Recommendations For Hospitals*, July 2005. The document provides recommendations for protecting healthcare providers and managing patients in the event of a hazardous materials exposure. Specific algorithms for different contamination events have been included in the guide. The guide can be accessed at: http://www.emsa.ca.gov/aboutemsa/emsa233.pdf. Although this guide was developed for hospitals, non-licensed healthcare facilities can use these recommendations to customize their own emergency management plan to meet the unique decontamination needs of the facility and event.

Some of the recommendations include:

1. Facilities must regularly assess the risks to the community and perform a hazards vulnerability analysis. The level of equipment and staff protection must be based on this analysis.
2. Facilities are encouraged to establish relationships and notification procedures with appropriate local agencies (e.g. local EMS and public health) in order to:
    - Ensure communication between the field and facility to allow for preparation.
    - Ensure that properly trained and equipped field/pre-facility responders decontaminate patients in the field in order to protect the facility as much as possible.
    - Understand the local protocols and capabilities for field decontamination of patients.
    - Ensure proper notification of an event to appropriate local agencies.
3. The primary role of a non-licensed healthcare facility in a hazardous materials event is to triage, treat, decontaminate and medically screen patients as necessary.
    - An influx of contaminated patients will overwhelm any facility and therefore facilities must work collaboratively with the community and local government to meet the challenges of a surge of contaminated patients.
    - Facilities must be prepared for potentially contaminated patients who self-refer and present to the facility.
    - 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. Note the exception for Radiological decontamination in which emergency treatment takes precedence over Radiological decontamination.
        - 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 EMS 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.

5.7 Medical Waste Management[186]

The regulations for medical waste management can be found in California's Medical Waste Management Act (Division 194, Part 14 of the Health and Safety Code). During events when waste volumes increase significantly, participating hospitals are to comply with established institutional plans as required by the California Department of Health Services' Medical Waste Management Act. Per Section 117960(i) of the Medical Waste Management Act (MWMA) an emergency action plan is required. Indicate in the emergency action plan the actions to be taken in the event of a disruption of service as a result of a natural disaster or an equipment failure. Existing federal and state waste disposal regulations and statutes are to be followed as these events unfold. Hospitals are to contact the state or local enforcing agency to determine regulations. Accurate record keeping is to be maintained as set forth in various sections of MWMA.

The Public Health and Hospital Preparedness - Public Health and Hospital Preparedness, state of Wisconsin, *Wisconsin Hospital Emergency Preparedness Plan (WHEPP)*, Version 3, provides guidelines for medical waste management. According to the report, in a mass casualty event, the potential for overloading the waste handling capacity of non-licensed healthcare facilities is greatly increased. Because of this potential, each non-licensed healthcare facility is to develop protocols in addition to existing waste management protocols that address the challenges associated with the increased volume of medical waste.

1. Greater quantities of materials suitable for containing biological agents or infectious organisms will be needed. These materials are to include but not limited to:
    a. Biohazard labeled bags
    b. Sharps containers
    c. Liquid handling containers
    d. Rigid, closeable, leak proof containers
    e. All other associated supplies materials
2. Facilities are to list the supplies with supporting information that shows:
    a. The quantity normally on hand
    b. An estimate of how long these supplies will last for an inpatient population level determined by the non-licensed healthcare facility.
3. If the existing inventory of materials or usage rate compromises patient care or waste containment needs, the non-licensed healthcare facility is to obtain additional material:
    a. If an Emergency Operation Center (EOC) is not activated, contact other participant non-licensed healthcare facilities and request the materials needed.
    b. If the EOC is activated, contact the EOC and request the materials needed. The EOC may obtain materials from:
        i. Participant hospitals
        ii. Other known sources
        iii. The state of California by submitting a request for materials from the Centers for Disease Control (CDC), "Vendor Managed Inventory Program"

Waste Storage:

1. Facilities are to consult with their medical waste disposal vendors for details of the vendor's ability to provide continued waste disposal services during a mass casualty emergency.
2. Facilities are to consult with their County/Tribal Emergency Management office for protocols for storage of medical waste during a mass casualty incident.
3. Medical waste may need to be stored under refrigeration (<34"F) to limit nuisance conditions.
    a. If the EOC is not activated, non-licensed healthcare facilities are to contact the County/Tribal Emergency Management office to obtain refrigerated storage.
    b. If the EOC is activated, non-licensed healthcare facilities are to contact the EOC to obtain refrigerated storage.
4. Separation of medical waste from the solid waste stream is to be maintained.
5. Combined waste streams are to be handled as medical waste.

6. Chemical and radiological wastes must be separated and segregated from medical waste in order to avoid dual contamination.
7. Waste stored on the premises of the non-licensed healthcare facility must be secure to prevent access by unauthorized persons and to prevent accidental spread of contamination.
8. The designated storage area for medical waste must display the appropriate warning signs using wording required by Medical Waste Management Act Section 118310.
9. Refrigerated storage areas need to be located away from external air intakes or they need to be maintained with negative airflow

5.8 Infection Control

Standards and Regulations
The Joint Commission infection control standard requires accredited organizations to offer influenza vaccinations to staff, which includes volunteers, and licensed independent practitioners with close patient contact. The standard has become an accreditation requirement beginning January 1, 2007, for the Critical Access Hospital, Hospital and Long Term Care accreditation programs.

The Joint Commission standard requires organizations to:

- Establish an annual influenza vaccination program that includes at least staff and licensed independent practitioners;
- Provide access to influenza vaccinations on-site;
- Educate staff and licensed independent practitioners about flu vaccination; non-vaccine control measures (such as the use of appropriate precautions); and diagnosis, transmission and potential impact of influenza;
- Annually evaluate vaccination rates and reasons for non-participation in the organization's immunization program; and
- Implement enhancements to the program to increase participation.

CCR Title 8, Section 5193 – Bloodborne Pathogens: applies to all occupational exposure to blood or other potentially infectious materials.

The Public Health and Hospital Preparedness - Public Health and Hospital Preparedness, state of Wisconsin, *Wisconsin Hospital Emergency Preparedness Plan (WHEPP)*, Version 3, provides guidelines for Infection Control. These guidelines have been adapted for California and reproduced below.

<u>Definitions</u>

"Isolation rooms" are defined (California Mechanical Code Section 414.0) as negative air pressure airborne isolation rooms (hereinafter, "NPAir") with a minimum of 12 air exchanges per hour and direct exhaust to the outside, which is located at least 7 ft above roof and more than 25 feet from an air intake and from areas where people may pass. If air cannot be exhausted directly to the outside more than 25 feet from an air intake and from areas where people may pass, then air should be filtered through an appropriately installed and maintained HEPA filter. These rooms should be appropriately alarmed (CMC 414.0) and tested monthly (and daily when in use) to verify negative airflow.

"Pre-identified room": In facilities that do not have "NPAir" that meet the above criteria, an enclosed private room(s) should be pre-identified for "isolating" patients with fever and rash illnesses to minimize exposure to other patients and staff (e.g., an examination room at the end of a hallway). A transportation route from the Emergency Department to this pre-identified room also is to be established.

Most non-licensed healthcare facilities do not have established negative pressure isolation rooms. However, the Minnesota Department of Health, Emergency Preparedness, Response and Recovery website has an "Airborne Infectious Disease Management" guide that non-licensed healthcare facilities can use to prepare appropriately. The guide was written to assist non-licensed healthcare facilities in developing strategies for temporary negative pressure isolation and provides instruction on the use of equipment used for airborne infectious disease management. Preventative maintenance schedules and a sample log for measuring particle counts are included for performance improvement planning. The guide can be found at:
http://www.health.state.mn.us/oep/training/bhpp/docs/AirborneWeb2_07Linked.pdf

5.9 Minimum Requirements for Medical Record Documentation

During a disaster scenario it may be reasonable to expect that most healthcare resources will be devoted to patient care and that administrative functions may need to be reduced to minimum requirements. It is recommended that non-licensed healthcare facilities and the affiliated healthcare professional staff use their standard medical record documentation if the surge event does not impact the ability to complete medical record documentation. Alternatively, the following information recommends minimum requirements for medical record documentation during healthcare surge.

5.9.1 Tool - Sample Medical Record Short Form

The following sample short form is an example of the type of medical record that could be initiated for a patient during a surge as needed. The short form medical record can be initiated during a surge and should be utilized to capture pertinent assessment, diagnosis, and treatment information. This short form is not expected to meet existing medical records documentation requirements. Rather it serves as a recommended set of elements that can be considered as accepted documentation during healthcare surge.

The "Short Form Medical Record" is shown below. The complete tool can be found in the Operational Tools Manual.

This document should be completed for victims seeking medical attention.

Demographic
Patient Demographic Information - include patient name, date of birth, parent/guardian, disaster incident number (DIN) 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 sticker could be affixed in place of handwriting the information.

History

- Chief Compliant - enter patient's primary complaint upon presenting for care
- Significant Medical History - enter notes on patient's medical history
- Glasgow Coma Scale - enter score for each area
- Field Triage Category - enter category
- Site Triage Category - enter category
- Pupil Size - enter pupil size
- Reactive - circle yes/no
- Pain - circle patient's level of pain
- Temp - indicate patient's temperature
- Pulse - indicate patient's pulse
- Respiration - enter patient's rate of respiration
- Blood Pressure - enter patient's systolic and diastolic blood pressure
- Intake - enter patient fluid intake
- Output - enter patient fluid output
- Special Dietary Needs - enter patient's special dietary needs
- Medications - indicate medications the patient is currently taking including name, dose, route, and time
- Last Menstrual Period - indicate last period
- Pregnancy Status - indicate status

Physical Exam

- Physical Exam - This section should be utilized to capture comments relative to the assessment of the patient's cardiovascular, pulmonary, and other body systems.

Re-Assessment

- This section is to be completed as a secondary assessment prior to a procedure. It includes a place for a set of vital signs and any lab results.

Procedure / Disposition

This section of the form includes space to document the following:

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

Demographic

Patient Name:_____ DOB/Age:_____

Parent / Guardian:_____ Primary Physician:_____

DIN:_____ MRN:_____

Allergies:_____ ☐ NKA

History

Chief Complaint:_____

Significant Medical History:_____

Last Menstrual Period:_____ Pregnancy Status:_____

Glasgow Coma Scale	
Eye	
Motor	
Verbal	
Total	

Field Triage Category: _____ Site Triage Category:_____

Pupil Size L:_____ Reactive: ☐ Yes ☐ No

Pupil Size R:_____ Reactive: ☐ Yes ☐ No

Circle pain (Adult): 0 (no pain) 1 2 3 4 5 6 7 8 9 10 (worst pain)

Circle pain[1] (Child/Other

Time recorded:			
Temp:			
Pulse:			
Respiration:			
Blood Pressure:			

Notes:_____

Intake		Output	
Total		Total	

Special Dietary Needs:_____

Medications

Name	Route		Dose	Time Frequency

Physician initials: _____ Nurse initials:_____ Other initials:_____

Physical Exam

Cardiovascular:_____ Pulmonary:_____

Neurological:_____

Other Significant Findings:_____

Physician initials:_____

Re-Assessment

Date:_____ Time:_____

System Review: Temp:____ Pulse:____ Respiration:____ Blood Pressure:____

Lab Results:_____ X-ray Results:_____

Physician initials: _____ Nurse initials:_____ Other initials:_____

Procedure / Disposition

Pre-Procedure DX:_____ Post-Procedure DX:_____

Procedure:_____ Findings:_____

Condition of Patient Post Procedure: ☐ Critical ☐ Guarded ☐ Stable

Discharge Instructions (YES/NO): Written_____ Verbal_____

Diet: ☐ Regular ☐ Soft ☐ Liquid ☐ Other:_____

Activities: ☐ No Restrictions ☐ Restrictions as Follows:_____

Discharge Medications:_____

Follow-Up Visit: When_____ NA:_____

Condition at discharge: ___ Critical ___ Guarded ___ Stable ___ Fair ___Deceased

___ Temp ___Pulse ___Respiration ___Blood Pressure

Discharge: ☐ Home ☐ Shelter ☐ ACS ☐ SNF ☐ Deceased Date: _____

☐ Transfer:_____ ☐ Other:_____ Time: _____

Admitted: ☐ Time admitted:_____

Physician order:_____

_____

Notes: _____

_____

Physician initials: _____ Nurse initials:_____ Other initials:_____

Wong, DL, Hockenberry-Eaton M, Wilson D, Winkelstein ML, Schwartz P: *Wong's Essentials of Pediatric Nursing* , ed. 6, St. Louis, 2001, p.1301.

5.10 HIPAA Compliance During Healthcare Surge

In order to effectively treat patients under healthcare surge conditions, covered entities may require flexibility to exercise professional discretion related to maintaining the privacy and security of protected health information (PHI). Waiver of existing HIPAA law during a disaster scenario is unlikely to be granted by the federal government and is not recommended due to the potential long-term effects of identify theft. However, as was demonstrated during Hurricane Katrina, the enforcement of HIPAA is unlikely so long as "…failure to comply is based on reasonable cause and is not due to willful neglect, and the failure to comply is cured within a 30-day period." [187, 188] The following information highlights provisions for covered entities under current HIPAA law that can be applied to disaster-related scenarios and healthcare surge.

5.10.1 Covered Entity

According to 45 CFR 160.103 covered entity means: (1) A health plan. (2) A health care clearinghouse. (3) A health care provider who transmits any health information in electronic form in connection with a transaction covered by this subchapter.

5.10.2 Business Associate Agreements

In response to Hurricane Katrina the U.S. Office of Civil Rights released a bulletin to provide guidance around business associate agreements under 45 CFR 164.504. The bulletin states the following:

"…business associates that are managing such information on behalf of covered entities may make these disclosures to the extent permitted by their business associate agreements with the covered entities, as provided in the Privacy Rule. For example, a business associate agreement may broadly permit the business associate to make disclosures the covered entity is permitted to make, or may otherwise permit the business associate to make treatment or other disclosures as permitted by the Privacy Rule. If the business associate agreement does not permit such disclosures, the covered entity and business associate can amend the agreement to permit them.

Similarly, if a business associate uses an agent to assist in performing its business associate functions, the business associate must ensure that the agent agrees to the privacy restrictions and conditions that apply to the business associate. The agreement between a business associate and its agent may also broadly permit the agent to make disclosures the covered entity is permitted to make or may otherwise permit the agent to make treatment or other disclosures permitted by the Privacy Rule.

Covered entities or their business associates may provide health information on evacuees to another party for that party to manage the health information and share it as needed for providing health care to the evacuees. Where a covered entity provides protected health information to another for this purpose, the Privacy Rule requires the covered entity to enter into a business associate agreement with this party. If the business associate, rather than the covered entity itself, is providing this information to another party that is acting as its agent, the covered entity's business associate must enter into an agreement to protect health information with this party. See 45 CFR 164.504(e)(2)(ii)(D)."

In summary, business associate agreements remain effective during disasters. Under surge conditions covered entities may be forced to engage with persons outside their workforce or with organizations in which no prior agreement has been established. *Workforce*, according to 45 CFR 160.103 means:

*"…*employees, volunteers, trainees, and other persons whose conduct, in the performance of work for a covered entity, is under the direct control of such entity, whether or not they are paid by the covered entity."

In these cases, however, it is recommended that covered entities make a reasonable effort to establish new business associate agreements during surge as soon as practicable.

5.10.3 Workforce Training

Covered entities should make reasonable efforts to maintain current training practices according to 45 CFR 164.530(a)(2) which states:

"A covered entity must train all members of its workforce on the policies and procedures with respect to protected health information required by this subpart, as necessary and appropriate for the members of the workforce to carry out their function within the covered entity."

5.10.4 Notice of Privacy Practices

Covered entities should make reasonable efforts to maintain current notice of privacy practices during surge according to 45 CFR 164.520 which states:

"…an individual has a right to adequate notice of the uses and disclosures of protected health information that may be made by the covered entity, and of the individual's rights and the covered entity's legal duties with respect to protected health information." [189]

5.10.5 Uses and Disclosures

HIPAA provides guidance related to uses and disclosures for disaster relief purposes but makes a qualified requirement that the covered entity obtain the patient's consent whenever possible, or rely on its professional judgment that disclosure is in the individual's best interest. According to 45 CFR 164.510(b)(4):

"A covered entity may use or disclose protected health information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating with such entities the uses or disclosures permitted by paragraph (b)(1)(ii) of this section. The requirements in paragraphs (b)(2) and (3) of this section apply to such uses and disclosure to the extent that the covered entity, in the exercise of professional judgment, determines that the requirements do not interfere with the ability to respond to the emergency circumstances." [190]

In response to Hurricane Katrina the U.S. Office for Civil Rights released a bulletin to provide guidance around HIPAA Privacy and Disclosures in Emergency Situations. The bulletin states the following:

"Providers and health plans covered by the HIPAA Privacy Rule can share patient information in all the following ways:

TREATMENT. Health care providers can share patient information as necessary to provide treatment.

- Treatment includes:
  - Sharing information with other providers (including hospitals and other facilities),
  - Referring patients for treatment (including linking patients with available providers in areas where the patients have relocated), and
  - Coordinating patient care with others (such as emergency relief workers or others that can help in finding patients appropriate health services).

- Providers can also share patient information to the extent necessary to seek payment for these health care services.

NOTIFICATION. Health care providers can share patient information as necessary to identify, locate and notify family members, guardians, or anyone else responsible for the individual's care of the individual's location, general condition, or death.

- The health care provider should get verbal permission from individuals, when possible; but, if the individual is incapacitated or not available, providers may share information for these purposes if, in their professional judgment, doing so is in the patient's best interest.
  - Thus, when necessary, the non-licensed healthcare facility may notify the police, the press, or the public at large to the extent necessary to help locate, identify or otherwise notify family members and others as to the location and general condition of their loved ones.

- In addition, when a health care provider is sharing information with disaster relief organizations that, like the American Red Cross, are authorized by law or by their charters to assist in disaster relief efforts, it is unnecessary to obtain a patient's permission to share the information if doing so would interfere with the organization's ability to respond to the emergency.

IMMINENT DANGER. Providers can share patient information with anyone as necessary to prevent or lessen a serious and imminent threat to the health and safety of a person or the public -- consistent with applicable law and the provider's standards of ethical conduct.

FACILITY DIRECTORY. Healthcare facilities maintaining a directory of patients can tell people who call or ask about individuals whether the individual is at the facility, their location in the facility, and general condition.

Of course, the HIPAA Privacy Rule does not apply to disclosures if they are not made by entities covered by the Privacy Rule. Thus, for instance, the HIPAA Privacy Rule does not restrict the American Red Cross from sharing patient information." [191]

Permitted use and disclosure of PHI is stipulated for public health activities. Covered entities should make reasonable efforts to maintain required practice during surge according to 45 CFR 164.512 which states:

"A covered entity may disclose protected health information for the public health activities and purposes described in this paragraph to: (i) A public health authority that is authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, including, but not limited to, the reporting of disease, injury, vital events such as birth or death, and the conduct of public health surveillance, public health investigations, and public health interventions; or, at the direction of a public health authority, to an official of a foreign government agency that is acting in collaboration with a public health authority; (ii) A public health authority or other appropriate government authority authorized by law to receive reports of child abuse or neglect; (iii) A person subject to the jurisdiction of the Food and Drug Administration (FDA) with respect to an FDA-regulated product or activity for which that person has responsibility, for the purpose of activities related to the quality, safety or effectiveness of such FDA-regulated product or activity."

Use and disclosure of PHI is permitted for cases related to averting threats to health or safety. There may be cases in which a covered entity may need to disclose PHI to a non-covered entity such as search and rescue. Under 45 CFR 164.512(j):

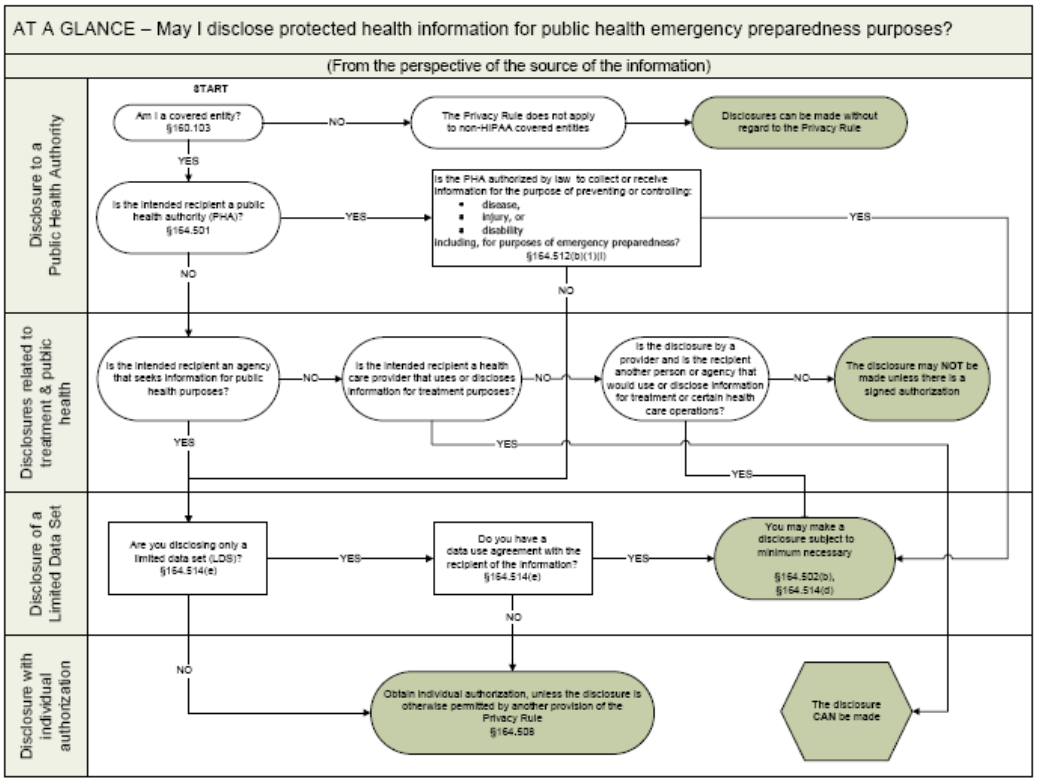
"A covered entity may, consistent with applicable law and standards of ethical conduct, use or disclose protected health information, if the covered entity, in good faith, believes the use or disclosure: (i)(A) Is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public; and (B) Is to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat; or (ii) Is necessary for law enforcement authorities to identify or apprehend an individual: (A) Because of a statement by an individual admitting participation in a violent crime that the covered entity reasonably believes may have caused serious physical harm to the victim; or (B) Where it appears from all the circumstances that the individual has

escaped from a correctional institution or from lawful custody, as those terms are defined in §164.501."

Finally, the U.S. Office for Civil Rights published a decision tool related to the disclosure of protected health information during emergency. The tool includes a process flow which could be applied to healthcare surge. Below is an image of a OCR decision tool.

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

The "Decision Making Tool for Disclosure of Protected Health Information (PHI)" is shown below. The complete tool can be found in the Operational Tools Manual.[192]



5.10.7 Security and Storage

Covered entities should take reasonable steps to establish the proper administrative safeguards according to 45 CFR 164.308(a)(7)(ii)(b)(c) and 45 CFR 164.310(a)(2)(i) which state:

"Establish (and implement as needed) policies and procedures for responding to an emergency or other occurrence (for example, fire, vandalism, system failure, and natural disaster) that damages systems that contain electronic protected health information. 1) Disaster Recovery Plan – Establish (and implement as needed) procedures to restore any loss of data. 2) Emergency mode operation plan – Establish (and implement as needed) procedures to enable continuation of critical business processes for protection of the security of protected health information while operating in emergency mode." [193]

"Establish (and implement as needed) procedures that allow facility access in support of restoration of lost data under the disaster recovery plan and emergency mode operations plan in the event of an emergency." [194]

5.10.8 California State Law Pertaining to Security of Information

California State law pertaining to security of information is expected to remain effective during healthcare surge. Entities covered under such laws should take reasonable steps to ensure the security of identity and health information. The list of relevant statutes includes but is not limited to the following:

- Confidentiality of Medical Information Act, California Civil Code 56 *et seq.*
- California Civil Code 1798.29
- California Civil Code 1798.81.5
- California Civil Code 1798.82
- California Civil Code 1798.83
- California Civil Code 1798.84
- California Civil Code 1798.85

Both covered entities under HIPAA may be covered by these State laws.

5.11 Patient and Valuables Tracking

The following section provides recommendations for county disaster planners on a paper-based patient tracking mechanism to be used during healthcare surge. Such a mechanism applies to facilities. Although electronic tracking systems are preferred, in cases where electronic systems are unavailable, paper-based tracking could serve as a viable alternative. Suggestions are provided for inter-facility tracking and patient valuables tracking. The recommendations in this section are based on the following major concepts:

- *Collect minimum necessary data:* Given that an unanticipated disaster may severely limit the capability of the healthcare system to obtain and transfer information, a manual tracking system should be simple to use and focus on collecting minimum data elements.
- *Assign patients a unique identifier:* A fundamental component of an effective tracking system will be to establish a unique patient identifier or "disaster incident number" (DIN).
- *Allow facilities to focus on treatment.* It is recommended that the operational area MHOAC be responsible for collecting tracking information from the hospitals within its jurisdiction. The American Red Cross or other appropriate agency could then be responsible for collecting the information and making it available to the public. Facilities would therefore be able to direct inquiries to these information sources and focus on delivering care to patients.
- *Patient tracking (vs. person tracking) is a priority:* Tracking persons who have sought treatment at healthcare system entry points (e.g. Hospitals, Alternate Care Sites, EMS) during surge is a priority versus 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. However, for the purposes of this section a focus on patient tracking is recommended.
- *Paper-based tracking is an essential contingency:* Although significant efforts are underway to develop robust electronic patient tracking systems for disaster and emergency purposes, manual back-up processes should be maintained in case of system outage. Additionally, 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.

The remaining portions of this section describe the critical components of paper-based patient tracking including the definition and use of a "disaster incident number", policies and procedures for patient and valuables tracking, and a sample patient tracking form.

5.11.1 Disaster Incident Number (DIN)

A disaster incident number is a unique identifier used to track patients during healthcare surge. The county Office of Emergency Services or Public Health is recommended to serve as the central source responsible for creating and disseminating DINs to public and private healthcare facilities including emergency medical services. Having a single entity responsible for creating DINs is essential to avoiding duplication.

A policy and form has been drafted that provides an example of the process and documentation that could be instituted at the county level for the purpose of tracking a patient during surge.

5.11.1.1 Tool - Disaster Incident Policy and Label

The "The Disaster Incident Policy and Label" is shown below. The complete tool can be found in the Operational Tools Manual.

Policy

1. Disaster Incident Number (DIN) would be 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 DIN would be comprised of 2 specific elements of identification:
    - The first 2 digits would be 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 would place a 0 in front of the first digit.
    - The second set of numbers would be a number from 1 to 9,999,999. That number would specifically identify that particular patient within that county.
    - Example: 01-0000025

3. The DIN could be assigned at any of the following entry points and/or locations:
    - Existing Facility - To be assigned at registration.
    - Alternate Care Site / Field Treatment Centers / Shelters - To be assigned at registration.
    - EMS (Field crew) - To be assigned upon pick up.

4. The DIN 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 DIN is initiated. When the DIN is initiated with EMS, condition, gender and destination are key data elements.
    - First Name - patient's first name
    - Last Name - patient's last name
    - Street Address - patient's home address
    - City - patient's city of residence
    - SSN - patient's social security number
    - Telephone - patient's home phone
    - Cell - patient's cell phone
    - Destination - place the patient is being triaged to
    - Condition (Minor compromise, Major compromise, No compromise, Shelter only)
    - Facility Name

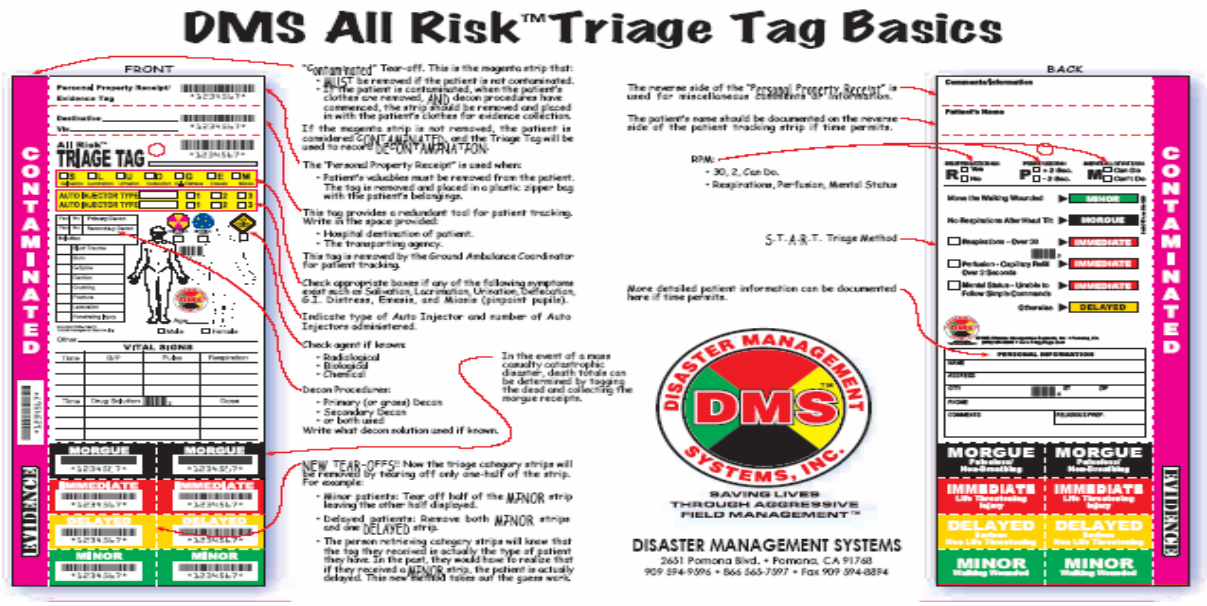
5. The DIN form may include a bar code that would represent the number for that form.
6. Disaster Management Systems has created "all risk" triage tags for disaster purposes.[195] It is recommended that tags are modified to include space for DIN information including space for a DIN sticker label. Additionally, it is recommended that the DIN and Triage # be identical to reduce the identifying information being transferred.

Disaster Incident Number Label

First Name:	BAR CODE
Last Name:	
DIN:	BAR CODE
Street Address:	
City:	BAR CODE
SSN:	
Tel:	BAR CODE
Cell:	
Destination:	BAR CODE
Facility Name:	
Condition (indicate condition with check mark):	
Minor compromise: [ ]	Not compromised: [ ]
Major compromise: [ ]	Shelter only: [ ]

Sample Triage Tag

Sample triage tags may be found in the Operational Tools Module. They are included for sample viewing purposes only and are not meant to endorse Disaster Management Systems as a vendor. A screen shot of the triage tags may be found below.



5.11.2 Tool - Disaster Victim/Patient Tracking Form[196]

The Disaster Victim/Patient Tracking Policy and Form is an example of the type of process and form that could be instituted at a long term facility for the purpose of tracking patients as they are transferred to other facilities when electronic systems are down. Additionally, this form could serve as a tool used to report facility census and bed capacity to the local incident command center.

The "Disaster Victim/Patient Tracking Form" is shown below. The complete tool can be found in the Operational Tools Manual.

INSTRUCTIONS:

Print legibly, and enter complete information.

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.
   - LAST NAME Record patient's last name
   - FIRST NAME Record patient's first name
   - DIN Disaster Identification Number is the unique identifier assigned to that patient for the surge
   - MR #/Triage # Medical record (MR) number and/or triage number assigned to patient at the facility
   - SEX Record "M" for male and "F" for female
   - 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.
   - 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.
   - AREA TRIAGED TO The area or zone a patient is triaged to
   - DISPOSITION The specific area, facility or location the patient is being transferred or discharged to

- 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, upon arrival of the first patient and until the disposition of the last. Operational period is defined by the Medical Health Operational Area Coordinator (MHOAC).

DISASTER VICTIM / PATIENT TRACKING FORM

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

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

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

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

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

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

6 Sources of Funds

During a catastrophic surge, the primary focus of the healthcare community is expected to be on responding to the event and caring for the ill and injured. However, the financial viability and stability of the healthcare system must be attended to as well in order to sustain operations at facilities and continue to provide medical care to the affected population. Ensuring this viability requires the healthcare community to recognize the kinds of financial challenges that may arise during a surge and to develop plans to respond accordingly. While there is a considerable amount of uncertainty in any surge, and especially with the financial implications of a surge, there are some practical planning tools and recommendations that healthcare providers can implement to mitigate some of the barriers and prepare for financial viability.

This chapter focuses on funding and reimbursement related to surge with consideration for preserving the financial viability of the existing healthcare system. As such, it is designed to identify financial barriers that may cause healthcare services to be interrupted during an emergent event and to compile recommendations for how these barriers can be addressed to facilitate access to and funding for delivery of care during a surge event. The contents of this chapter are assembled into two sections:

- **Preparing in Advance:** provides recommendations providers can adopt to prepare in advance for the financial considerations of a surge. Recommendations include:
  - Minimum required data elements for billing
  - Processes for advancing and expediting payment
  - Disaster planning funding sources

- **Maintaining Revenue Stream & Financial Liquidity During a Surge:** outlines some of the ways in which providers can maintain their current revenue stream during a surge, including:
  - Existing laws and rules governing emergency provisions
  - Opportunities for waivers and declarations to address the possible barriers of the current funding and reimbursement system during a surge
  - Patient transfer guidelines for reimbursement
  - Sources of funding during a disaster

6.1 Preparing in Advance

There are actions healthcare providers can focus on doing to preserve revenue and liquidity in advance of a disaster.

1. During contracting, negotiate a minimum data set for charge capture and billing purposes
2. Discuss various provisions ahead of time for advancing and accelerating payments
3. Identify and apply for appropriate funds for surge planning.

Sufficient planning and coordination between payers and providers will be essential to maintaining business continuity and sustaining operations at facilities providing medical care. Such coordination and planning may include creating new/modifying existing contracts to include disaster provisions such as minimum required data elements for reimbursement purposes during surge, third party vendors who may assist with billing on behalf of an existing facility during an extended surge, and creating policies to expedite cash flow during a declared surge. Additionally, provider organizations can identify and apply for funds that can help them in their surge planning efforts.

The following section reviews these recommendations that providers can adopt to prepare in advance for the financial considerations of a surge.

6.1.1 Minimum Required Data Elements for Billing

During a surge, complete billing processes and data elements should be accomplished when possible. However, during a disaster scenario it may be reasonable to expect that most personnel will be devoted to patient care and that current electronic systems may be nonfunctional or unavailable. As such, administrative billing functions under surge conditions may need to be reduced to minimum requirements. A fundamental component of minimizing requirements will be to minimize the billing data that needs to be captured by providers and reported to payers. The following includes recommended data elements required for billing purposes during healthcare surge.

The following data elements for billing are included as recommendations and ultimately depend on private and pubic payers agreeing to accept these recommended minimum data elements for billing purposes. It is recommended that providers review these recommendations and incorporate them into contract negotiations with payers.

6.1.1.1 Recommended Minimum Required Data for Billing

The following list was derived from existing UB-04 (or CMS 1450) and CMS 1500 forms. Under normal conditions the UB-04 form is used by institutional providers (e.g. hospitals, skilled nursing facilities, hospices) to submit Medicare paper claims. Under normal conditions the CMS 1500 form is used by non-institutional providers (e.g. physicians) to submit Medicare paper claims. It is recommended that private payers consider a similar list for providers to submit within their network.

UB-04 Data Elements	CMS 1500 Data Elements
• Subscriber ID/policy # • Time in, time out 1: Provider name, address, phone # 4: Type of bill 8b: Patient name 42: Revenue Codes 43: Revenue Description 44: HCPCS Rates/Codes 46: Units of Service 47: Total Charges 50: Payer 56: NPI 58: Insured's Name 67: Principal Diagnosis Code 69: Admitting Diagnosis 74: Principal Procedure Code 76: Attending 77: Operating	• Subscriber ID/policy # • Time in, time out 1:MEDICARE / MEDICAID / CHAMPUS / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER 1a: Insured's I.D. Number 2: Patient Name 3: Patient's Birth Date 5: Patient's Address 21: Diagnosis or nature of illness or injury 24 A-G: Date of service, Place of service, Type of service, Procedures/services/supplies, Diagnosis code, $ Charges, Days or units 24K: Use space to include condition code 25: Federal Tax I.D. Number 27: Accept Assignment? (yes/no) 28: Total Charge 33: Physician's, Supplier's Billing Name, Address, Zip Code & Phone #

Additional guidance regarding billing and coding during a disaster is provided in the following research.

6.1.1.2 Administrative Simplification Compliance Act Waiver Application[197]

"There are also some situations when this electronic billing requirement could be waived for some or all claims, however a provider must obtain Medicare pre-approval to submit paper claims in these situations:

- Any situation where a provider can demonstrate that the applicable adopted HIPAA claim standard does not permit submission of a particular type of claim electronically;
- Disability of all members of a provider's staff prevents use of a computer for electronic submission of claims;
- Other rare situations that cannot be anticipated by CMS where a provider can establish that due to conditions outside of their control, it would be against equity and good conscience for CMS to enforce this requirement.

A request for this type of waiver must be sent by letter to the Medicare contractor to which a provider submits claims."

6.1.1.3 National Modifier and Condition Code To Be Used To Identify Disaster Related Claims[198]

"In order to track and facilitate processing of claims for disaster victims, a national modifier has been established for providers' use on claims.

Policy
In order to facilitate claims processing and track services and items provided to victims of Hurricane Katrina and any future disasters, a new modifier and condition code have been established for providers to use on disaster related claims. The new modifier and condition code are effective for dates of service on and after August 21, 2005. The new modifier is CR (Catastrophe/Disaster Related). The new condition code is DR (Disaster Related). The new modifier and/or condition code can be used by providers submitting claims for beneficiaries who are Katrina disaster patients in any part of the country.

For physicians or suppliers billing their local carrier or DMERC, only the modifier (CR) may be reported and not the condition code. A condition code is used in fiscal intermediary billing. For institutional billing, either the modifier or condition code may be reported. The condition code would identify claims that are or may be impacted by specific payer policies related to a national or regional disaster, while the modifier would indicate a specific Part B service that may be impacted by policy related to the disaster."

6.1.1.4 ICD-9-CM Coding Advice for Healthcare Encounters in the Hurricane Aftermath Introduction[199]

"To be used as a guide to help coding professionals when coding healthcare encounters of those individuals affected by the hurricane. This coding advice has been approved by the four Cooperating Parties – American Health Information Management Association, American Hospital Association, Centers for Medicare & Medicaid Services, and National Center for Health Statistics. It is recommended that State of CA stakeholders work with these organizations to develop additional codes specific to other diseases such as pandemic flu.

Use of E Codes
An External Cause code (E code) should be assigned to identify the cause of an injury(ies) incurred as a result of the hurricane. The use of E codes is supplemental to the application of ICD-9-CM diagnosis codes. E codes are never to be recorded as principal diagnoses (first-listed in non-inpatient setting). The appropriate injury code should be sequenced before any E codes.

The use of E codes is limited to injuries, adverse effects, and poisonings. They should not be assigned for encounters to treat hurricane victims' medical conditions when no injury, adverse effect, or poisoning is involved.

E codes should be assigned for each encounter for care and treatment of the injury. Note that this advice is an exception to the *ICD-9-CM Official Guidelines for Coding and Reporting* and applies only to healthcare encounters resulting from the hurricane. E codes may be assigned in all healthcare settings. For the purpose of capturing complete and accurate ICD-9- CM data in the aftermath of the hurricane, a healthcare setting should be considered any location where medical care is provided by licensed healthcare professionals.

Sequencing of E Codes
Cataclysmic events, such as hurricanes, take priority over all other E codes except child and adult abuse and terrorism and should be sequenced before other E codes. Assign as many E codes as necessary to fully explain each cause. For example, if an injury occurs as a result of a building collapsing during the hurricane, E codes for both the hurricane and the building collapse should be assigned with the E code for hurricane being sequenced as the first E code.

For injuries incurred as a direct result of the hurricane, assign the appropriate code(s) for the injuries, followed by code E908.0, Hurricane, and any other applicable E codes. Code E908.0 should be assigned when an injury is incurred as a result of flooding caused by a levee breaking. Code E909.3, Collapse of dam or man-made structure, should not be assigned when the cause is a hurricane. Code E909.3 is limited to collapses of man-made structures due to earth surface movements, and tidal surges caused by storm action are excluded from category E909."

6.1.2 Advancing and Expediting Payment

In some surge situations, cash flow may present a challenge for large, small and independent providers. As such, the following tool outlines possible opportunities for advancing and expediting payment from a range of payers. In many cases, there is no formalized policy or procedure for advancing or expediting payments, but there is an established practice for doing so on an "as needed" basis. Providers in need of expedited or advanced payment options will likely need to contact their plan or program representative directly to discuss advancing and expediting payments and establish memorandum of understanding (MOUs) and protocols in advance or at the time funds are needed.

The following table summarizes some of the options available by payer type with respect to 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. In the past, intermediaries have been asked to immediately process any requests for accelerated payments or increases in PIP for providers. The 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.[200]
Medicare Part B	Advance Payments	Cash flow problems can be resolved through advance payments rather than through suspension of the mandatory payment floor. In the past, intermediaries have been asked to immediately process any requests for accelerated payments or increases in PIP for providers. The 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.[200]
Medi-Cal	Advance Payments	Medi-Cal has a process in place for advancing payment to participating providers. This interim payment process can be used in instances when providers are experiencing cash flow inadequacies, where Medi-Cal is experiencing payment delays, or when a provider's business

Payer	Option Available	Examples
		operations are temporarily challenged. However, 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 provider has claims pending in the State system, the State can issue an interim payment and will reconcile 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 provider. The provider 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 provider's cash flow positive until business operations can resume to normal. Medi-Cal can issue this advance by either valuing the claims that are currently in the State processing system or run a report of a provider's claim payment history and issue an advance in lieu of receiving claims. Should the State issue an advance without having evidence of claims in the payment system, they cannot qualify for the Federal match. Claims must be submitted as proof of loss in order for the State to establish that they have a liability to pay. In circumstances where claims have not been received the Deputy Director of Medical Care Services, Department of Health Services 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 it would take some time to orchestrate given the number of providers that may be requesting it.[201]
Private Payer		Private payers 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 provider's business operations are temporarily challenged. The amount of the advance can vary depending on provider need, provider volume, previous payment history, contractual parameters, and re-payment factors. Upon provider request, private payers will typically offer one of two options: 1) Advance a lump sum amount for a specified period of time to be re-paid in full when the agreed period elapses, or 2) Advance an agreed amount based upon previous payment history and provider need to be reconciled against future claim submissions. Contracted providers in good standing in need of expedited or advanced payment options will likely need to contact their plan or program representative directly to discuss advancing and expediting payments and establish memorandum of understanding (MOUs) and protocols in advance or at the time funds are needed.

6.1.3 Disaster Planning (Pre-Surge) Funding Sources

This section outlines the funds that are available to assist a healthcare facility prepare for a catastrophic surge. Recognizing that the healthcare system may incur additional costs as a result of preparing or responding to a surge, these sources of funding were identified as an addition to the reimbursement providers receive as a direct provision of care to prepare, support and replenish the healthcare system as needed in response to a surge. This list identifies sources of funding by who

and what services are eligible for funding and describes the rules for accessing those funds. It is a tool that a range of stakeholders including providers, volunteers, government entities and individuals can use to identify relevant sources of funding and develop plans to access those funds for their surge related needs. Stakeholders can utilize this tool in advance of surge to identify and apply for funds to aid in planning and preparedness.

The Federal government appropriates funds on a fiscal year basis to the Department of Homeland Security (DHS), Federal Emergency Management Authority (FEMA) and the Department of Health and Human Services (HHS), Hospital Preparedness Program. These agencies set up programs and grants for which state and local providers, hospitals, clinics, public agencies, health departments, and first responders can apply. The disaster planning programs and grants focus on training and educating personnel on disaster preparation and disaster relief. These funds may cover the purchase of educational materials, classroom training, drills, coordination of personnel, medical equipment and supplies, technical assistance, and more.

- HRSA Bioterrorism Training and Curriculum Development Program (BTCDP). BTCDP is intended to improve the capability of the Nation's healthcare workforce to respond to bioterrorism and other public health emergencies. In past fiscal years, total nationwide funding has been between $20 million to $27 million. HRSA believes possible new applicants have been exhausted, and FY2007 funding decreased to slightly over $12 million for existing grantees only to maintain previous fiscal year's BTCDP.

- Hospital Preparedness Program. This program enhances the ability of hospitals and health care systems to prepare for and respond to bioterrorism and other public health emergencies. Program priority areas include improving bed and personnel surge capacity, decontamination capabilities, isolation capacity, pharmaceutical supplies, and supporting training, education, and drills and exercises.

- FEMA Commercial Equipment Direct Assistance Program (CEDAP). CEDAP helps meet the equipment needs of smaller jurisdictions, especially for first responders, by providing communications interoperability, information sharing, chemical detection, sensors, personal protective equipment, technology, and training in using the equipment, devices, and technology. Awards are made to law enforcement and emergency responder agencies not currently eligible for funding through the Department's Urban Areas Security Initiative grant program[202].

- FEMA Pre-Disaster Mitigation (PDM) Program. The PDM program provides funds to eligible public and private, not for profit groups for hazard mitigation planning and implementation of mitigation projects prior to a disaster event. Funding these plans and projects reduces overall risks to the population and structures, while also reducing reliance on funding from actual disaster declarations.

- DHS Emergency Management Performance Grants (EMPG). EMPG structures emergency management programs based on identified needs and priorities to strengthen their ability to support emergency management mission areas while simultaneously addressing issues of national concern as identified in the Department of Homeland Security's National Priorities and Target Capabilities List of the National Preparedness Goal.

Foundations and organizations recognize that the private sector may be under the same strain during a disaster or pandemic and may have more limited resources available to fund operations through a strained period. Several loans and funds are available for small private businesses to plan and prepare for disasters and fund their response. Each program is unique and has specific criteria to qualify for funding. More detail may be found in the Funding Sources Eligibility, Benefits and Application Procedures tables in the Operational Tools Module.

- U.S. Small Business Association Pre-Disaster Mitigation Loan Program
- VHA Innovations in Hospital Emergency Preparedness

Legislative appropriation enables the continuance and evolution of these funds for the U.S Small Business Association Pre-Disaster Mitigation Loan Program and VHA Innovations in Hospital Emergency Preparedness and consequently the amount and existence of these funds is subject to Federal fiscal year budget appropriation. Most funds cover eligible services such as property casualty losses and could possibly cover medical services that are outside the direct provision of care. These programs and grants are not a form of temporary or permanent health care coverage.

For detailed eligibility, benefits, application procedure and additional resources please refer to the Funding Sources Eligibility, Benefits and Application Procedures tables in the Operational Tools Module.

6.2 Maintaining Revenue Stream and Liquidity during a Surge Event

One of the key challenges for healthcare providers during a surge will be maintaining adequate cash flow and liquidity in order to sustain operations and continue to provide medical care to the affected population. This section outlines some of the ways in which providers can maintain their current revenue stream, through protections afforded by existing laws and regulations, waivers or declarations that may be issued in response to a specific disaster, or steps and planning measures that providers can take in advance of a surge.

During a surge, the enforcement of certain rules and requirements may preclude the effective and timely care of patients affected by the event and the prompt reimbursement of that care. To ensure that care is delivered to meet the healthcare needs during a surge, certain rules and requirements may need to be flexed and/or waived during these events. The specific rules and requirements addressed in this document are:

- Physician / Network Requirements
- Facility Reimbursement
- Pre-Authorization
- Pharmaceutical Coverage
- Co-Pay Requirements
- Non-Payment of Premiums and Coverage Continuity
- Claims Management
- Insurance Questions and Coverage Verification

This section outlines the existing rules and regulations governing these provisions as well as the opportunities for waivers and declarations to address additional barriers and concludes with examples from previous disasters that represent some of the ways in which these rules may be addressed in California during similar events.

6.2.1 Existing Laws and Rules Governing Emergency Provisions

The following section outlines existing laws and rules that govern emergency provisions in California. The laws and regulations stipulate what services must be made available to patients during a disaster and what, if any, cost implications result from that emergency coverage. These rules and regulations are broken out by payer type and include private payers, Medicare Advantage, traditional Medicare and Medi-Cal.

6.2.1.1 Private Payers

From US Code 42, Chapter 6a, Subchapter XI, §300e, also known as the Public Health Service Act, provides guidelines for what services must be available to members of health maintenance organizations. Specifically it stipulates that:

- Basic health services shall be accessible to each member of a health maintenance organization with " reasonable promptness and in a manner which assures continuity, and when medically necessary be available and accessible twenty-four hours a day and seven days a week."
- A health maintenance organization "make a good-faith effort to provide or arrange for the provision of [basic or supplemental service]" to its members following a "natural disaster, war, riot, civil insurrection, or any other similar event not within the control of a health maintenance organization results in the facilities, personnel, or financial resources of a health maintenance organization not being available to provide or arrange for the provision" of such services to its members.[203]

The California Code of Regulations Title 28 CCR further stipulates that "emergency health care services be available and accessible to enrollees on a twenty-four hour a day, seven days a week, basis within the health care service plan area." Emergency services defined in section 1317.1 include active labor. 'Urgently needed services' are those services necessary to prevent serious deterioration of the health of an enrollee, resulting from an unforeseen illness, injury, or complication of an existing condition, including pregnancy, for which treatment cannot be delayed until the enrollee returns to the plan's service area.[204]

Furthermore, 28 CCR § 1300.67 indicates that health care services cannot be limited or excluded when the need for that service comes as a result of an Act of War. "The term 'Act of War' includes any act or conduct, or the prevention of an act or conduct, resulting from war, declared or undeclared, terrorism, or warlike action by any individual, government, military, sovereign group, terrorist or other organization."[205]

6.2.1.2 Medicare Advantage

Unlike private health maintenance organizations, no "good faith" provision exists similar to the Public Health Service Act under Medicare Advantage. As indicated by the Centers for Medicare and Medicaid Services (CMS) website, "therefore, Medicare Advantage plans are required to continue directly providing all Part A and Part B services, or otherwise arranging for such services to be provided, so that statutory and regulatory requirements for accessibility and availability of services continue to be met."

Urgently needed services are defined as services that are "medically necessary and immediately required

- as a result of an unforeseen illness, injury, or condition;
- and it was not reasonable, given the circumstances, to obtain the services through the plan's provider network."

Medicare Advantage plans are required to cover urgently needed services beyond the organization's provider network when:

- "due to unusual and extraordinary circumstances, the organization's provider network is temporarily unavailable or inaccessible, for example because of a natural disaster or electrical power outage" or when
- the Medicare beneficiary is temporarily outside of the plan's service area, in need of "medically necessary and immediately required [services]…and it was not reasonable, given the circumstances, to obtain the services through the plan's provider network."[206]

6.2.1.3 Traditional Medicare

Per 42 CFR 424.103, Medicare pays for emergency services in nonparticipating hospitals. For traditional Medicare, *Emergency* is defined at 42 CFR 424.101 as inpatient or outpatient hospital services necessary to prevent death or serious impairment of health and, because of the danger to life or health, require use of the most accessible hospital available and equipped to furnish those services. Per 42 CFR 424.105 determination of emergency requires

- an emergency exists with regard to the patient's condition;
- the treating hospital is a qualified emergency services hospital;
- the treating hospital is substantially more accessible from the site of the emergency than the nearest participating hospital.

These provisions, however, relate to patient emergencies and not a general state of emergency.

6.2.1.4 Medi-Cal

For Medi-Cal, per 22 CCR 51056, *emergency services* mean services required for alleviation of severe pain, or immediate diagnosis and treatment of unforeseen medical conditions, which, if not immediately diagnosed and treated, would lead to disability or death. For purposes of treating eligible

aliens it means a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- placing the patient's health in serious jeopardy
- serious impairment to bodily functions
- serious dysfunction of any bodily organ or part

More detail on these laws and regulations can be found in the Detail of Previously Issued Waivers and Declarations By Rule / Requirement.

6.2.2 Opportunities for Waivers and Declarations to Address Rules, Requirements and Other Barriers

As the regulations governing emergency provisions do not fully address all of the funding and reimbursement issues that may arise during a surge, the opportunity exists for the issuance of waivers and declarations to address these barriers. The following section outlines the opportunities to address these rules and requirements for public and private payers. These opportunities include the Section 1135 Waivers impacting programs managed by the Centers for Medicare and Medicaid Services, Section 1115 Demonstration Waivers affecting Medicaid.

6.2.2.1 Waiver and Declaration Matrix

The following matrix summarizes the key waivers and declarations that may be issued in response to a surge that would impact the reimbursement process to providers. While providers serve to benefit from the flexed rules and requirements that these waivers and declaration would implement, they have little influence over their issuance. However, this tool helps illustrate the kinds of financial response that may occur following a surge. This table can be used by providers to identify the rules that may pose a challenge and how they may be responded to during an event in California, giving providers some context for how they may provide care during a surge. It also highlights to those who are in a position to influence the release of these waivers and declarations the relative impact of such actions.

The table below is also useful as it highlights the waivers and declarations that best serve the healthcare system, indicating the areas that key influencers and persons of authority should focus their attention. Most notably, Section 1135 offers the most financial impact with the least amount of effort and time, whereas the 1115 Demonstration Waivers are more cumbersome with less likelihood of significant and timely impact.

Key Influencer[1]	Waiver or Declaration Name	Issued By	Rules / Requirements Potentially Addressed	Relative Potential Impact[2]	Relative Effort to Enact[3]	Expected Time To Enact[4]
Healthcare Providers and State	Waiver Under Section 1135 of the Social Security Act	Secretary of Health and Human Services	• Conditions of Participation • Pre-Approval Requirements • State Licensure Requirements • Out-of-Network Providers	$$$$	Low	
State	Disaster Relief Emergency Medicaid Waiver Section 1115 Model Waiver	Secretary of Health and Human Services	• Simplified Eligibility Chart • 5 Months Temporary Eligibility • Simplified Application and Self-Attestation • Uncompensated Care Pool • Simplified, expedited patient enrollment • Expanded eligibility guidelines	$	High	

[1]Key Influencer – Entity who can influence the development and implementation of applicable waiver or declaration

[2]Relative potential impact - Relative impact on the revenue amounts and flow in the system
[3]Effort - Relative measure of complexity, skills and resources to get waiver or declaration approved
[4]Time - Relative expected time from application initiation to fund initiation

6.2.2.2 Section 1135 Waivers

One mechanism to address rules and requirements that may present a financial barrier during a surge is the Section 1135 Waiver. Under 42 U.S.C. § 1320b-5 (section 1135 of the Social Security Act), the Secretary of Health and Human Services has the authority to waive certain requirements of CMS programs in an emergency area during a federal emergency period.[207] These waivers are known as Section 1135 Waivers. As documented in the Federal Register, "the stated purpose of section 1135 of the Social Security Act (the Act) is to enable the Secretary to ensure, to the maximum extent feasible, in any emergency area and during an emergency period, that sufficient health care items and services are available to meet the needs of enrollees in Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP)."[208]

The purpose of section 1135 of the Social Security Act also ensures "that health care providers (as defined in subsection (g)(2)) that furnish such items and services in good faith, but that are unable to comply with one or more requirements described in subsection (b), may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse."[209]

Section 1135 Waivers can be issued in an emergency area during a federal emergency period. For purposes of Section 1135 Waivers, "an 'emergency area' is a geographical area in which, and an 'emergency period' is the period during which, there exists an emergency or disaster declared by the President pursuant to the National Emergencies Act or the Robert T. Stafford Disaster Relief and Emergency Assistance Act and a public health emergency declared by the Secretary pursuant to section 319 of the Public Health Service Act."[210] "The term 'health care provider' means any entity that furnishes health care items or services, and includes a hospital or other provider of services, a physician or other health care practitioner or professional, a health care facility, or a supplier of health care items or services."[211]

These waivers or modifications can "be made retroactive to the beginning of the emergency period or any subsequent date in such period specified by the Secretary" at the Secretary's discretion and[212] are issued in response to specific events and defined for a designated time and place. These waivers provide general flexibility to the Secretary of Health and Human Services, but some of the key elements that can be addressed by these waivers are:

- Conditions of Participation
- Physician State Licensure Requirements
- EMTALA
- Physician Referral Limitations
- HIPAA
- Medicare Advantage Payment Limitations
- Deadlines and Timetables[213]

As stipulated in 42 U.S.C. § 1320b-5 (b), "If a public health emergency described in subsection (g)(1)(B) involves a pandemic infectious disease (such as pandemic influenza), the duration of a waiver or modification under paragraph (3) shall be determined in accordance with subsection (e) as such subsection applies to public health emergencies."[214]

As the Section 1135 Waiver is a key mechanism for addressing the financial barriers that public program rules and requirements may pose during a surge, it is helpful for healthcare professionals to be familiar with its existence and opportunity for issuance. While these waivers are situational and cannot be relied on to be issued in response to a surge event in California, they do provide a

significant opportunity to address the financial barriers some of the CMS rules and requirements may present during a surge. The Detail of Previously Issued Waivers and Declarations by Rule / Requirement table outlines in more detail how these waivers have been used in the past and may be used to address specific issues that the California healthcare system may face during a surge. Additional information can also be found in the Appendix on Funding Deployed and Waiver Examples from Katrina.

For full text of the Section 1135 Waiver under 42 U.S.C. § 1320b-5, please see the Appendix.

6.2.2.3 Section 1115 Demonstration Waivers

In addition to the Section 1135 Waivers addressing Medicare, Medicaid and SCHIP, Section 1115 Demonstration Waivers provide another mechanism to make modifications to the Medicaid program. These waivers are generally more cumbersome and time consuming and should not be depended upon to provide primary relief during a surge.

According to CRS Report RL33083, "Section 1115 of the Social Security Act…authorizes the Secretary [of Health and Human Services] to waive certain statutory requirements for conducting demonstration projects that further the goals of Titles XIX (Medicaid) and XXI (SCHIP). Under Section 1115, the Secretary may waive Medicaid requirements contained in Section 1902 (known as “freedom of choice” of provider, “comparability,” and “statewideness”). States must submit proposals outlining terms and conditions for proposed waivers to CMS for approval before implementing these programs."[215]

Section 1115 waiver programs "serve as a precedent for federal and state officials who wish to make temporary changes to the Medicaid program in response to the unique circumstances resulting from events such as the devastation of Hurricane Katrina."[215] Under current law, Section 1115 waivers allow states to:

- provide services to individuals not traditionally eligible for Medicaid
- cover non-Medicaid services
- limit benefit packages for certain groups
- adapt their programs to the special needs of particular geographic areas or groups of recipients
- accomplish a policy goal such as to temporarily provide Medicaid assistance in the aftermath of a disaster.[215]

Under current law, states may obtain waivers that allow them to provide services to individuals not traditionally eligible for Medicaid, cover non-Medicaid services, limit benefit packages for certain groups, adapt their programs to the special needs of particular geographic areas or groups of recipients, or accomplish a policy goal such as to temporarily provide Medicaid assistance in the aftermath of a disaster, among other purposes.

While Section 1115 is explicit about provisions in Medicaid law that may be waived in conducting research and demonstration projects, a number of other provisions in Medicaid law and regulations specify limitations or restrictions on how a state may operate a waiver program. For example, one provision restricts states from establishing waivers that fail to provide all mandatory services to the mandatory poverty-related groups of pregnant women and children; another provision specifies restrictions on cost-sharing imposed under demonstration waivers.

Other features of the Section 1115 waiver authority that may be relevant include:

Federal Reimbursement for Section 1115 Demonstrations. Approved Section 1115 waivers are deemed to be part of a state’s Medicaid state plan. Project costs associated with waiver programs are subject to that state’s FMAP. Changes to these financing

arrangements, even under a Section 1115 waiver, would require congressional action.

Financing and Budget Neutrality. Unlike regular Medicaid, CMS waiver guidance specifies that costs associated with waiver programs must be *budget neutral* to the federal government over the life of the waiver program. To meet the budget neutrality test, estimated spending under the waiver cannot exceed the estimated cost of the state's existing Medicaid program under current law program requirements.

Financing and Allotment Neutrality. Under the SCHIP program, a different budget neutrality standard applies. States must meet an "allotment neutrality test" where combined federal expenditures for the state's regular SCHIP program *and* for the state's SCHIP demonstration program are capped at the state's individual SCHIP allotment. This policy limits federal spending to the capped allotment levels. Any additional financial resources for SCHIP would require congressional action.

Relationship of Medicaid/SCHIP Demonstration Waivers to Other Statutes. Section 1115 waiver projects may interact with other program rules outside of the Social Security Act; for example, employer-sponsored health insurance as described by the Employee Retirement Income Security Act (ERISA), or alien eligibility as contained in immigration law. In cases like these, the Secretary does not have the authority to waive provisions in these other statutes.

Program Guidance. The Secretary can develop policies that influence the content of demonstration projects and prescribe approval criteria in three ways: (1) by promulgating program rules and regulations; (2) through the publication of program guidance (e.g., the waiver program must meet a budget neutrality test); and (3) waiver policy may also be implicitly shaped by the programs that have been approved. Legislative action may be required if Congress chooses to further shape the Secretary's authority over the content of the demonstration programs or dictate specific Section 1115 waiver approval criteria."[215]

Although health professionals will likely not be involved in the development of any Section 1115 waivers during a healthcare surge, it is useful for those involved in the delivery of care to be aware of this opportunity for addressing some of the financial barriers that may present itself during a surge.

6.2.3 Previous Financial Responses

One of the challenges with preparing for the financial consequences of a surge is the highly situational nature of any surge response. As such, it may be helpful to review in more depth the kinds of responses that have occurred in the past as a reference for the kinds of responses that *may* occur in the future. The following table, 'Detail of Previously Issued Waivers and Declarations By Rule / Requirement' outlines the rules and requirements for each administrative rule and requirement by payer, with relevant examples or potential applications to waive or flex these rules. This table serves as a tool for providers to identify how specific rules or requirements may be addressed by various payers, giving providers additional context for how they may provide care during a surge and how that care may be reimbursed.

6.2.3.1 Detail of Previously Issued Waivers and Declarations By Rule / Requirement

The expanded table below outlines the rules and requirements for each administrative rule and requirement by payer, with relevant examples or potential applications to waive or flex these rules. This expanded table serves as a tool for providers to identify how specific rules or requirements may be addressed by various payers, giving providers additional context for how they may provide care during a surge.

This tool addresses the following rules / requirements / issues by private payers, Traditional Medicare, Medicare Advantage and Medi-Cal:

- Physician / Network Requirements
- Facility Reimbursement
- Pre-Authorization
- Pharmaceutical Coverage
- Co-Pay Requirements
- Non-Payment of Premiums and Coverage Continuity
- Claims Management
- Insurance Questions and Coverage Verification

The "Detail of Previously Issued Waivers and Declarations By Rule / Requirement" is shown below. The complete tool can be found in the Operational Tools Manual.

Physician / Network Requirements	
A. Payer / Organization	**Private Payers**
B. Pertinent Regulations	(1) Emergency health care services which shall be available and accessible to enrollees on a twenty-four hour a day, seven days a week, basis within the health care service plan area. Emergency health care services shall include ambulance services for the area served by the plan to transport the enrollee to the nearest twenty-four hour emergency facility with physician coverage, designated by the Health Care Service Plan. (2) Coverage and payment for out-of-area emergencies or urgently needed services involving enrollees shall be provided on a reimbursement or fee-for-service basis and instructions to enrollees must be clear regarding procedures to be followed in securing such services or benefits. Emergency services defined in section 1317.1 include active labor. "Urgently needed services" are those services necessary to prevent serious deterioration of the health of an enrollee, resulting from an unforeseen illness, injury, or complication of an existing condition, including pregnancy, for which treatment cannot be delayed until the enrollee returns to the plan's service area. "Urgently needed services" includes maternity services necessary to prevent serious deterioration of the health of the enrollee or the enrollee's fetus, based on the enrollee's reasonable belief that

Physician / Network Requirements	
A. Payer / Organization	**Private Payers**
	she has a pregnancy-related condition for which treatment cannot be delayed until the enrollee returns to the plan's service area.[216] No health care service plan contract executed or amended on or after the effective date of this regulation shall limit or exclude health care services based on a determination that the need for the health care service arose as a result of an Act of War. The term "Act of War" includes any act or conduct, or the prevention of an act or conduct, resulting from war, declared or undeclared, terrorism, or warlike action by any individual, government, military, sovereign group, terrorist or other organization.[217] Basic health services (and only such supplemental health services as members have contracted for) shall within the area served by the health maintenance organization be available and accessible to each of its members with reasonable promptness and in a manner which assures continuity, and when medically necessary be available and accessible twenty-four hours a day and seven days a week, except that a health maintenance organization which has a service area located wholly in a non-metropolitan area may make a basic health service available outside its service area if that basic health service is not a primary care or emergency health care service and if there is an insufficient number of providers of that basic health service within the service area who will provide such service to members of the health maintenance organization. A member of a health maintenance organization shall be reimbursed by the organization for his expenses in securing basic and supplemental health services other than through the organization if the services were medically necessary and immediately required because of an unforeseen illness, injury, or condition.[218] To the extent that a natural disaster, war, riot, civil insurrection, or any other similar event not within the control of a health maintenance organization (as determined under regulations of the Secretary) results in the facilities, personnel, or financial resources of a health maintenance organization not being available to provide or arrange for the provision of a basic or supplemental health service in accordance with the requirements of paragraphs (1) through (4) of this subsection, such requirements only require the organization to make a good-faith effort to provide or arrange for the provision of such service within such limitation on its facilities, personnel, or resources.[219] **California - Legislation (CA Statutes) California Business And Professions Code** **Chapter 1.5. Exemption From Licensure § 900 Bus. & Prof.** (a) Nothing in this division applies to a health care practitioner licensed in another state or territory of the United States who offers or provides health care for which he or she is licensed, if the health care is provided only during a state of emergency as defined in subdivision (b) of Section 8558 of the Government Code, which emergency overwhelms the response

Physician / Network Requirements	
A. Payer / Organization	**Private Payers**
	capabilities of California health care practitioners and only upon the request of the Director of the Emergency Medical Services Authority. (b) The director shall be the medical control and shall designate the licensure and specialty health care practitioners required for the specific emergency and shall designate the areas to which they may be deployed. (c) Health care practitioners shall provide, upon request, a valid copy of a professional license and a photograph identification issued by the state in which the practitioner holds licensure before being deployed by the director. (d) Health care practitioners deployed pursuant to this chapter shall provide the appropriate California licensing authority with verification of licensure upon request. (e) Health care practitioners providing health care pursuant to this chapter shall have immunity from liability for services rendered as specified in Section 8659 of the Government Code. (f) For the purposes of this chapter, "health care practitioner" means any person who engages in acts which are the subject of licensure or regulation under this division or under any initiative act referred to in this division. (g) For purposes of this chapter, "director" means the Director of the Emergency Medical Services Authority who shall have the powers specified in Division 2.5 (commencing with Section 1797) of the Health and Safety Code. [220] **California - Legislation (CA Statutes) California Business And Professions Code** **Chapter 1.6. Health Care Professional Disaster Response Act § 921 Bus. & Prof.** The Legislature finds and declares the following: (1) In times of national or state disasters, a shortage of qualified health care practitioners may exist in areas throughout the state where they are desperately required to respond to public health emergencies. (2) Health care practitioners with lapsed or inactive licenses could potentially serve in those areas where a shortage of qualified health care practitioners exists, if licensing requirements were streamlined and fees curtailed. (b) It is, therefore, the intent of the Legislature to address these matters through the provisions of the Health Care Professional Disaster Response Act.[221]
C. Previous Response Example, Pertinent Waivers or other	Under the authority of the Governor of Louisiana's numerous Emergency Declarations and Executive Orders, the Commissioner of Insurance for the state of Louisiana issued Emergency Rules 15, 17, 19 and 20. • These Emergency Rules suspended certain statutes and regulations regarding health insurance in Louisiana.[222] • These rules applied to primary and limited secondary parishes in Louisiana affected by the hurricanes over specific time periods.[223],[224]

Physician / Network Requirements	
A. Payer / Organization	**Private Payers**
Application During a Surge	• These rules applied only to products regulated by the Louisiana Department of Insurance. • These rules waived all restrictions relative to out-of-network access. Along with the Governor's Emergency Rules: • Aetna implemented policies for its members to receive in-network benefits for care out of their network in any state, and seek care from providers, including dentists, other than their designated primary care physicians.[225] • United Healthcare provided emergency transportation and treated all area hospitals as participating network hospitals under existing emergency benefit provisions.[226] • Members from the affected disaster areas who could not access CIGNA participating physicians, hospitals or other providers for the dates of service from August 27, 2005 to September 30, 2005 were able to seek care as needed, for which in-network benefits applied. If members were unable to see their primary care physician, they sought care as needed from any available medical professional.[227] • Blue Cross of California made revisions that applied to members who were living in Alabama, Louisiana and Mississippi at the time of the disaster that: o Allowed the affected members to see any physician necessary to provide access to care. o Blue Cross of California paid all claims as in-network, regardless of whether or not the health care provider was in network.[228]

6.2.4 Tool - Patient Transfer

During a surge event, it may be necessary to transfer patients between healthcare facilities as a response to public health needs as well as medical need. The following table outlines the rules and requirements that must be met for reimbursement of patient transfer during a surge, for both medical necessity and reasons other than the patient's medical condition.

The "Patient Transfer Tool" is shown below. The complete tool can be found in the Operational Tools Manual.

Transportation / Transfer Scenario	Reimbursable		Coverage Rule
		Payer	
Patient transfer for reasons other than medical condition? • Evacuation to/from facility	Y: See Rules	Medicare	Following a recent disaster, charges for ambulance transportation are paid according to the usual Payment guidelines. The regulatory requirements must be met (i.e. the vehicle must be an ambulance, the crew must be certified, the patient must need an ambulance transport and the transport must be to an eligible destination). (See Additional Regulatory Requirements Below) Ambulance transportation charges for patients who are evacuated from and returned to originating hospitals are included on the inpatient claims submitted by the originating hospitals. **Inpatient**: Payment is included in the DRG Payment amounts made to hospitals paid under the prospective payment system. **Outpatient**: Outpatient claims are submitted for ambulance charges incurred by patients who are transported from the originating hospitals and subsequently discharged by receiving hospitals. The Medicare contractors made payment for ambulance transportations that evacuated patients from affected locations when the regulatory requirements were met. From a claims perspective, in using the CR HCPCS 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 are disaster related, the institutional provider can use the condition code DR to indicate that the entire claim is disaster related.[229] (10/12/05)
		Private Payers	Some private payer contracts indicate this is not a covered service.
Patient Transfer		Medicare	Under sections 1834(l) and 1861(s)(7) of the Social Security Act (the Act), Medicare Part B (Supplemental Medical Insurance) covers and pays for ambulance services, to the extent prescribed in regulations, when the

Transportation / Transfer Scenario	Reimbursable		Coverage Rule
		Payer	
			use of other methods of transportation would be contraindicated by the beneficiary's medical condition. The ambulance benefit cover transportation services only if other means of transportation are contraindicated by the beneficiary's medical condition; and Only ambulance service to local facilities will be covered unless necessary services are not available locally, in which case, transportation to the nearest facility furnishing those services is covered (H.R. Rep. No. 213, 89th Cong.,1st Sess. 37 and Rep. No. 404, 89th Cong., 1st Sess. Pt 1, 43 (1965)). The reports indicate that transportation may also be provided from one hospital to another, to the beneficiary's home, or to an extended care facility. Ambulance services are subject to basic conditions and limitations set forth at § 410.12 and to specific conditions and limitations included at § 410.40.[230] **Vehicle and Crew Requirement** Any vehicle used as an ambulance must be designed and equipped to respond to medical emergencies and, in non-emergency situations, be capable of transporting beneficiaries with acute medical conditions. The vehicle must comply with State or local laws governing the licensing and certification of an emergency medical transportation vehicle. At a minimum, the ambulance must contain a stretcher, linens, emergency medical supplies, oxygen equipment, and other lifesaving emergency medical equipment and be equipped with emergency warning lights, sirens, and telecommunications equipment as required by State or local law. This should include, at a minimum, one 2-way voice radio or wireless telephone. **Vehicle Requirements for Basic Life Support and Advanced Life Support** Basic Life Support ambulances must be staffed by at least two people, at least one of whom must be certified as an emergency medical technician (EMT) by the State or local authority where the services are being furnished and be legally authorized to operate all lifesaving and life-sustaining equipment on board the vehicle. Advanced Life Support (ALS) vehicles must be staffed

Transportation / Transfer Scenario	Reimbursable	Payer	Coverage Rule
			by at least two people, at least one of whom must be certified by the State or local authority as an EMT-Intermediate or an EMT-Paramedic. **The Destination** Medicare covers ambulance transports (that meet all other program requirements for coverage) only to the following destinations: • Hospital; • Critical Access Hospital (CAH); • Skilled Nursing Facility (SNF); • Beneficiary's home; or • Dialysis facility for ESRD patient who requires dialysis; or A physician's office is not a covered destination. However, under special circumstances an ambulance transport may temporarily stop at a physician's office without affecting the coverage status of the transport. There are certain circumstances in which ambulance service is covered and payable as a beneficiary transportation service under Part A; however in this case the service cannot be classified and paid for as an ambulance service under Part B. Once a beneficiary is admitted to a hospital, Critical Access Hospitals (CAH), or Skilled Nursing Facility (SNF), it may be necessary to transport the beneficiary to another hospital or other site temporarily for specialized care while the beneficiary maintains inpatient status with the original provider. This movement of the patient is considered "patient transportation" and is covered as an inpatient hospital or CAH service under Part A and as a SNF service when the SNF is furnishing it as a covered SNF service and Part A payment is made for that service. Because the service is covered and payable as a beneficiary transportation service under Part A, the service cannot be classified and paid for as an ambulance service under Part B. This includes intra-campus transfers between different departments of the same hospital, even where the departments are located in separate buildings. Such intra-campus transfers are not separately payable under the Part B ambulance benefit.[231]

Transportation / Transfer Scenario	Reimbursable		Coverage Rule
		Payer	
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. In almost all cases, eligibility for compensation requires that resources are requested through the appropriate means and consistent with NIMS. A mission tracking number needs to be assigned which links the request to the event, and thus to the reimbursement. Transportation resources can be broadly classified as Traditional Medical, ambulances, gurney vans, wheel chair cars, etc., and non-medical, school and or transit buses, vanpools, etc. Traditional medical resources can generally be funded through either direct fee-for-service billing or reimbursement from disaster relief funds. In order to be eligible for the latter, it is critical that resources be requested through the proper channels and in accordance with NIMS. The request should come through the Logistics Branch of the appropriate Emergency operations Centers (EOC), either at the City, County or Regional level, generally progressing from City to Region. The requests must be accompanied by a Mission Tasking Number. Non-medical 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 NIMS.

6.2.5 Sources of Funding During a Disaster

This section outlines existing sources of funds and funding opportunities that providers and the healthcare community can access to help them recoup some of the costs incurred as a result of a surge. Recognizing that when an event occurs it may be too late to undertake a comprehensive analysis of how to access additional funds, stakeholders can use this information to develop familiarity with the funds that can be accessed during a healthcare surge and their corresponding application procedures. The main source for additional funding in response to a catastrophic event comes from the Federal Emergency Management Agency (FEMA) whose funding response is highly situational and often complex. However, there are steps that the healthcare community can take to facilitate the FEMA application process, and this funding source is reviewed to encourage this process.

6.2.5.1 Federal Emergency Management Authority and National Disaster Medical System

This section outlines the process, rules and requirements for initiating and receiving FEMA funds to enable healthcare entities to become familiar with this funding resource. Developing broader familiarity with FEMA may facilitate the delivery of these funds to a healthcare community following a surge.

During a disaster or pandemic response, the State's disaster funds may quickly be depleted, and the Governor may request Federal government aid and invite Federal personnel to augment current strained personnel. This section details how FEMA's public assistance funds flow from FEMA and NDMS, through the State, and finally to the providers who render medical care during a surge.

FEMA has traditionally focused on aiding individuals who have experienced property casualty losses due to a disaster. However, as a result of temporary but substantial population displacement during the Hurricane Katrina disaster and the SARs pandemic, FEMA funds have been appropriated for payment of medical stabilization services during a disaster and immunizations against the human influenza pandemic. Providers will need to seek education on how to maximize reimbursement for rendered care and acquire sufficient knowledge to submit necessary documents, including funding applications and substantiation, to FEMA in a limited time frame.

For more complete information on FEMA and sources of funds during a disaster, please see the Appendix.

California has a well-defined process to escalate local emergencies to the State first and subsequently to Federal attention. When disaster relief costs and response requirements are expected to deplete local government resources, the local government may declare a local disaster within 10 days of the event. Following the declaration, local government works with the Director of the California Office of Emergency Services to achieve concurrence on the declaration. If the local community is devastated by a natural disaster, the State may aid the locality under the California Natural Disaster Assistance Act (NDAA). If additional help is needed, the Governor may proclaim a state of emergency and direct execution of the State's emergency plan, use State Police or the National Guard, or commit other State resources as the situation demands.

The President may declare a state of emergency on the federal level when damages due to the disaster exceed a per capita threshold. "The Robert T. Stafford Disaster Relief and Emergency Assistance Act (the Stafford Act) authorizes the President to issue major disaster declarations that directly order any Federal agency, with or without reimbursement, to use the authorities and resources in support of State and local assistance efforts[232]. The President may delegate certain agencies such as the Federal Emergency Management Agency (FEMA), within the Department of Homeland Security (DHS), responsibility for administering the major provisions of the Stafford Act. Congress appropriates funds to the Disaster Relief Fund (DRF) for these dire situations, with over $10 billion in DRF appropriation in FY2005[232]. Unspent funds may carry over to subsequent fiscal years, and Congress may legislate for supplemental fund appropriation as needed. In the midst of a disaster, it is not necessary for Congress to enact new legislation to provide funds as the Stafford Act "provides the President with permanent authority to direct federal aid to stricken states."[233]

Under the National Response Plan, the National Disaster Medical System (NDMS) may deploy personnel to provide medical care "under any conditions at a disaster site, in transit from the impacted area, and into participating definitive care facilities."[234] The amount of FEMA funds and number of NDMS personnel deployed is variable and contingent on the scope of mitigation effort to comply with the above mission statement. FEMA broadly lists eligible persons and groups, services, and costs. Since each grantee is assessed separately, it is crucial for eligible grantees to cooperate with the FEMA project officers throughout the application process in order to maximize and expedite assistance. The proceeding FEMA information is general information that potential applicants can us to gain access to Federal aid.

FEMA Public Assistance (PA) Eligible Services

The following section outlines the Public Assistance program, the most applicable type of aid and coverage available to healthcare entities during a surge.

During a disaster, the Disaster Relief Fund is the main source of public assistance for state, tribal, local governments, certain private nonprofit organizations that provide assistance to States, local governments, and certain non-profit organizations to alleviate suffering and hardship resulting from major disasters or emergencies declared by the President.

Through the PA Program, FEMA provides supplemental Federal disaster grant assistance for various medical surge services. During mass evacuation, FEMA and NDMS have a process beginning from patient evacuation transport to treatment at a Federal public designated patient site. The medical personnel stabilize injuries resulting from the disaster, treats pre-existing conditions exacerbated by the disaster and illnesses arising during the emergency period, and provide on-going care interrupted by the disaster. This process is separate from the existing private medical provider system and the aforementioned funding mechanism. FEMA may reimburse eligible public and non-profit heath facilities on site or at an emergency location (e.g. shelter) for direct costs associated with stabilization care for the provision of emergency or austere care when patients are not billed for services. These eligible costs may include some personnel costs, equipment, supplies, and utilities. FEMA and NDMS may provide its staff to augment existing public providers to render medical stabilization. Separate medical records are kept. The hospital itself does not bill for stabilizing services or for immunizations because the federal and state cost sharing funds pay the providers for these direct costs or expenses for qualifying hospitals and providers as long as services have clear documentation.

FEMA and NDMS do not provide ongoing definitive or fee-for-service care such as follow-up care or long term care. In limited situations, NDMS has provided for definitive care in a Veterans Affairs system or Department of Defense federal facility. For ongoing needs, the patient's primary insurance coverage is considered in addition to possible patient out-of-pocket cost share.

FEMA and NDMS also do not compensate for disaster-related stabilization and care administered in a private, for-profit health care setting. Limited funding is available to not-for-profit agencies without government function.

Public Assistance Ineligible Services

It is important for healthcare entities to be aware of the services and expenses that are ineligible for reimbursement from FEMA so they can plan accordingly.

Hospitals are expected to have capacity and reserves for surges in demand for medical services. Staffing, equipment, and supply costs are not compensated by FEMA. FEMA compensates medical costs only when a disaster victim has made a point-of-service contact with the provider for stabilization of injuries as a direct result of the disaster or an illness that presents in a designated disaster area during the declared emergency time period. When billing mechanisms are in place and utilized, providers are held accountable to secure reimbursement for care from the primary and any subsequent insurance provider before defaulting to FEMA as the payer of last resort. Primary insurance coverage includes but is not limited to private employer insurance, Medicare, and Medicaid. Otherwise FEMA may compensate only for the actual cost of care and providers of service must provide documentation.

Eligibility

FEMA stipulates specific eligibility requirements for its funding assistance and healthcare entities can better prepare for the kinds of funding they may receive if they are more familiar with these requirements. Overall eligibility for FEMA assistance requires the individual applicant to:

- apply funds towards eligible disaster services,
- reside within a designated disaster area, and
- be legally responsible for the eligible applicant.

FEMA further designates the entities that are available for public assistance funds. These entities include State, Tribal, and local governments and certain private nonprofit organizations[235] including the following:

- State government agencies
- Federally recognized Indian Tribes, Alaskan Tribal Governments, Alaskan Native village organization, and authorized tribal organizations within the areas declared a federal disaster area. This does not include the Alaska Native Corporations, which are owned by private individuals.
- Any local governments with special districts such as county, city, village, town, district, or other political subdivision government of any State and includes any rural community, unincorporated town or village, or other public entity for which an application for assistance is made by a State or political subdivision thereof.
- Other State and local political subdivisions may be eligible if they are formed in accordance with State law as a separate entity and have taxing authority. These include, but are not limited to, school districts, irrigation districts, fire districts, and utility districts.
- Eligible private non-profit organizations that own or operate facilities that provide essential services and are open to the general public. Examples include:
    - Hospitals, outpatient facilities, rehabilitation facilities, or facilities for long-term care, mental illness, physical injury, or disease
    - Colleges, universities, parochial, and other private school
    - Systems of energy, communication, water supply, sewage collection and treatment, or other similar public facilities
    - Homes for the elderly and similar facilities that provide institutional care for persons who require close supervision but do not require day-to-day medical care
    - Community centers
    - Fire protection, ambulance, rescue, and similar emergency services
    - Libraries
    - Homeless shelters or other shelters that provider health and safety services of a governmental nature such as low-income housing, alcohol and drug rehabilitation programs, battered spouses program, transportation to medical facilities, and food programs
    - Museums that offer cultural programs
    - Senior citizen centers
    - Zoos

The following table, Table 1, matches the various types of assistance available through FEMA, Individual Assistance, Public Assistance and Hazard Mitigation Assistance, with the entities eligible to receive that assistance to provide context around other types of FEMA assistance. The highlighted square in the table below outlines the assistance that is most applicable to the healthcare audience.

Table 1. Type of Aid, eligible entities, and example of eligible services.

Eligible Entity v. Aid for Eligible Services	Individual Assistance	Public Assistance	Hazard Mitigation Assistance
Individuals and Households	**Medical & dental; funeral & burial**; temporary housing; housing repair/replacement, clothing; household	Not available.	Not available.

Eligible Entity v. Aid for Eligible Services	Individual Assistance	Public Assistance	Hazard Mitigation Assistance
	items; job tools; educational materials; fuel; clean-up; vehicle; moving & storage		
State, tribal, and local governments, and certain private nonprofit organizations	Not applicable.	**Medical stabilization and pre-existing illnesses exacerbated by the event**; disaster-damaged, publicly owned facilities and certain private non-profit facilities repair, replacement, or restoration; debris removal	Home elevation to prevent flood water invasion; facility retrofitting; vegetative and mud-slide erosion prevention
Private, for profit organizations (ineligible)	Not available.	Not available.	Not available.

Public Assistance (PA) Program Application and Fund Allocation

The process to apply for FEMA funds can be complicated, and the following information serves to highlight the process with the intent of providing some clarity for the healthcare audience. The State OES, in conjunction with FEMA Region IX representatives, may conduct a preliminary damage assessment (PDA) across all eligible entities and report actual and estimated total costs to FEMA. These representatives interview local government representatives and potential fund applicants, accept documentation of eligible services rendered, evaluate level of severity, and estimate need.

FEMA assigns a Public Assistance Coordinator (PAC) to each applicant. The PAC acts as a liaison for the applicant on all eligible funding requests both for emergency and permanent work reimbursement. The State also assigns a companion State liaison to advocate for the applicant and to collaborate with FEMA. The FEMA PAC assigns project file officers to interview prospective aid applicants, evaluate provided services, map timeline of events and services, and collect documentation on eligible costs and services rendered and restoration or repair of the facility, such as an alternative care facility, to its normal business function. Any fee schedules for care, lost business revenues due to interruption of normal day-to-day business, or staff time-off is not considered an actual cost. Public agencies are encouraged to cooperate with FEMA agents to elicit a transparent process and clear evidence of services in order to qualify for federal funds. Prudent repairs and restoration of facilities must be immediately committed and completed to avoid preventable repair costs. All applicants must be eligible agencies that provide eligible services with adequate documentation of how funds are spent.

Based on collected information and extensive cooperation, FEMA agents write a grant application on behalf of all applicants or sub-grantees. Project worksheets are presented to each applicant for a signature for data collection information verification. Signatures are usually from a designated leader, typically the chief operations officer. Project worksheet may be submitted to the FEMA PA without a signature.

After a series of regulatory and quality assurance reviews, FEMA obligates funds for each eligible project worksheet. These funds are first disbursed to the State as the official FEMA public assistance grantee, and the State releases funds to the sub-grantee or applicant. Federal funding to a State is authorized under the FEMA-State Agreement and is passed to the State by electronic funds transfer through the Payments Management System (PMS) operated by the

Department of Health and Human Services (HHS)[236]. Finally the State is responsible for the expenditure and must return any unspent or ineligible funds as well as refunds to FEMA.

Recommendations to Facilitate Payment

Recognizing that receiving reimbursement from FEMA can be complicated and delayed, the following section highlights key recommendations for the healthcare community to follow to facilitate reimbursement from FEMA following a disaster. The following are not guarantees of payment, but understanding some of the potential barriers prior to submitting an application can improve the likelihood that the application will be well received.

For all recipients, auditable documentation is required for FEMA reimbursement. Basic information may include the patient's name, permanent and temporary displacement addresses, telephone number, disaster-related medical conditions or pre-existing condition flare up, specific services rendered, cause of the injury or illness, date, time, and location of treatment, provider, provider license and Medicaid/Medicare ID number, and provider's signature. In addition, documentation of care should also include the stage of care whether it is a moment of care or stabilization. For each administration of care, the provider must indicate if treatment is for medical stabilization or regular medical care.

Since most FEMA medical care funding is restricted to stabilization, the State may provide definitions of the level of care to properly attain FEMA funding and it is recommended that the State define or establish criteria for stabilization. Ambiguous documentation may lead to a delay in reimbursement without interest payment or no reimbursement ultimately for care rendered. Please see Administrative Guidelines on Minimum Data Sets - Registration, Charge Capture, and Billing as a foundation to collaborate with private and government payers on generating a sole documentation source of acceptable data elements for reimbursement.

Mutual aid agreements (MAA) may increase the likelihood that FEMA funds will flow from one eligible entity to another. The State and FEMA application agents can better identify eligible sub-grantees through MAA networks rather than stand alone sub-grantees.

One recommendation for the State is to evaluate, enforce, and manage the MAA. MAA can also be in place between governments and private, non-profit and public hospitals and providers. Private for-profit hospitals and other healthcare facilities are not eligible to be reimbursed through FEMA’s Public Assistance because they do not meet the eligible applicant criteria.

State or local government may explore public-private partnerships and contracts with for-profit entities. These service agreements evoked during a disaster with the nearest sizeable hospitals and clinics can strengthen the existing fragile emergency resources for rural or isolated providers. These agreements designate the public entity as the cognizant agency with the for-profit provider assuming the contractor role. Through the PA program, FEMA will consider reimbursing direct costs to the public entity for services provided by the contractor(s) if services are not offered on a fee basis to the patient receiving stabilization care. Reimbursable costs must be reasonable and represent only the direct costs of providing care that result from the disaster and do not include costs of business interruption/lost revenue.

It is strongly recommended that healthcare facilities, providers, communities, and stakeholders annually review FEMA funding policies and procedures and that they take accountability to educate their organizations on the available resources and mechanisms that can be deployed for healthcare surge pre-planning, preparation and response. Organizations can infuse existing training curriculum and required annual training with these concepts and program elements.

FEMA Public Assistance Process and Checklist

The State/applicant and the potential subgrantees for FEMA Public Assistance are strongly recommended to review the Public Assistance Policy Digest - FEMA Report 321 and Applicant Handbook - FEMA Report 323. Both handbooks are available online and provide a comprehensive review of the applicant's role and responsibility for Public Assistance funding.[237,238] Familiarity of these two handbooks will provide stakeholders with a context for the handbook excerpts and checklist below. This process flow and checklist may serve as a brief reference during a disaster.

Each parallel process and checklist is broken down by the three main participatory stakeholders: FEMA, California Governor's Office of Emergency Services, and the eligible entity requesting FEMA Public Assistance. Each parallel process and checklist is broken down by two main participatory stakeholders: California Governor's Office of Emergency Service, and the eligible entity requesting FEMA Public Assistance. These checklists outline the key steps that need to be taken by these stakeholders, providing a tool that can better assist healthcare entities in the FEMA application process. Although during the actual application process FEMA provides a Public Assistance Coordinator to work with applicants, understanding the key steps of the process may assist healthcare entities to provide the appropriate staff and complete the appropriate documentation to obtain reimbursement for services provided during a healthcare surge.

Stakeholder: State Governor Office of Emergency Services

Public Assistance Steps	Stakeholder: State Governor Office of Emergency Representing the State or Indian Tribe Grantee	Checklist
(1) Preliminary Damage Assessment (PDA)	▪ Visits local potential subgrantees to view damage, assesses scope of damage, estimates repair costs, and identifies unmet needs that requires immediate attention ▪ Uses result of PDA to determine if situation is beyond combined capabilities of State and local resources and verifies the need of supplemental Federal assistance ▪ Identifies Applicant Liaison from State's customer service representative for providing potential subgrantees with specific information on State regulations, documentation, reporting requirements, and technical assistance	☐ Interviews potential subgrantees ☐ Decides whether or not to request for Federal aid based on PDA ☐ Identifies Applicant Liaison from State's customer service representative
↓	↓	
(2) Presidential Disaster Declaration	▪ If the Governor has already declared state of emergency, then the State sends Governor's request letter to the President, directed through the Regional Director of FEMA Region IX	☐ Submits request letter to President for disaster declaration on federal level
↓	↓	
(3) Applicants' Briefing by Grantee	▪ Conducts prospective subgrantee briefing to reveal available technical advice and assistance and eligibility requirements for Federal assistance ▪ Presents incident period and description of declared event ▪ Discusses funding options, record keeping and documentation requirements, and special considerations* issues ▪ Submits to FEMA form (FF) 424 at briefing meeting ▪ Collect potential subgrantees' FF 90-49 Request for PA to forward to regional FEMA Office	☐ Conducts briefing ☐ State Liaison meets with subgrantee ☐ Completes and submits FF 424
↓	↓	
(4) Submission of Request for Public Assistance by Applicant	▪ If not done during briefing, State submits to FEMA FF 424 via fax, mail, or delivery within 30 days of the date of designation of any area. ▪ Continue to collect potential subgrantees' FF 90-49 Request for PA to forward to regional FEMA Office	☐ Completes and submits FF 424 ☐ PAC contacts subgrantee within 1 week of the Request for PA receipt
↓	↓	
(5) Kick-off Meeting with Public Assistance Coordinator (PAC)	▪ State/Applicant Liaison and subgrantees meets with FEMA PAC, designated FEMA PO, and subgrantees	☐ State Liaison in conjunction with FEMA PAC conducts kick-off meeting with FEMA PO and subgrantees
↓	↓	
(6) Project Formulation and Cost Estimating	▪ Formulates a team effort with FEMA and local representatives to target large projects	
↓	↓	
(7) Project Review and Validation	*Not Applicable*	
↓	↓	
(8) Obligation of Federal Funds and Disbursement to Subgrantees	▪ Notifies FEMA that state is ready to award grants to the appropriate subgrantees. ▪ Makes federal and state cost share funds available to subgrantees of small projects ▪ Makes federal and state cost share progress funds available to subgrantees of large projects as actual costs are documented ▪ Minimizes the time between the transfer of funds and disbarment by the State in accordance with Federal cash management requirements ▪ Forwards subgrantee's incurred costs documentation of large projects to FEMA	☐ Notifies subgrantee of fund availability ☐ Disperses State/Indian Tribe and Federal cost share of funds to subgrantees ☐ Forwards large project grantee's actual incurred costs documentation to FEMA
↓	↓	
(9) Appeals and Closeout	▪ Certifies all recovery work has been completed ▪ Resolves all appeals ▪ Reimburses all eligible costs	☐ Returns unused Federal aid funds

Stakeholder: Local Sub applicant(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 ☐ Tours of all damages ☐ Provides documentation, environmental or historic issues, and insurance coverage information ☐ Identifies and explains immediate expenditures for emergency work and decides whether or not to apply for Immediate Needs Funding (INF) ☐ 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 ▪ Prepare and submit Requests for PA no later than 30 days of the date designation of any area.	☐ Subgrantee's management representative attends Briefing ☐ Meets with State Liaison ☐ Mentions any Immediate Needs Funds (INF) requests ☐ 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 Public Assistance 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 ☐ 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 ▪ State liaison provides State specific details on documentation and reporting requirements ▪ Identify special considerations that require special review, such as insurance coverage, environmental resource issues, and historic preservation ▪ Request any clarification	☐ Sends appropriate management including risk manager to Kick-Off ☐ Identify management that will fully manage all repair projects including small projects ☐ Contacts State Liaison if have not heard from PAC 2 weeks of request for PA submission ☐ Regularly meets with PAC ☐ Compiles list of all damages ☐ Reviews with State liaison specific details on documentation and reporting requirements ☐ Identify with PAC and state Liaison circumstances that require special review
↓	↓	

Stakeholder: Local Sub applicant(s) or Subgrantee(s) (*continued*)

Public Assistance Steps	Stakeholder: Local Applicant(s) or Subgrantee(s)	Checklist
(6) Project Formulation and Cost Estimating	▪ Complete Project Worksheets ▪ Document extent of facility damage, identify eligible scope of work estimate costs associated with scope of work for each project, plan repair work ▪ Administratively consolidate multiple work items into single projects to expedite approval and funding and project management ▪ Divide work projects into small (up to $59,700 for FFY2007) and large projects[239] ▪ Identify and provide basic description of project and broad coast estimate ▪ Maintain records of completed work and work to be completed ▪ If necessary, specialist reviews with subgrantee Special Considerations Questionnaire	☐ Complete Project Worksheets: ☐ Project Worksheet (PW) FF90-91 ☐ PW FF90-91A Damage Description and Scope of Work Continuation Sheet ☐ PW FF90-91B Cost Estimate Continuation ☐ PW FF90-91C Maps and Sketches Sheet ☐ PW FF90-91D Photo Sheet ☐ If necessary complete FEMA Special Considerations Questions FF90-120 ☐ Organize records by the following suggested summary forms: ☐ Force Account Labor Summary FF 90-123 ☐ Force Account Equipment Summary FF 90-127 ☐ Materials Summary Record Summary FF 90-124 ☐ Rented Equipment Summary Record FF 90-125 ☐ Contract Work Summary Record FF 90-126 ☐ Applicant's Benefits Calculation Worksheet FF 90-128 ☐ Establish file for each project and record specific costs and scope of work by site ☐ Retain all documentation up to 3 years from the date the State closes subgrantee grant ☐ Escort PO and State representative on a site visit and collaboratively develop a complete scope of work and accurate large project cost estimate
↓	↓	
(7) Project Review and Validation	▪ PAC schedules review with subgrantee for preparation of records for review ▪ 20% or 2 small projects is the minimum level of review for projects submitted within 30 days after the Kickoff meeting ▪ 100% validation for projects submitted after 30 days ▪ Validation can normally be completed within 15 days of submission of all Project Worksheets to the PAC ▪ 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
↓	↓	

Stakeholder: Local Sub applicant(s) or Subgrantee(s) (*continued*)

Public Assistance Steps	Stakeholder: Local Applicant(s) or Subgrantee(s)	Checklist
(8) Obligation of Federal Funds and Disbursement to Subgrantees	▪ Notified of availability of Federal FEMA funds and State cost share funds ▪ Submit documentation of actual incurred costs associated with approved scope of work for subgrantees with large projects ▪ 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. ☐ File appeal with State within 60 days of receipt of a notice of any action that is being appealed ☐ Provide documentation explaining why the original determination is wrong or overrun costs and the amount of adjustment being requested ☐ Closeout large projects as each project is completed, and reconcile estimated and actual costs when large projects are complete ☐ Close small projects when all small projects have been funded and completed ☐ Notify State when projects are compete ☐ Return any unused money to State ☐ Certify to the State that all funds were suspended and all the work described in the project scope of work is complete ☐ 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[240].

Human Influenza Pandemic Flu Emergency Management 241

Recognizing that a Pandemic Influenza scenario may require a different kind of local, State and Federal response, the Department of Homeland Security recently outlined a policy document on FEMA's Emergency Assistance for Human Influenza Pandemic. Given the rapidly infectious and deadly nature of human influenza, Federal resource response for an outbreak is different from other disaster relief undertakings, and as such, a separate policy was developed to address this potential situation. One of the differences between a pandemic and most other emergencies is that a pandemic may last much longer than most public emergencies, and may include "waves" of influenza activity separated by months, affecting the ability of interstate mutual aid to respond and reducing the number of health care workers and first responders available to work. Additionally, resources in many locations could be limited, depending on the severity and spread of an influenza pandemic.

The FEMA policy document lists a series of Emergency Protective Measures that may be eligible for reimbursement to State and local governments and certain private non-profit organizations. These measures are

1. Activation of State or local emergency operations center to coordinate and direct the response to the event.
2. Purchase and distribution of food, water, ice, medicine, and other consumable supplies.
3. Management, control, and reduction of immediate threats to public health and safety.
4. Movement of supplies and persons.
5. Security forces, barricades and fencing, and warning devices.
6. Emergency medical care (non-deferrable medical treatment of disaster victims in a shelter or temporary medical facility and related medical facility services and supplies, including emergency medical transport, X-rays, laboratory and pathology services, and machine diagnostics tests for a period determined by the Federal FEMA Coordinating Officers).
7. Temporary medical facilities (for treatment of disaster victims when existing facilities are overloaded and cannot accommodate the patient load).
8. Congregate sheltering (for disaster victims when existing facilities are overloaded and cannot accommodate the patient load).
9. Communicating health and safety information to the public.
10. Technical assistance to State and local governments on disaster management and control
11. Search and rescue to locate and recover members of the population requiring assistance and to locate and recover human remains.
12. Storage and internment of unidentified human remains.
13. Mass mortuary services.
14. Recovery and disposal of animal carcasses (except if another Federal authority funds the activity -- e.g., U.S. Department of Agricultural, Animal, Plant and Health Inspection Services provides for removal and disposal of livestock).
15. Coordination with Emergency Support Function (ESF), Coordination among ESFs 3, 5, 6, 8, 9, 11, and 14 will be required.
16. Coordination among ESFs 3, 5, 6, 8, 9, 11, and 14 will be required.

Due to the limited number of NDMA personnel aid, FEMA has identified eligible costs for regular personnel not usually available through public assistance programs such as overtime pay for an applicant's regular employees. However, the straight-time salaries of an applicant's regular employees who perform eligible work are not eligible for reimbursement. Regular and overtime pay for extra-hires may be eligible for reimbursement and eligible work accomplished through contracts, including mutual aid agreements, may be eligible for reimbursement. Equipment, materials, and supplies used for emergency protective measures may also be eligible.

Note: Ineligible costs remain ineligible even if they are covered under contract, mutual aid, or other assistance agreements.

California State Coordinated FEMA Resources Contact Information

Governor's Office of Emergency Services
Departments: Office of the Director & Chief Deputy Director, Law Enforcement & Victim Services Division, Response & Recovery Division, Preparedness & Training Division, and Administration Division

3650 Schriever Avenue
Mather, CA 95655

(916) 845-8510 (main)
(916) 845-8506 (executive office)
(916) 845-8511 (fax)

http://www.oes.ca.gov

6.2.5.2 Funding Sources for Personnel During A Disaster

Although social and job responsibilities require personnel to work through disaster-relief medical surges during a disaster or pandemic, many organizations may have high personnel absenteeism rates and may be strained for personnel resources. They may recruit additional providers and staff to accommodate the medical surge. Organizations may consider the resources of these available programs that compensate for additional personnel salaries and overtime.

- FEMA Disaster Assistance for State Units on Aging (SUAs) and Tribal Organizations in National Disasters Declared by the President
- FEMA Emergency Assistance for Human Influenza Pandemic
- VHA Disaster Relief Program

More information on the funding sources for personnel during a disaster can be found in the Sources of Funds chapter of this volume. For detailed program information please see the Funding Sources Eligibility, Benefits and Application Procedures tables in the Appendix.

6.2.5.3 Funding Sources Matrix

The Funding Sources Matrix that begins on the next page is designed to be a quick reference guide for the healthcare community to identify sources of funding that may be used to meet the financial needs of planning and responding to a surge. It is included as a tool to highlight available funds and their prescribed uses. This matrix outlines a summary of key grants and funding opportunities with the relative funding amount matched to the relative effort of the application. This tool can help the State, local health departments and health care providers better identify the grants and funding sources that will most meet their needs before and during a surge.

This list of funding sources provides available grants that facilities or individuals may apply for to plan and prepare for a disaster, to cope with a disaster, or to deal with the aftermath of a disaster. The majority of these funds are Federal government appropriations enabled by specific Congressional legislation. Supplemental information on this matrix including specific rules and guidelines on how agencies or individuals may qualify, apply, and receive funds to cover defined benefits can be found in the Funding Sources Eligibility, Benefits and Application Procedures tables in the Appendix. These programs and grants are not a form of temporary or permanent source of health care coverage. Most funds cover eligible services such as property casualty and some cover medical services that is outside the direct provision of care. The amount and existence of funds is subject to Federal fiscal year budget appropriation.

For the majority of the public funds, private for profit organization are ineligible. However, these stakeholders may understand the type of funds and its intentions and may seek to influence Congress to also streamline assistance during a catastrophic disaster.

The following key was used to identify relative funding impact and application effort:

<u>Relative Funding Impact</u>
$ - $$$$
The funding impact indicator is based on the amount of total funding available and its relevance to funding medical services and associated costs. The indicator ranges from limited funding source and scope with eligibility restrictions to a major funding source for a wide array of medical services during a surge.

<u>Application Effort</u>
Low - Application requires easily accessible and existing documentation or application process is handled by the program sponsor
Medium - Application requires coordination with other stakeholders such as the State and/or program sponsor
High - Application requires coordination with other stakeholders such as the State and/or program sponsor and additional rigorous documentation

This information is current as of April 2007.

Application Owner	Grant Program / Sponsor	Application / Funding Timing	Relative Funding Impact	Application Effort	Funding For: Facility	Medical Svc	Planning	Staffing	Training	Supplies & Equip
Healthcare Provider Organzizations & Businesses	Bioterrorism Training and Curriculum Development Program (BTCDP) / HRSA	Pre-Disaster	$$$	High					✔	
Healthcare Provider Organzizations & Businesses	Economic Injury Disaster Loans for Small Businesses / SBA	Post-Disaster	$$	Low	✔					
Healthcare Provider Organzizations & Businesses	Competitive Training Grant Program (CTGP) / FEMA	Pre-Disaster	$$	Medium					✔	
Healthcare Provider Organzizations & Businesses	Pre-Disaster Mitigation Loan Program / SBA	Pre-Disaster	$$	Medium	✔					
State, Tribes, Local Governments & Not-for-Profits	Metropolitan Medical Response System (MMRS) Program / FEMA	Pre-Disaster	$$$$	Medium	✔	✔	✔			✔
State, Tribes, Local Governments & Not-for-Profits	National Bioterrorism Hospital Preparedness Program (NBHPP) 2006 / HRSA	Pre-Disaster	$$$	Medium			✔	✔	✔	✔
State, Tribes, Local Governments & Not-for-Profits	Pre-Disaster Mitigation (PDM) Program / FEMA	Pre-Disaster	$$$	High	✔		✔			
State, Tribes, Local Governments & Not-for-Profits	State Homeland Security Program (SHSP) / FEMA	Pre-Disaster	$$$	Medium			✔		✔	✔
State, Tribes, Local Governments & Not-for-Profits	Emergency Management Performance Grants (EMPG) / Office of Grants and Training	Pre-Disaster	$$$	High				✔	✔	✔
State, Tribes, Local Governments & Not-for-Profits	Superfund Amendments and Reauthorization Act (SARA), Title III / FEMA	Pre-Disaster	$$	Low					✔	
State, Tribes, Local Governments & Not-for-Profits	Commercial Equipment Direct Assistance Program (CEDAP) / FEMA	Pre-Disaster	$	Medium						✔
State, Tribes, Local Governments & Not-for-Profits	Flood Mitigation Assistance (FMA) program / FEMA	Pre-Disaster	$	Medium	✔					
State, Tribes, Local Governments & Not-for-Profits	Urban Areas Security Initiative (UASI) Program / FEMA	Pre- and Post-Disaster	$$$	Medium			✔		✔	✔
State, Tribes, Local Governments & Not-for-Profits	National Disaster Medical System (NDMS) Uncompensated Care Pool/Reimbursement / FEMA, HHS	Post-Disaster	$$$$	Low		✔				
State, Tribes, Local Governments & Not-for-Profits	Emergency Assistance for Human Influenza Pandemic / FEMA	Post-Disaster	$$$$	Medium	✔	✔		✔		✔
State, Tribes, Local Governments & Not-for-Profits	Public Assistance Grant Program / FEMA	Post-Disaster	$$$$	High		✔				✔
State, Tribes, Local Governments & Not-for-Profits	Hazard Mitigation Grant Program (HMGP) / FEMA	Post-Disaster	$$	High	✔					
State, Tribes, Local Governments & Not-for-Profits	Disaster Assistance for State Units on Aging (SUAs) and Tribal Organizations in National Disasters Declared by the President / HHS, AoA	Post-Disaster	$	Medium		✔		✔		✔
VHA Hospital	VHA Innovations in Hospital Emergency Preparedness / VHA Foundation	Pre-Disaster	$	Medium			✔			
VHA Hospitals	VHA Disaster Relief Program / VHA Foundation	Post-Disaster	$	Low				✔		

7 Endnotes

[1] Govt. Code, §§8550, et seq.
[2] Depending upon the jurisdiction, the designated official may be the director of emergency services, the director or medical director of the local emergency medical services agency, or medical health operational area coordinator. A description of these officials is provided later in this document.
[162] Adapted from Medical Board of California, Division of Licensing, Standard of Care for California Licensed Midwives. *Midwifery Standards of Care* (September 15, 2005). http://www.mbc.ca.gov/MW_Standards.pdf
[163] Virginia Jury Instructions, Civil Instruction No. 35.000. Steven D. Gravely, Troutman Sanders LLP. *Altered Standards of Care: An Overview.*
http://www.vdh.state.va.us/EPR/pdf/Health_and_Medical_Subpanel.pdf
Note: In The Supreme Court Of The State Of Hawaii, In the Matter of the Publication and Distribution of the Hawai`i Standard Civil Jury Instructions, Instruction No. 14.2: Standard Of Care:
"It is the duty of a [physician/nurse/specialty] to have the knowledge and skill ordinarily possessed, and to exercise the care and skill ordinarily used, by a [physician/nurse/specialty] practicing in the same field under similar circumstances. A failure to perform any one of these duties is a breach of the standard of care".
[164] The Agency for Healthcare Research and Quality
[3] Health & Saf. Code, §1276.
[4] Govt. Code, §8571.
[5] Govt. Code, §8567. Local governing bodies have similar authority under a local emergency to enact ordinances, but these ordinances would be subordinate to state statutes, regulations, and orders of the Governor.
[6] 22 Cal. Code Reg., §70217. This regulation does allow for some flexibility where a healthcare emergency (i.e., an unpredictable or unavoidable occurrence at unscheduled or unpredictable intervals relating to healthcare delivery requiring immediate medical interventions and care) causes a change in the number of patients on a hospital unit. However, the hospital must demonstrate that prompt efforts were made to maintain required staffing levels.
[7] See Govt. Code, §8550.
[8] Civil Code, §1714.
[9] Government Code, §8659.
[10] *Burciaga v. St. John's Hospital* (1986) 187 Cal.App.3d 710.
[11] *Bryant v. Bakshandeh* (1991) 226 Cal.App.3d 1241
[12] *Calatayud v. State of California* (1998) 18 Cal. 4th 1057, 1064.
[13] Bus. & Prof. Code, §2727.5
[14] Bus. & Prof. Code, §1627.5.
[15] Bus. & Prof. Code, §2861.5.
[16] Bus. & Prof. Code, §3503.5
[17] Health & Saf. Code, §1799.102.
[18] Health & Saf. Code, §1799.104.
[19] Health & Saf. Code, §1799.106.
[20] Health & Saf. Code, §1799.107.
[21] See, e.g. Bus. & Prof. Code, §2727.5, applying to nurses.
[22] Health & Saf. Code, §1799.102, applying to any person outside of an emergency room or place where care is usually offered.
[23] Bus. & Prof. Code, §2397.
[24] See Govt. Code, §204; "The State may require services of persons, with or without compensation: . . . in protecting life and property from fire, pestilence, wreck and flood."
[25] Govt. Code, §8599.
[26] Govt. Code, §3101.
[27] Govt. Code, §3100.
[28] See Labor Code, §3600.6, §§3211.9-3211.93a, and §§4350-4355; 19 Cal. Code Reg. 2570, et seq.
[29] 19 Cal. Code Reg. 2570.2.
[30] Govt. Code 8657.
[31] Civil Code, §1714.5; the exception here is essentially identical to the Good Samaritan exception for physicians, and the exception to the specific provider immunity in a declared emergency under Govt. Code section 8659, discussed above.
[32] 19 Cal. Code Reg. 2572.1(j).

[33] Civil Code, §1714.5.
[34] Health & Saf. Code, §1317(a).
[35] Health & Saf. Code, §1317(c).
[36] Health & Saf. Code, §1317(g).
[37] Govt. Code, §8665.
[38] Civil Code, §1714.6.
[39] Civil Code, §1714.6.
[40] There is an immunity from liability for refusal to treat based on a determination that the health facility does not have the appropriate facilities or qualified personnel available to render those services. (Health & Saf. Code, §1317(c)).
[41] Hospitals with emergency departments are required under the Emergency Medical Treatment and Labor Act (EMTALA) to provide a screening and stabilization within the abilities of the staff and facilities available prior to transferring the patient to another facility. (42 U.S.C. 1395dd.) This federal requirement can be waived by the Secretary for Health and Human Services under 42 U.S.C. 1320b-5(b)(3).
[42] See, e.g., Business & Profs. Code, §§1627.5, 2395, 2727.5, 2861.5, and 3503.5.
[43] At present, no standby orders suspending healthcare standards exist.
[44] Health & Saf. Code, §1276.
[45] Govt. Code, §8567.
[46] Govt. Code, §8665.
[47] Govt. Code, §8567b.
[48] A local health officer may take preventive measures to protect public health, including protective step that may be taken against any public health hazard that is caused by a disaster and affects the public health. This could, in limited circumstances, include control over vaccine distribution, but not commandeering of either the vaccine or personnel to administer it.
[49] Govt. Code, §8567.
[50] Govt. Code, §§8550, et seq.
[51] Govt. Code, §8550.
[52] Govt. Code, §8567.
[53] Govt. Code, §8571.
[54] Govt. Code, §8572.
[55] There are three types of emergencies under the ESA; state of war emergency, state of emergency, and local emergency. (See Govt. Code, §8558.)
[56] Govt. Code, §8627.
[57] Govt. Code, §8628.
[58] Govt. Code, §8575, et seq.
[59] Govt. Code, §8579(b)(1).
[60] Govt Code, §8549.10.
[61] Govt Code, §8549.13.
[62] Govt. Code, §8585.
[63] Govt. Code, §8586.
[64] Govt. Code, §8587.
[65] Ibid.
[66] California State Emergency Plan, 2005, pp. 8, 9.
[67] Govt. Code, §8569.
[68] Govt. Code, §8568.
[69] Govt. Code, §8595.
[70] Govt. Code, §8570.
[71] Govt. Code, §8572.
[72] Health & Saf. Code, §§1797.100, et seq.
[73] Health & Saf. Code, §§1797.150.
[74] California State Emergency Plan, 2005, p. 58.
[75] California State Emergency Plan, 2005, p. 56.
[76] Health & Saf. Code, §1797.160.
[77] Ibid.

[78] Health & Saf. 100100, et seq.; effective July 1, 2007, the public health duties of the State Department of Health Services are transferred to the new State Department of Public Health, Health & Saf. Code, §131000, et seq.
[79] California State Emergency Plan, 2005, p. 58.
[80] California State Emergency Plan, 2005, p. 56.
[81] Health & Saf. Code, §§1200, et seq.
[82] Health & Saf. Code, §1276.
[83] Govt. Code, §6502.
[84] Govt. Code, §8615.
[85] Govt. Code, §§8617, 8561.
[86] California Disaster and Civil Defense Master Mutual Aid Agreement, ¶1.
[87] Govt. Code, §8615.
[88] Govt. Code, §8600.
[89] Govt. Code, §8559(a).
[90] California State Emergency Plan, 2005, pp. 8, 10.
[91] Health & Saf., §1797.152(a).
[92] Health & Saf., §1797.152(b).
[93] Govt. Code, §8619.
[94] Govt. Code, §§178, et seq.
[95] Govt. Code, §179.5, et seq.; inoperative effective March 1, 2007; for proposed extension of operability, see AB 1564 (Nava), 2007-2008 Session.
[96] Robert T. Stafford Disaster Relief and Emergency Assistance Act, P.L. 93-288,100-707, and 106-390, 42 U.S.C. §5121, et seq.
[97] Govt. Code, §8560.
[98] Govt. Code, §8616.
[99] Govt. Code, §8610.
[100] Ibid.
[101] Ibid.
[102] Govt. Code, §8585.5.
[103] 19 Cal. Code Reg. 2570.2
[104] Govt. Code, §8612; 19 Cal. Code Reg. §2571.
[105] Labor Code, §3211.92.
[106] Govt. Code, §8610.
[107] Govt. Code, §8610.
[108] Govt. Code, §8614.
[109] In a letter dated September 28, 2006, the Director of OES certified to the federal Department of Homeland Security the compliance of SEMS with the National Incident Management System (NIMS) for fiscal year 2006.
[110] 19 Cal. Code Reg., §2400, et seq.
[111] Govt. Code, §8607(d).
[112] Govt. Code, §8607(e).
[113] Govt. Code, §8607(a)(1); Cal.Code Reg., §§2401, 2402(l), and 2405.
[114] Govt. Code, §8607(a)(2); 19 Cal.Code Reg., §2401, 2402(n).
[115] Govt. Code, §8607(a)(3); 19 Cal. Code Reg., §2415; See *Emergency Management in California*, OES, 2003, p. 8.
[116] Govt. Code, §8618.
[117] Govt. Code, §§8559(b), 8605, and 8607(a)(4);
[118] Govt. Code, §§8559(b), 8605.
[119] Govt. Code, §8605.
[120] 19 Cal. Code Reg., §2402(f).
[121] 19 Cal. Code Reg., §2402(c).
[122] Health & Saf. Code, §1797.153.
[123] Health & Saf. Code, §1797.153(c).
[124] Under the proposed tool, such a declaration could occur at surge levels Orange, Red or Black.
[125] Govt. Code, §8630.
[126] Govt. Code, §8631.

[127] Govt. Code, §8632.
[128] Govt. Code, §8634.
[129] Govt. Code, §26620.
[130] Govt. Code, §26621.
[131] Health & Saf. Code, §1797.200.
[132] Health & Saf. Code, §1797.202(a).
[133] Health & Saf. Code, §101000.
[134] Health & Saf. Code, §101030.
[135] Health & Saf. Code, §101460.
[136] Health & Saf. Code, §101375.
[137] Health & Saf. Code, §101175.
[138] See, generally, *Health Officer's Practice Guide for Communicable Disease Control*, 2007, DPH.
[139] Health & Saf. Code, §120176.
[140] Health & Saf. Code, §§101040, 101475.
[141] Govt. Code, §8630.
[142] Health & Saf. Code, § 101080.
[143] Health & Saf. Code, §101085(c).
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[146] Health & Saf. Code, §101080.2(a).
[147] Health & Saf. Code, §101275.
[148] Health & Saf. Code, §101310.
[149] Health & Saf. Code, §1797.153.
[150] Health & Saf. Code, §1797.153(d).
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[152] Govt. Code, §§27460, et seq.
[153] Govt. Code, §§27490, et seq. and 27520, et seq.
[154] Coroners Mutual Aid Plan, OES, 2006, p. 11.
[155] Coroners Mutual Aid Plan, OES, 2006, p. 16.
[156] Govt. Code, §8630(b).
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[158] Govt. Code, §8630(d).
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[180] James Lenthall. Director, Safety/Security & Emergency Management, Saddleback Memorial Medical Centers.
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[182] California Business and Professions Code, Section 4062, subdivision (b).
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[187] U.S. Social Security Act 1176(b)
[188] http://www.hhs.gov/ocr/hipaa/EnforcementStatement.pdf
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[194] 45 CFR 164.310(a)(2)(i)
[195] www.triagetags.com
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California Department of Health Services

Development of Standards and Guidelines for Healthcare Surge during Emergencies

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Introduction

A healthcare system needs surge capability when the medical needs of the population exceed existing resources. To effectively respond to a healthcare surge, four essential components must be appropriately managed. These four components include staff, supplies, structure and sources of funds. By augmenting these essential components of surge, patient-care capability is enhanced. For example, supplementary staff may be required to deliver population care; additional supplies such as medical/surgical, equipment, and pharmaceuticals supplies may be required to treat patient population; a simpler structure to manage the administrative functions may be required; and identifying sources of funds and processes to preserve revenue streams to ensure continued operations of the healthcare facility. This volume provides guidance for health professionals on how to appropriately augment these components during surge to fulfill the guiding principle of doing the greatest good for the greatest number.

Target Audience

The target audience for this section, Delivery of Care, includes all individuals whose primary responsibility is to provide clinical care during a healthcare surge. This includes all physicians, nurses, and allied health professionals.

Contents

This volume contains seven chapters. Each chapter contains several topics that pertain to individuals with a Delivery of Care function within the Clinic. The topics reference Operational Tools contained in Module IV of the Standards and Guidelines Manual and they reference the Training Curriculum.

1. Chapter One provides an operational understanding of surge, as well as the rules, regulations and standards that could affect the standard delivery of care.

2. Chapter Two covers the definition of Standard of Care and distinguishes the difference between “normal” standard of care and the standard of care during a healthcare surge.

3. Chapter Three covers key concepts of Surge Capacity and highlights the importance of community planning.

4. Chapter Four covers Staffing. Topics included in this chapter are the processes by which facilities may acquire and deploy staff, scope of practice and professional liability issues, staffing regulations and strategies, and safety considerations and support provisions for staff during a healthcare surge.

5. Chapter Five covers Supplies, Pharmaceuticals and Equipment. Topics included in this chapter are the role of healthcare professionals, particularly pharmacists, in the planning for the acquisition of pharmaceuticals. Professionals’ role in the planning for the acquisition of supplies and equipment is also discussed.

6. Chapter Six covers Structure particularly that around the delivery of care during a healthcare surge. Topics discussed include the standard of care and patient management during a healthcare surge and how it affects requirements such as medical record documentation, patient tracking and the impact of HIPAA and patient management strategies.

7. Chapter Seven covers Sources of Funds. Topics discussed in this chapter are the minimum data elements for charge capture, processes by which providers can maintain their current revenue stream, an

outline of the opportunities for the issuance of waivers and declarations to address the possible barriers of the current funding and reimbursement system during a surge, and an overview of the recommended waivers and declarations to address funding and reimbursement issues.

Module IV: Operational Tools

This module contains operational tools that enable planning, management, delivery of care and administrative functions that can be used for surge planning during catastrophic healthcare emergencies by healthcare facilities, alternate care sites, and professionals. These tools are referenced in the section above.

Training Curriculum

The Training Curriculum enables planning, management, delivery of care and administrative functions that can be used for surge planning during catastrophic healthcare emergencies by healthcare facilities, alternate care sites and professionals. The Training Curriculum is companion to Modules III and IV of the Standards and Guidelines Manual. The Training Curriculum is referenced in the section above.

1 Introduction to Healthcare Surge

1.1 Definition of a Healthcare Surge

"Healthcare surge" means different things to people from different disciplines.

- To the operators of healthcare facilities (hospitals, clinics, or other kinds of health care facilities): A healthcare surge can refer to 'a routine increase in the number of patients which push the facility to or even beyond the limitations imposed on that facility by regulatory agencies.'
- To regulatory agencies: A healthcare surge can refer to a 'routine situation in which a waiver of certain regulatory requirements to facilitate patient care is justified.'
- To local and regional emergency response planners: A healthcare surge can refer to 'a situation in which a sudden increase in demands on the healthcare system overwhelms local resources, requiring the waiver of regulatory mandates and activating mutual aid.'
- To statewide emergency response planners: A healthcare surge refers to 'an overwhelming increase in demands for medical care services arising out of a moderate to severe emergency.' In such circumstances, the combined federal, state and local public and private resources needed to provide care consistent with optimal patient outcomes may be exhausted, and the exercise of extraordinary powers may be necessary to allow more effective disaster mitigation to occur.

The purpose of this document is not to address the concept of "healthcare surge" in all its permutations. On the other hand, a clear definition of "healthcare surge" is a necessary first step under SEMS (Standardized Emergency Management System) for local government to inform state government when extraordinary measures may be warranted, and to determine the substance of the extraordinary measures taken to mitigate the effects of the emergency.

Healthcare surge is **not** the frequent emergency department overcrowding experienced by healthcare facilities (for example, Friday/Saturday night emergencies). It is also not a local casualty event that might overcrowd nearby facilities but have little to no impact on the healthcare delivery system. Healthcare providers and regulators have well-established procedures for addressing these routine fluctuations in the demand for emergency medical services. Local, regional and hospital emergency planners have Emergency Operations plans and procedures and the Standardized Emergency Management System (SEMS) to address larger local emergencies and to invoke mutual aid from adjacent jurisdictions and facilities, which can permit the timely augmentation of resources to respond to the increased demand. A healthcare surge, as referenced in this guide, specifically relates to a mass casualty or catastrophic event that overwhelms the healthcare delivery system, thus implicating the extraordinary emergency powers of the Governor available under the California Emergency Services Act.[1]

For purposes of this document, "healthcare surge" means the following:

> **A Surge Event is proclaimed in a local health jurisdiction when an authorized local official, such as a local health officer or other appropriate designee[2], using professional judgment determines, subsequent to a significant event or circumstances, that the healthcare delivery system has been impacted, resulting in an excess in demand over capacity and/or capability in hospitals, community care clinics, public health departments, other primary and secondary care providers, resources, and/or emergency medical services. The local official uses the situation assessment information provided from the healthcare delivery system partners to determine overall local healthcare jurisdiction/operational area medical and health status.**

1.2 Standard of Care

The Standard of Care in California is defined by the scope of practice each provider is licensed to provide. It provides a framework to identify the professional responsibilities of licensed personnel and permit individual licensed personnel to be rationally evaluated, to ensure that it is safe, ethical and consistent with the professional practice of the licensed profession in California[162]. Standard of Care is a legal concept that not only encompasses the diagnosis and treatment of patients but overall management of patients as well.[163]

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

For the purposes of this document, **Standard of Care during a Healthcare Surge is the degree of skill, diligence and reasonable exercise of judgment in furtherance of optimizing population outcome during a healthcare surge event that a reasonably prudent person or entity with comparable training experience or capacity would have used under the circumstances.**

Under normal conditions, current standards of care might be interpreted as employing appropriate health and medical resources to improve the health status and/or save the life of each individual patient. However, according to a report by, Health Systems Research Inc., *Altered Standards of Care in Mass Casualty Events;* an AHRQ[164] Publication, April 2005) in the aftermath of a mass casualty event, the demand for care provided in accordance with normal conditions (current standards) would exceed system resources resulting in a healthcare surge. Therefore, it is critically important to identify, plan, and prepare for making the necessary adjustments in current health and medical care standards to ensure that the care provided in response to a healthcare surge results in as many lives being saved as possible.

The AHRQ report further states that currently no universally accepted definition of Standard of Care during a mass casualty event exists. JCAHO refers to such standards as “graceful degradation” under which care and access to caregivers may become rationed. Per the AHRQ report, Altered Standards of Care is referred to as "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." According to the report, examples of shift in care include:

- "Triage efforts that will need to focus on maximizing the number of lives saved. Instead of treating the sickest or the most injured first, triage would focus on identifying and reserving immediate treatment for individuals who have a critical need for treatment and are likely to survive. The goal would be to allocate resources in order to maximize the number of lives saved. Complicating conditions, such as underlying chronic disease, may have an impact on an individual’s ability to survive.
- Triage decisions that will affect the allocation of all available resources across the spectrum of care: from the scene to hospitals to alternate care sites. For example, emergency department access may be reserved for immediate-need patients; ambulatory patients may be diverted to alternate care sites (including non-medical space, such as cafeterias within hospitals, or other non-medical facilities) where “lower level” hospital ward care or quarantine can be provided. Intensive or critical care units may become surgical suites and regular medical care wards may become isolation or other specialized response units.
- Needs of current patients, such as those recovering from surgery or in critical or intensive care units; the resources they use will become part of overall resource allocation. Elective procedures may have to be cancelled, and current inpatients may have to be discharged early or transferred to another setting. In addition, certain lifesaving efforts may have to be discontinued.

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

While the examples suggest how clinical practices might shift, the definition of Altered Standards of Care does not explore the liability and compliance issues that could arise. The following principles were used to support the definition of "Standard of Care" described at the beginning of the section.

Guiding Principles

- The Adjusted or Altered Standard of Care during a healthcare surge will be **"the"** Standard of Care available and should be termed "Standard of Care during a Healthcare Surge".
- The Standard of Care definition, under normal conditions, adapted for large number of victims as opposed to individual patients, would apply to healthcare surges.
- The definition should broaden the scope of caregivers and afford protection to not just licensed personnel but also volunteers and facilities.
- The “under the circumstances” clause in the definition for “Standard of Care during a Healthcare Surge” provides some protection to healthcare providers (facilities, personnel and volunteers) during a healthcare surge as long as there is evidence to support that there was no negligence, appropriate steps were taken (planning, periodic training, relevant documentation, etc.) and that there was reasonableness demonstrated.

1.3 The Exercise of Extraordinary Powers during a Healthcare Surge

1.3.1 The Progression of Medical Mutual Aid in Response to a Mass-Casualty Event

When a mass-casualty event occurs, resources within individual hospitals are mobilized under an incident command system, such as HICS, to deal with the actual or anticipated influx of patients. If conditions within the hospital are sufficiently strained, the hospital may consult with regulatory agencies to determine if specific requirements related to staffing and patient management can be waived to maximize the hospital's response capabilities.[3] If circumstances become overwhelming, the hospital may, following local Emergency Medical Services Agency's policies, divert incoming ambulance patients to other hospitals, if available. The hospital may also draw upon resources from other hospitals and facilities to augment its response capabilities.
At this point in the progression, a "healthcare surge," within the meaning of this document, **does not yet exist**. However, hospital administrators can inform appropriate local governmental officials about the limitations of their resources and, more importantly, to request additional resources. This is the first step in the process of identifying a "healthcare surge." It is important to note that there is not a proclamation of surge. The existence of a surge is a determination, which is then communicated within the Standardized Emergency Management System (SEMS) for purposes of obtaining mutual aid and/or seeking the exercise of the Governor's powers. Local resources would be activated to provide medical mutual aid. Local officials may contact and request aid from other local jurisdictions in the operational area. When local resources in the operational area are overwhelmed, as determined by the authorized local official, it may be determined that a condition of "healthcare surge" exists in the operational area. Separately, a local emergency may be proclaimed by the local governing body or designated official.

The medical and health status of the operational area will be communicated, for example, by the medical health operational area coordinator (MHOAC) or other authorized official, to Regional and State Emergency Operations Centers. The State Emergency Operations Center can draw upon resources statewide to acquire requested mutual aid.

Finally, the Governor has the additional authority to proclaim a "State of Emergency," which can make the resources of state agencies available to mitigate the effects of the emergency. In addition, the Governor's Office can, if needed, request federal resources after proclaiming a "State of Emergency."

1.3.2 Regulatory Standards as Potential Obstacles to Mitigating Medical Disasters

Up until this point, the focus of the emergency response is the acquisition of requested mutual aid. However, a disaster could be so severe that mutual aid resources statewide are exhausted. For example, it is conceivable that a pandemic of influenza could cause a medical and health disaster in every operational area of the state, with no operational area having resources to share because all jurisdictions are utilizing every available resource to mitigate the disaster within their operational area. Further, it may not be possible in all circumstances to deliver requested medical mutual aid to an affected operational area in a timely fashion. For example, a severe-magnitude earthquake in the San Francisco Bay region could make roads and bridges into San Francisco impassable, while at the same time causing a "healthcare surge" within that operational area.

In addition to the consequences of such a proclamation which occur by operation of law, the Emergency Services Act (ESA) authorizes the Governor during a "state of emergency" to suspend any regulatory statute, or statute prescribing the procedure for conduct of state business, or the orders, rules, or regulations of any state agency, where the Governor determines and declares that strict compliance would in any way prevent, hinder, or delay the mitigation of the effects of the emergency.[4] The authority to suspend statutes is unique to the Governor. Local governing bodies and officials acting under a proclaimed local emergency do not have this power.

The Act also authorizes the Governor to make, amend, and rescind orders and regulations necessary to carry out the provisions of the Act, and further provides that the orders and regulations have the force and effect of law.[5]

The effect of a suspension of regulatory statutes and regulations can have several consequences. During the period of the proclaimed emergency and suspension, the suspended statutes and regulations have no force and effect. Consequently, regulatory and law enforcement agencies cannot prevent or penalize persons for failing to comply with the statute or regulation. Further, the statute or regulation cannot provide a basis for finding negligence as a matter of law, which can lessen the potential for civil liability should a person be unintentionally harmed by emergency response activities. The absence of specific regulatory restraints can serve as an incentive for persons to act beneficially to mitigate the effects of the emergency and generally to protect the health and safety and preserve the lives and property of the people of the state without fear of subsequent criminal, administrative or civil liability.

In a medical or health disaster, a suspension of appropriate healthcare-related regulatory statutes and regulations could be used to increase the capacity and/or capability of providers of care to render medical services which, under normal standards, might not be available. Most medical care in California is delivered by persons and entities in the private sector who are highly regulated through the imposition of licensure and certification requirements. Under normal circumstances, a failure to comply with these requirements can result in criminal, administrative, and/or civil liabilities. Not all requirements, however, are indispensable under all circumstances to protect the consumer. For example, a mandated nurse-to-patient staffing ratio, while consistent with expectations for patient care under normal circumstances, may be unworkable in an emergency. This requirement may even be an obstacle to providing care to the increased number of patients in need of care, if hospitals divert ambulance patients for lack of adequate nurse staffing.[6]

Generally, state regulatory agencies have administrative discretion in the enforcement of regulatory requirements. During an emergency, the state, including its political subdivisions, is responsible for the mitigation of the effects of the emergency.[7] If the strict enforcement of a regulatory requirement will serve as a disincentive to persons who can assist the state in mitigating the effects of the emergency, it would be in the interest of the state to administratively relax its enforcement of that requirement. However, the relaxation of administrative or criminal enforcement of a requirement does not eliminate the requirement itself. The requirement is still the law, and as such could provide a basis for the imposition of civil liability. Everyone, including every medical practitioner, is responsible for any injury occasioned to another by his or her want of ordinary care or skill in the management of his or her property or person, unless the injured person has, willfully or by want of ordinary care, brought the injury upon himself or herself.[8] The failure to exercise ordinary care is commonly referred to as negligence.

What constitutes ordinary care by a medical practitioner or facility is determined in part by whether the care conforms to the standard exercised by prudent practitioners acting under the same or similar circumstances. Ordinary care may also be determined by the standard established by statutory and regulatory requirements applicable to the medical provider. Thus, failure to comply with these requirements, even if not enforced by the regulatory agency, can establish negligence as a matter of law and lead to liability if the failure to comply with the requirement is a proximate cause of harm to a person.

The determination of what constitutes ordinary care is generally made by the courts, often long after the act or omission which gave rise to the alleged claim or injury. It can be difficult even under normal conditions to describe

what constitutes ordinary care by a medical practitioner. What constitutes ordinary care under conditions of disaster may be even less certain. Thus, a provider of medical care faced with a perceived need during an emergency to deviate from the normal standards of care to save a disaster victim's life may have no way of knowing with any degree of certainty prior to rendering care whether rendering assistance may subsequently subject him or her to civil liability. If the perceived risk of liability is too great, the provider may choose to withhold care, or may feel bound to provide care and utilize scarce resources for the one patient rather than benefit a number of patients.

1.3.3 Immunities from Liability Available in an Emergency

To some extent, the Legislature has already recognized this dilemma. There are several statutes providing qualified immunity to persons rendering aid during an emergency. These immunity provisions instruct the courts not to impose liability in specified emergency circumstances. Thus, if the immunity applies, there can be no liability. This, in turn, may reduce the need for a suspension of regulatory requirements, because the immunity already contemplates that the standard of care is altered in emergency circumstances.

Therefore, before examining more closely the authority and procedures for suspending regulatory statutes or promulgating emergency orders and regulations, or what regulatory statutes, or state agency orders, rules or regulations, if suspended, would assist in the mitigation of the effects of a medical and health emergency, we must first examine the immunities available by law for emergency care.

Healthcare Services during a Proclaimed Emergency at Request of Responsible Government Official
Under the ESA, any physician or surgeon (whether licensed in this state or any other state), hospital, pharmacist, nurse, or dentist who renders services during any state of war emergency, a state of emergency, or a local emergency at the express or implied request of any responsible state or local official or agency is immune from liability for any injury sustained by any person by reason of such services, regardless of how or under what circumstances or by what cause such injuries are sustained.[9] This immunity, however, does not apply "in the event of a willful act or omission."

It has been argued that the phrase "willful act or omission" completely negates the immunity, because every act undertaken by a health facility or professional to render services during an emergency is willful, i.e., the product of a deliberate choice. However, there does not appear to be any case to support such an interpretation of Government Code section 8659. To the contrary, cases interpreting section 2395 of the Business and Professions, the "Good Samaritan" statute for physicians (see below), which contains an identical exclusion for a "willful act or omission," have repeatedly supported the application of immunity notwithstanding very deliberate actions on the part of the defendants in those cases to treat their patient. For example, in ***Burciaga v. St. John's Hospital,***[10] a pediatrician summoned under emergency circumstances to the delivery room administered suction and applied oxygen to an infant in respiratory distress, then secured a transfer of the infant to a neonatal unit in a different hospital, and was still found to be immune. Similarly, in *Bryant v. Bakshandeh*,[11] a urologist who was summoned to assist in the catheterization of an infant patient prior to surgery, but despite repeated attempts was unable to do so due to complications, was also found to be immune.

As a general rule, the purpose of statutory construction is to ascertain the intent of the legislature so as to effectuate the purpose of the law.[12] The clear purpose of the Government Code section 8659 is to induce providers of medical care to render emergency aid to individuals who otherwise would not receive it. To construe section 8659 to exclude any deliberate attempt to render emergency aid would completely defeat the statute's apparent purpose. Although it remains unclear precisely what the Legislature intended by the words "willful act or omission," it seems obvious that it did not intend that the qualification would negate the purpose of the statute altogether.

The immunity provided by section 8659 is distinctive in other ways. Unlike the immunity provided by the Good Samaritan statute for physicians (see below), the services rendered do not need to be emergency care. It appears sufficient that the care was rendered at the express or implied request of an authorized official. Also, unlike the immunity provided to disaster service workers under the ESA (see below), the providers of care do not need to be registered disaster services workers in order to receive the immunity. The facility or professional simply needs to fall within one the licensure categories described in the statute.

Emergency Care at the Scene of an Emergency
Business and Professions Code section 2395 provides immunity from civil damages to physicians for acts and omissions in rendering emergency care in good faith at the scene of an emergency. The statute specifically includes, but is not limited to, the emergency rooms of hospitals in the event of a medical disaster within the meaning of the phrase "the scene of an emergency." The phrase "medical disaster" specifically refers to a duly proclaimed state of emergency or local emergency declared pursuant to the ESA. It applies to acts or omissions which occur after the declaration of a medical disaster and those which occurred prior to such declaration but after the commencement of such medical disaster.

Similar provisions exist for nurses,[13] dentists,[14] licensed vocational nurses,[15] physician's assistants,[16] any person providing on-scene emergency care,[17] physicians providing instructions to EMT-IIs or paramedics,[18] law enforcement and emergency response personnel providing on-scene emergency care,[19] and public entities and emergency rescue personnel providing emergency care.[20] In some cases, the immunity will not apply where the person is grossly negligent.[21] In other cases, it will apply if the person acted simply in good faith.[22]

Failure to Obtain Informed Consent Under Emergency Conditions
Physicians and surgeons are also immune from civil damages for injuries in emergency situations in their office or in a hospital on account of a failure to obtain fully informed consent where the (1) the patient was unconscious, (2) the lack of informed consent was due to the provider's reasonable belief that a medical procedure should be undertaken immediately and that there was insufficient time to fully inform the patient or a person authorized to give such consent for the patient.[23] Either criteria could easily apply under emergency conditions. However, it is unclear whether the concept of "insufficient time" applies only to the needs of the patient being treated, or includes a lack of time due to an overwhelming number of patients requiring treatment.

Lawfully Ordered Services by Disaster Service Workers
In an emergency, the service of persons not already employees of the state will be utilized. These persons may be volunteers registered with the state or local disaster councils, or they may be impressed into service.[24] The state Office of Emergency Services is required to develop a plan for state and local governmental agencies to utilize volunteer resources during a state of emergency proclaimed by the Governor.[25] Whether a volunteer or someone impressed into service, a person providing disaster relief is referred to as a "disaster service worker."[26] In addition, all state and local public employees are, by law, disaster service workers.[27] Disaster service workers are covered, to the extent funds are available, by worker's compensation for injuries sustained in the course of training for or providing relief work.[28] Volunteer disaster service workers are not compensated, but may be reimbursed for expenses.[29]

Disaster service workers are also entitled to the same immunities as public employees,[30] and if performing services during a proclaimed disaster under the ESA are also immune from civil damages on account of personal injury to or death of any person or damage to property resulting from any act or omission in the line of duty, except one that is willful.[31]

Some volunteers will be medical staff, who will staff casualty stations, establish and operate medical and public health field units; assist in hospitals, out-patient clinics, and other medical and public health installations.[32] These persons would have immunity for their negligent acts and omissions.

Facilities Used as Mass Care Centers
The same Civil Code section that provides immunity for disaster service workers provides immunity to anyone, including a public agency, who owns or maintains any building or premises which is used as a mass care center, first aid station, temporary hospital annex, or other necessary facility for mitigating the effects of an emergency. The immunity is from liability to any person, who has entered to seek refuge, treatment, care or assistance and while in or upon the premises, for injuries sustained as a result of the condition of the building or premises, or as the result of any act or omission, or as a result of the use or designation of the premises as a mass care center, first aid station, temporary hospital annex, or other necessary facility for emergency purposes. The only exclusions are the willful acts of the owner or occupant or their employees.[33]

Health Facilities with Inadequate Resources
By law, emergency services and care must be provided to any person upon request for any condition in which the person is in danger of loss of life, or serious injury or illness, at any health facility licensed by the State that maintains and operates an emergency department to provide emergency services to the public when the health facility has appropriate facilities and qualified personnel available to provide the services or care.[34] However, the health facility and its employees, including any physician, surgeon, dentist, clinical psychologist and podiatrist, are immune from liability in any action arising out of a refusal to render emergency services or care if the refusal is based on the determination, exercising reasonable care, that the person is not suffering from an emergency medical condition, or that the health facility does not have the appropriate facilities or qualified personnel available to render those services.[35]

Hospital Rescue Teams
For purposes of the immunity provision, a “rescue team” is a special group of physicians and surgeons, nurses, and employees of a health facility who have been trained in cardiopulmonary resuscitation and have been designated by the health facility to attempt, in cases of emergency, to resuscitate persons who are in immediate danger of loss of life.[36] So long as good faith is exercise, any act or omission of any rescue team of a licensed health facility, or operated by the federal or state government, a county, or by the Regents of the University of California, done or omitted while attempting to resuscitate any person who is in immediate danger of loss of life, is immune from any liability that might otherwise be imposed upon the health facility, the officers, members of the staff, nurses, or employees of the health facility, including, but not limited to, the members of the rescue team, or upon the federal or state government or a county.

Violation of Statute or Ordinance under Emergency Orders
As previously discussed, violation of a statute can provide the basis for a claim of negligence as a matter of law. In an emergency, however, it is a misdemeanor to refuse or willfully neglect to obey any lawful order or regulation promulgated or issued under the ESA.[37] Such orders and regulations may compel a person to violate a statute. Consequently, the law also provides that the violation of any statute or ordinance shall not establish negligence as a matter of law where the act or omission involved was required to comply with any regulation, directive, or order of the Governor promulgated under the California Emergency Services Act.[38] In addition, a person cannot be prosecuted for a violation of any statute or ordinance when the violation was required in order to comply with any regulation, directive, or order of the Governor.[39]

1.3.4 Suspension of Regulatory Statutes Where Needed to Expand Availability of Care

For purposes of the following discussion, we must assume that the Governor has determined that, despite all the mutual aid provided and the immunities available to professionals and facilities providing emergency care, extraordinary measures must be taken to suspend regulatory statutes under Government Code section 8571 in order to induce providers of medical care to render emergency aid to individuals who otherwise would not receive it. Whether this point is ever achieved may depend upon several factors. For example, some organized health systems may have a contractual responsibility to provide medical care to their members even under disaster conditions, and therefore may be willing to provide care to their customers despite a perceived increased risk of liability. There may also be good reasons, from the standpoint of maintaining good will in the community, for a

health facility to do everything within its power following a disaster to provide the medical care services needed by the community.

Many of the immunities discussed in the following paragraphs would apply, and these immunities may be sufficient to justify the provision of services despite degraded circumstances.
Nevertheless, there may be a sufficient number of health facilities for which the availability of immunity is uncertain. It is possible that these facilities will continue to provide care as best they can under the circumstances, hoping that subsequently the courts will agree that the circumstances altered the standard of ordinary care or that an immunity will be found to apply. However, some could refuse to provide care beyond what is enabled by activation of the hospital incident command system, because it cannot provide services at a level normally consistent with ordinary care. There is no general statutory or regulatory requirement that healthcare providers be available to provide care to the public under all circumstances.[40,41] Indeed, this fact accounts for the existence of the Good Samaritan laws discussed above.[42]
Therefore, the Governor may be persuaded to suspend those regulatory requirements perceived to be an obstacle to the emergency mitigation effort. The suspension would be implemented through an executive order of the Governor either suspending specific regulatory requirements, or delegating to another state official, e.g. the Director of the Office of Emergency Services, the Emergency Medical Services Authority, or the Department of Public Health, the authority to suspend requirements consistent with the Governor's authority to do so. The proclamation of a state of emergency alone is not sufficient to effectuate a suspension. The proclamation would also need to include a separate order as described above, or would need to implement pre-approved standby orders of a similar nature.[43]

It should be emphasized that, until such an order is issued subsequent to a proclamation of a state of emergency, no regulatory requirement is suspended (except to the extent that the regulatory agency has waived enforcement).[44] Therefore, medical providers not operating under emergency conditions offering immunity must ascertain the existence and scope of the proclaimed state of emergency, and extent and applicability of any suspension of regulatory requirements.

1.3.5 Issuance of Emergency Regulations Amending Standards of Care

In addition to the Governor's authority to suspend regulatory requirements, the Governor is also authorized to issue necessary orders, rules and regulations to carry out the provisions of the ESA. These orders and regulations have the force and effect of law.[45] As previously noted, willful violation of these orders and regulations is a misdemeanor.[46] Such orders and regulations could be used during a medical and health emergency to establish altered standards of care consistent with the ESA's goal of preserving lives.

As with the suspension of regulatory requirements, the decision to issue orders or regulations altering standards of care will depend upon several factors. For example, to what extent will the provision of mutual aid avoid the need to alter standards of care? To what extent will the available immunities provide sufficient protections to professionals and facilities providing emergency care? Given these factors, is an alteration of the standards of care necessary to induce providers to render emergency aid to individuals who otherwise would not receive it?

Orders and regulations of the Governor must be in writing, and take effect immediately. Thus, a proclamation of emergency alone is insufficient to change the standard of care. A separate order, or implement of pre-approved standby orders in conjunction with the proclamation, would be needed.

1.3.6 Commandeering of Facilities and Personnel

During a proclaimed state of emergency, the Governor is authorized to commandeer or utilize any private property or personnel deemed by him necessary in carrying out the responsibilities hereby vested in him as Chief Executive of the state.[47] The power to commandeer exists only under a state of emergency, and may only be exercised by the Governor or an authorized designee. It is not available under a local emergency.[48] It must also

be distinguished from other, more commonly used methods, such as contracts and agreements, to obtain necessary resources.

It is conceivable that this power could be exercised to take over the operations of any facility that is unwilling to risk providing expanded services due to a perceived increased risk of liability. However, it is unclear how an order to commandeer a facility or personnel would be implemented. Further, the state is required to pay the reasonable value of the property or personnel commandeered or used.[49]

1.4 Emergency Preparedness and Response in California

1.4.1 California Emergency Services Act[50]

The California Emergency Services Act (ESA) recognizes the State's responsibility to mitigate the effects of natural, manmade, or war-caused emergencies which result in conditions of disaster or in extreme peril to life, property, and the resources of the state, and generally to protect the health and safety and preserve the lives and property of the people of the state.[51] To insure adequate preparations to deal with emergencies, the ESA confers emergency powers upon the Governor and upon the chief executives and governing bodies of political subdivisions of the State, provides State assistance for the organization of local emergency response programs, and creates the Office of Emergency Services (OES) within the Office of the Governor.

The ESA recognizes the need to assign emergency functions to State agencies and to coordinate and direct the emergency actions of those agencies. It provides for the rendering of mutual aid by the State and its political subdivisions to carry out the purposes of the ESA. Further, the ESA makes it State policy that all State emergency services functions be coordinated as far as possible with the comparable functions of its political subdivisions, of the federal government, of other states, and of private agencies of every type, to make the most effective use of all manpower, resources, and facilities for dealing with any emergency that may occur.

1.4.2 Role of the Governor

The Governor is given broad powers under the ESA. Some powers granted to the Governor have been previously discussed, e.g., the power to make, amend and rescind orders and regulations having the force and effect of law,[52] to suspend regulatory statutes and regulations,[53] and the power to use and commandeer property and personnel.[54] In addition, the Governor has powers which are specific to the type of emergency proclaimed.[55] For example, during a state of emergency, the Governor has authority over all agencies of State government and the right to exercise all police power vested by law in the State within the area designated.[56] Also during a state of emergency, the Governor can direct all state government agencies to utilize and employ state personnel, equipment, and facilities for the performance of any and all activities designed to prevent or alleviate actual and threatened damage due to the emergency, and he can direct them to provide supplemental services and equipment to political subdivisions to restore any services which must be restored in order to provide for the health and safety of the citizens of the affected area.[57]

In carrying out his/her responsibilities under the ESA, the Governor is assisted by the California Emergency Council.[58] Among other duties, the California Emergency Council must consider, recommend, and approve orders and regulations that are within the province of the Governor to promulgate.[59] This would include orders and regulations to suspend regulatory requirements or to alter standards of care.

The Governor is also assisted by the Emergency Response Team for State Operations,[60] whose task is to improve the ability of state agencies to resume operations in a safe manner and with a minimum of delay if their operations are significantly interrupted by a business interruption.[61]

1.4.3 Governor's Office of Emergency Services

The Office of Emergency Services (OES) is created by the ESA in the Governor's Office.[62] The Governor is required to assign all or part of his powers under the ESA to the Office of Emergency Services,[63] but cannot delegate to OES his/her authority to issue orders and regulations.[64] During a state of emergency or a local emergency, the Director of OES is responsible to coordinate the emergency activities of all state agencies in connection with such emergency.[65] It does so through the State Operations Center (SOC) and Regional Emergency Operations Centers (REOC).

OES has established three OES Administrative Regions, the Southern Region, the Coastal Region, and the Inland Region.[66] These Administrative Regions coordinate emergency management in the six mutual aid regions created by the Governor (see The Concept of Mutual Aid, below).

Within the SOC, the REOCs and Operational Area Emergency Operations Centers, the ICS structure organizes emergency response disciplines into Branches under the Operations Section. The Medical and public health issues are handled by the Medical and Health Branch.

1.4.4 State Emergency Plan

The Governor is responsible to coordinate the State Emergency Plan and programs necessary for the mitigation of the effects of an emergency. He is also responsible for coordinating the preparation of local plans and programs, and to see that they are integrated into and coordinated with the State Emergency Plan and the plans and programs of the federal government (and of other states) to the fullest possible extent.[67] By law, the State Emergency Plan is in effect in each political subdivision of the state, and the governing body of each political subdivision is obligated to take whatever action may be necessary to carry out its provisions.[68]

As part of the state plan, the Governor can assign to a state agency any activity concerned with the mitigation of the effects of an emergency of a nature related to the existing powers and duties of the agency, including interstate activities. Such an assignment makes it the duty of the agency to undertake and carry out that activity on behalf of the state.[69]

In accordance with the State Emergency Plan, the Governor can plan for the use of any private facilities, services, and property and, when necessary, and when in fact used, provide for payment for that use under the terms and conditions as may be agreed upon.[70] This planning authorization is consistent with the Governor's power, described above, to commandeer property and personnel.[71]

1.4.5 Emergency Medical Services Authority

The Emergency Medical Services Authority (EMSA)[72] is required by law to respond to any medical disaster by mobilizing and coordinating emergency medical services mutual aid resources to mitigate health problems.[73] The State Emergency Plan (see below) designates the EMSA as the lead state agency for the medical response to an emergency.[74] Also, EMSA is responsible under the Plan for medical situation status and analysis in conjunction with the Department of Public Health.[75]

Generally, any attendant in a publicly or privately owned ambulance must possess evidence of specialized training as set forth in the emergency medical training and educational standards for ambulance personnel established by EMSA.[76] However, this requirement does not apply in any state of emergency declared under the ESA when it is necessary to fully utilize all available ambulances in an area and it is not possible to have the ambulance operated or attended by persons with the qualifications required by EMSA.[77]

1.4.6 State Department of Public Health

The State Department of Public Health (DPH)[78] is designated the lead for the public health component of the Medical and Health Services operations set forth in the State Emergency Plan (see below).[79] Both EMSA and DPH share responsibility for the lead in the Medical/Health Branch. Also, DPH, in conjunction with EMSA, is responsible under the Plan for public health situation status and analysis.[80]

DPH is also the agency which regulates acute care hospitals and many other health-related facilities.[81] Therefore, during the early stages of an incident when acute care hospitals are reaching the limits of their capacity, hospital

administrators may contact the Licensing and Certification Division of DPH in their region to obtain waivers of specific regulatory requirements.[82]

1.4.7 The Concept of Mutual Aid

Mutual aid is a concept under which separate jurisdictional or organizational units share and combine resources in order to accomplish their mutual goals. The ESA recognizes that, during emergencies, the rendering of mutual aid by State government, including all its departments and agencies, and its political subdivisions will be necessary to mitigate the effects of the emergency. Public agencies are authorized by law to enter into joint powers agreements, and these agreements can be for the purposes of providing assistance to each other.[83] However, given the number of cities and counties in the State, it would be impractical to require that each jurisdiction have a separate agreement with each other jurisdiction in order to assist each other in the event of an emergency.

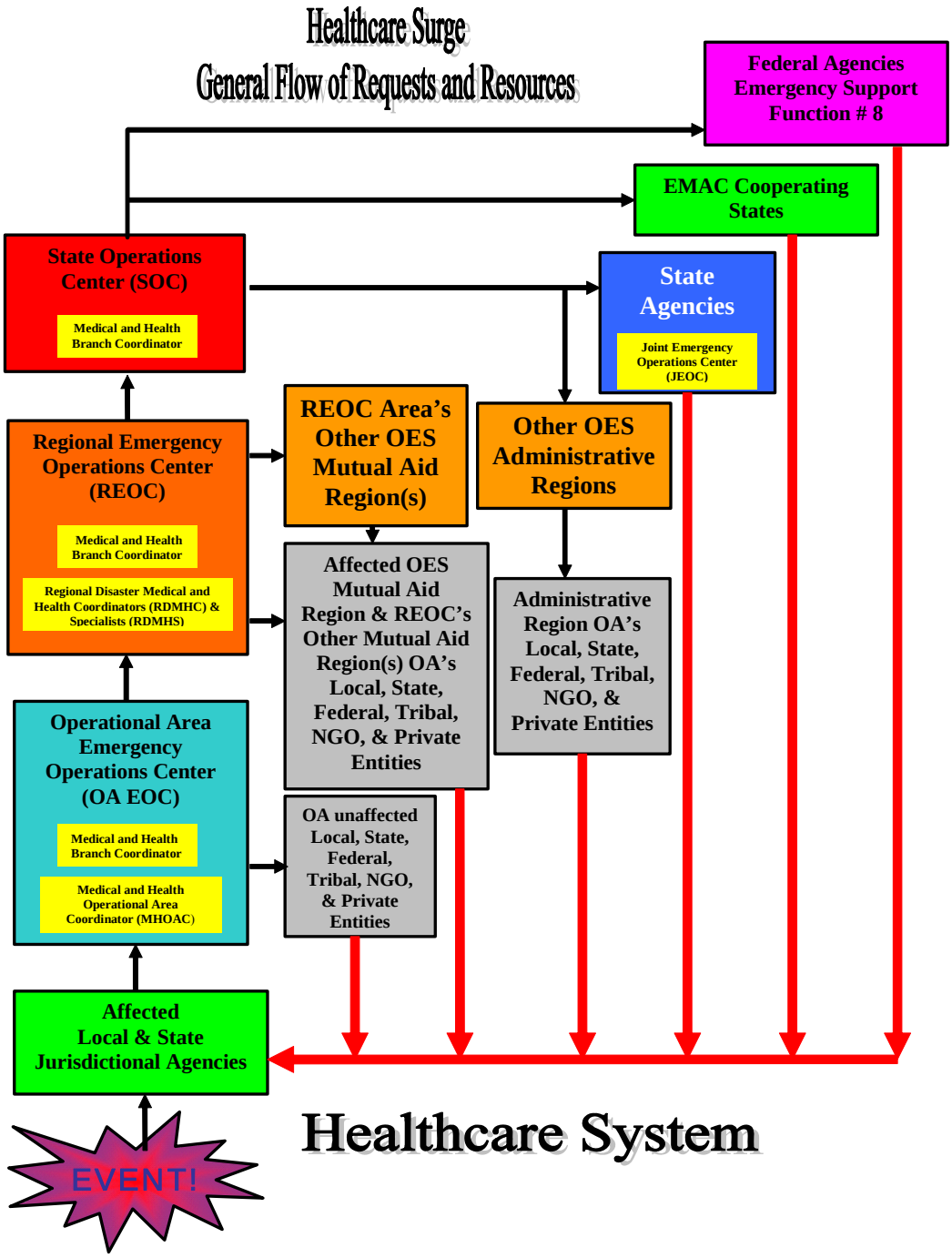
Accordingly, one purpose of the ESA is to make it unnecessary for public agencies to execute written agreements to render aid to areas stricken by an emergency.[84] It accomplishes this goal by authorizing state and local public agencies to exercise mutual aid powers in accordance with the California Disaster and Civil Defense Master Mutual Aid Agreement, and local plans, ordinances, resolutions and agreements.[85] The Master Mutual Aid Agreement requires that each party develop a plan providing for the effective mobilization of all its resources and facilities, both public and private, to cope with any type of disaster.[86] These plans are known as “mutual aid operational plans.” Under the ESA, a duly adopted and approved emergency plan is deemed to satisfy the Master Mutual Aid Agreement’s requirement for a “mutual aid operational plan.”[87]

As previously discussed, the Governor is authorized to divide the state into mutual aid regions for the more effective application, administration, and coordination of mutual aid and other emergency-related activities.[88] A "mutual aid region" is part of the state, not local, emergency services organization, and is established to facilitate the coordination of mutual aid and other emergency operations within an area of the state consisting of two or more county operational areas.[89] (See discussion of Operational Areas, below.) Currently, the State is divided into six mutual aid regions for general mutual aid coordination.[90] Each mutual aid region consists of designated counties/operational areas.

Within each mutual aid region, there may be a Regional Disaster Medical and Health Coordinator (RDMHC), who is appointed by the Directors of EMSA and DHS.[91] The RDMHC must be either a county health officer, a county coordinator of emergency services, an administrator of a local EMS agency, or a medical director of a local EMS agency (see below for a discussion of these officials). The job of the RDHMC during an emergency is to coordinate the acquisition of requested medical or public and environmental health mutual aid in an affected region to deliver to the area affected by the disaster. In a proclaimed emergency and at the request of EMSA, DHS or OES, an RDMHC in an unaffected region may also coordinate the acquisition of requested mutual aid resources in his/her region.[92]

Mutual aid is not limited to aid between jurisdictions in California. The Governor may also enter into reciprocal aid agreements or compacts, mutual aid plans, or other interstate arrangements for the protection of life and property with other states and the federal government, either on a statewide or a political subdivision basis.[93] The State has entered into two interstate compacts; the Interstate Civil Defense and Disaster Compact[94] and the Emergency Management Assistance Compact.[95] The State can also seek federal mutual aid by requesting a Presidential Declaration of an Emergency or Major disaster under the provisions of the Stafford Act.[96] A Presidential declaration makes federal assistance programs available, depending on the level of the declaration, as outlined in the Federal Response Plan, which includes contributions from several federal agencies and non-governmental organizations, such as the American Red Cross.

The healthcare surge general flow of requests and resources is described in the following chart.



1.4.8 Local Emergency Plans and Local Disaster Councils

The ESA defines "emergency plans" to mean those official and approved documents which describe the principles and methods to be applied in carrying out emergency operations or rendering mutual aid during emergencies. These plans include such elements as continuity of government, the emergency services of governmental agencies, mobilization of resources, mutual aid, and public information.[97] During a state of emergency, outside aid must be rendered in accordance with approved emergency plans, and public officials are required to cooperate to the fullest extent possible to carry out such plans.[98]

Cities and counties are authorized to create disaster councils by ordinance.[99] If created, the disaster council is responsible for developing emergency plans.[100] The plans must meet any condition constituting a local emergency or state of emergency, including, but not limited to, earthquakes, natural or manmade disasters specific to that jurisdiction, or state of war emergency, and must provide for the effective mobilization of all of the resources within the political subdivision, both public and private.[101]

The primary motivation for organizing a disaster council is that the disaster council can register "disaster service workers." Under the ESA, the OES is authorized to adopt regulations for the classification and registration of disaster service workers.[102] The regulations provide that a disaster service worker is a person registered either with OES, a state agency authorized to register disaster service workers, or a disaster council.[103] Registered disaster service workers can be afforded worker's compensation benefits and liability protections for their acts and omissions during an emergency.

Disaster councils may become accredited by the Office of Emergency Services, by agreeing to comply with the ESA and submitting to the office a certified copy of the ordinance which provides for the disaster council and its leadership, the local emergency organization and compliance with the ESA.[104] The main reason for a disaster council to receive and maintain accreditation is that the term "disaster service worker," for purposes of worker's compensation benefits, only applies to person registered by an "accredited disaster council" or a state agency.[105] Thus, if a volunteer is registered with an unaccredited disaster council, the volunteer arguably is not a "disaster service worker" for purposes of worker's compensation coverage.

The governing body of a city or county is authorized to provide by ordinance or resolution for the organization, powers and duties, divisions, services, and staff of the emergency organization.[106] This ordinance or resolution, in effect, authorizes individuals within the city or county to take actions in accordance with the emergency plan. The city or county can also authorize public officers, employees, and registered volunteers to command the aid of citizens when necessary during a state of war emergency, a state of emergency, or a local emergency.[107]

It is the legal duty of each organizational component, officer, and employee of each political subdivision of the state to render all possible assistance to the Governor and to the Director of the Office of Emergency Services in mitigating the effects of an emergency. Their emergency powers are subordinate to any emergency powers exercised by the Governor.[108]

1.4.9 Standardized Emergency Management System

The Standardized Emergency Management System (SEMS) is a system for managing the response to multi-agency and multi-jurisdictional emergencies in California.[109] OES has developed regulations to implement SEMS.[110] All state agencies are required to use SEMS to coordinate multiple jurisdiction or multiple agency emergency and disaster operations.[111] Every local agency, in order to be eligible for any funding of response-related (i.e., personnel) costs under disaster assistance programs, must also use SEMS to coordinate multiple jurisdiction or multiple agency emergency and disaster operations.[112] This means that local emergency plans must also incorporate SEMS, assuming the local government wants to be reimbursed for emergency personnel costs.

Incident Command System (ICS)
SEMS is required to be based in part on the concept of the Incident Command System (ICS),[113] which had been developed and used by the fire services to respond to all types of emergencies. The system standardizes the organizational structure and terminology used by every response agency. ICS recognizes that every response, regardless of size, requires that five management functions be performed:

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

Even the issuance of a speeding ticket involves each of these five ICS functions, i.e. a policy against speeding, the intelligence gathering which detects and identifies a speeding driver, the operation of pulling the driver over and issuing the citation, the logistics of providing the equipment (car, radar, ticket book) needed to conduct the operation, and the administrative tracking of submitting the citation into the court system. At the other extreme there may be a multi-jurisdictional wild-land fire involving the same functions, i.e. a policy of protecting lives and property, intelligence and planning on how to stop the fire, operations in which firefighters and equipment are committed to the fire-line, logistics to obtain, equip and support the firefighting operation, and finance/administration to determine how to pay for it all.

As an incident expands in scope, the ICS expands and adapts with it. When multiple jurisdictions or agencies become involved, a “unified command” management organization is formed, under which members representing different organizations at the Incident Command Post establish a common set of objectives and strategies and a single incident action plan.

Multi-Agency Coordination System
Together with ICS, SEMS incorporates the Multi-Agency Coordination (MAC),[114] in which jurisdictions and organizations work together to coordinate and prioritize the allocation of resources and emergency response activities. In practical application, facilities, equipment, personnel, procedures and communications are integrated into a common system under an organization typically located as part of an emergency operations center. The multi-agency organization does not direct operational activities, but rather ensures situational and resource status awareness, helps establish policies and priorities, acquires and allocates resources, plans for anticipated resource requirements, and provides strategic coordination.

Mutual Aid
SEMS also embraces the concept of mutual aid, discussed above.[115] SEMS applies this concept by recognizing five organizational levels for response. The levels are in the order in which the levels become involved in the response under the mutual aid concept:

1. Field – where diverse local response organizations (law enforcement, fire, public health) use their own resources to carry out tactical decisions and activities.
2. Local – where local governments, e.g. cities, counties and special districts, manage and coordinate the emergency response and recovery.
3. Operational Area – the entity that coordinates resources, the provision of mutual aid, emergency response and damage information.
4. Regional – manages and coordinates resources and information among operational areas.
5. State – this level is responsible for statewide resource allocation. If State resources are inadequate, this level is integrated with federal agency resources.

It should here be emphasized that under the ESA, unless the parties to a mutual aid agreement expressly provide otherwise, the responsible local official in whose jurisdiction an incident requiring mutual aid has occurred remains in charge at such incident, including the direction of personnel and equipment provided through mutual aid.[116] Thus, the fact that higher organizational levels become involved in coordinating resources and information does not mean that officials at that higher level take charge of the incident.

Operational Area
The State and regional levels have been discussed previously and are reflected in the ESA. The Operational Area (OA) is also defined in the ESA, and is a required concept of SEMS.[117] In accordance with SEMS and the ESA, the OA consists of a county and all political subdivisions within the county area, and serves as an intermediate level of the state emergency services organization.[118] The governing bodies of each county and of the political subdivisions in the county are authorized to organize and structure their OA. An OA is used by the county and the political subdivisions comprising the OA for the coordination of emergency activities and to serve as a link in the communications system during a state of emergency or a local emergency.[119]

There are 58 OAs in California. Practically speaking, the OA within the SEMS structure is embodied in its emergency operations center (EOC). An EOC is a location from which centralized emergency management can be performed.[120] Political subdivisions within a county may have their own EOCs in addition to the Operational Area EOC. OES has an Operational Area Coordinator assigned to each OA.

The OA EOC must be distinguished from department operations centers (DOC). Under SEMS, a DOC is an emergency operations center used above the field level by a specific discipline (e.g., flood operations, fire, medical, hazardous material), or a governmental unit (e.g., Department of Public Works or Department of Health).[121] There may be as many DOCs as there are public agencies involved in the response above the field level.

Communications
Finally, SEMS addresses the concept of emergency communications by supporting networks to ensure that all levels of government can communicate during a disaster. Two systems have been established:

1. The Response Information Management System (RIMS) – an electronic data management system that links emergency management offices throughout California.
2. The Operational Area Satellite Information System (OASIS) – a portable satellite-based network that provides communication when land-based systems are disrupted.

In addition, there are discipline specific communications systems, such as the California Health Alert Network (CAHAN). CAHAN is the emergency preparation and notification system used by the California Department of Health Services and many emergency preparedness stakeholders and partners associated with public health. CAHAN contains both an alerting system that provides rapid notification of emergencies to public health stakeholders and partners and a highly secure web-based document repository used for the creation and collaboration of information pertaining to preparation and/or response to various incidents or events.

1.4.10 Medical and Health Disaster Plans

If an operational area has a medical health operational area coordinator (MHOAC), the MHOAC is responsible for the development of a discipline-specific operations plan known as the “medical and health disaster plan” for the provision of medical and health mutual aid for the operational area. The medical and disaster plans must comply with the framework established by SEMS.[122]

At a minimum, the medical and health disaster plan, policy, and procedures must include the following components relevant to healthcare surge:

1. Assessment of immediate medical needs.
2. Coordination of disaster medical and health resources.
3. Coordination of patient distribution and medical evaluations.
4. Coordination with inpatient and emergency care providers.
5. Coordination of out-of-hospital medical care providers.
6. Coordination and integration with fire agencies personnel, resources, and emergency fire pre-hospital medical services.
7. Coordination of providers of non-fire based pre-hospital emergency medical services.
8. Coordination of the establishment of temporary field treatment sites.
9. Health surveillance and epidemiological analyses of community health status.
10. Provision or coordination of mental health services.
11. Provision of medical and health public information protective action recommendations.
12. Investigation and control of communicable disease.[123]

During a medical or health disaster, the MHOAC is responsible for implementing this plan, and coordinating with the Regional Disaster Medical Health Coordinator (RDMHC) on the acquisition of resources or the movement of patients to other jurisdictions.

1.4.11 Persons Responsible for Local and Regional Emergency Response Related to Healthcare Surge

Thus far, we have discussed the role of the following State officials at the State and, to some extent, regional levels in emergency preparedness and response:

1. Governor
2. California Emergency Council/State Emergency Response Team
3. Office of Emergency Services (OES)
4. Emergency Medical Services Authority (EMSA)
5. Department of Health Services (DHS)
6. OES Administrative and Mutual Aid Regions
7. Regional Disaster Medical Health Coordinator (RDMHC)

It is often said that all emergencies are local. We have already discussed the role of the Operational Area within the SEMS framework, and the fact that the Operational Area consists of the political subdivisions within a county. We now discuss the local officials involved in emergency response as it relates to healthcare surge.

Local Governing Body
The local governing body can be either the county board of supervisors or a city council. These bodies are authorized to proclaim a "local emergency."[124] They may also designate an official by ordinance who can proclaim local emergencies.[125] During a proclaimed local emergency, political subdivision of the state have full power to provide mutual aid to any affected area in accordance with local ordinances, resolutions, emergency plans, or agreements,[126] and state agencies are authorized to provide mutual aid in accordance with mutual aid agreements, or upon direction from the Governor.[127]

The local governing body is also authorized during a local emergency to promulgate orders and regulations necessary to provide for the protection of life and property, including orders or regulations imposing a curfew within designated boundaries where necessary to preserve the public order and safety.[128]

County Director of Emergency Services
Counties may appoint a County Director of Emergency Services, however in absence of this, by virtue of his/her office, the county sheriff serves in this role.[129] The county director of emergency services has all the duties prescribed by state law and executive order, the California Disaster and Civil Defense Master Mutual Aid Agreement, mutual aid operational plans, and by county ordinances and resolutions.[130]

County Emergency Medical Services Agency/Medical Director
Each county is authorized to develop an emergency medical services program. Each county developing such a program must designate a local EMS agency. It may be the county health department, or a separate agency established and operated by the county. It may also be an entity with which the county contracts or a joint powers agency created for the administration of emergency medical services by agreement between counties.[131]

Every local EMS agency shall have a full- or part-time licensed physician and surgeon as medical director, to provide medical control and to assure medical accountability throughout the planning, implementation and evaluation of the EMS system.[132]

Health Officer
Each county is required to appoint a health officer.[133] The county health officer is responsible to enforce and observe in the unincorporated territory of the county, the orders and ordinances of the board of supervisors

pertaining to the public health and sanitary matters, orders, including quarantine and other regulations, prescribed by DPH, and statutes relating to public health.[134]

There is similar authority for the appointment of city health officers.[135] However, most cities contract with the county health officer to provide local public health services.[136] At present, only three cities in California operate their own public health departments. Thus, in most counties, the county health officer has jurisdiction throughout the county.

Both city and county health officers are authorized, regardless of whether or not an emergency is declared, to take measures as may be necessary to prevent the spread, or the occurrence of additional cases, of any communicable disease that he or she reasonably believes may exist within his or her jurisdiction.[137] This includes the power to quarantine and isolate persons, animals or places, conduct investigations and examinations, and to disinfect where necessary to protect public health.[138] The local health officer can also require, during an outbreak of disease, or when an outbreak appears imminent, that health care providers disclose their inventories of critical medical supplies, equipment, pharmaceuticals, vaccines, or other products that may be used for the prevention of, or may be implicated in the transmission of communicable disease.[139]

In addition, during any “state of war emergency,” “state of emergency,” or “local emergency,” a local health officer is authorized to take any preventive measure within his or her jurisdiction that may be necessary to protect and preserve the public health from any public health hazard. For purposes of this authorization, the term “preventive measure” means abatement, correction, removal or any other protective step that may be taken against any public health hazard that is caused by a disaster and affects the public health.[140]

In some jurisdictions, the local health officer is authorized by the governing body to declare a local emergency.[141] A local health officer may also declare a “local health emergency” whenever there is an imminent and proximate threat of the introduction of any contagious, infectious, or communicable disease, chemical agent, non-communicable biologic agent, toxin, or radioactive agent, in the jurisdiction or any area thereof affected by the threat to the public health.[142] However, such a declaration does not carry all the implications of a “local emergency.” Only the immunity granted to hospitals, physicians and other medical practitioners under section 8659 of the Government Code (see above) is implicated.[143] Otherwise, the declaration only authorizes the exercise of mutual aid,[144] allows the exchange of health information, and authorizes the determination of the cause of the emergency.[145]

When an incident first arises, the local health officer may issue an order authorizing first responders to immediately isolate exposed individuals that may have been exposed to biological, chemical, toxic, or radiological agents that may spread to others. Such an order lasts only two hours, but may be sufficient time to allow the health officer to reach the scene of the incident, and to issue more comprehensive orders if needed.[146]

County Director of Environmental Health
Some counties have separated the public health and environmental health responsibilities of the local health officer by creating a comprehensive environmental health agency.[147] During a local emergency or a state of emergency, the county director of may be responsible for the coordination of emergency response under his/her jurisdiction. However, during a health emergency declared by the board of supervisors, or a county health emergency declared by the local health officer (see above), the local health officer shall have supervision and control over all environmental health and sanitation programs and personnel employed by the county during the state of emergency.[148]

Medical Health Operational Area Coordinator
Each OA may appoint a Medical Health Operational Area Coordinator (MHOAC). The MHOAC may be the local health officer and the county emergency medical services coordinator acting jointly, or a separate person appointed by these officials. The MHAOC is responsible, under the local emergency plan, to coordinate with inpatient and emergency care providers, assess medical needs, and coordinate disaster medical and health resources, among other things.[149]

In the event of a local, state, or federal declaration of emergency, the MHOAC must assist the OES operational area coordinator in the coordination of medical and health disaster resources within the OA.[150] The MHOAC is also the point of contact in that OA, for coordination with the RDMHC, OES at the regional level, DPH, and EMSA.

County Coroner
Each county in California has either a Sheriff/Coroner, a Coroner, or a Medical Examiner.[151] His/her duty is to manage the remains of deceased persons within the county, their personal effects if necessary,[152] and to inquire into the cause of deaths under specified circumstances.[153] In a mass casualty event also involving mass fatalities, this officer serves as the OA Coroner Mutual Aid Coordinator.[154] The state is divided into seven coroners mutual aid regions, and each region has a Coroners Regional Mutual Aid Coordinator.

Each operational area Coroner/Medical Examiner is advised to develop local contingency plans to deal with mass fatality events, including those involving chemical, biological and radiological contamination of human remains. These plans should also address issues such a storage capacity for human remains, and disposition of remains, including cremation, isolated burial, mandatory mass disposition, and return to family.[155]

1.4.12 Healthcare Surge Emergency Response

When a mass-casualty event occurs, hospitals would activate Emergency Operations Plans and mobilize under an incident command system, such as the Hospital Incident Command System (HICS) to manage the actual or anticipated influx of patients. If conditions within the hospital are sufficiently strained, the hospital may consult with regulatory agencies to determine if specific requirements related to staffing and patient management can be waived to maximize the hospital's response capabilities. If circumstances become overwhelming, the hospital can divert inbound ambulance patients, if possible, or patients that have been medically screened and deemed stable for transfer to other hospitals, or to alternate care sites established by local authorities.

All private entities,(e.g., private hospitals, clinics, pre-hospital providers, and ambulance services), would obtain their necessary day-to-day support and operational resources through their internal systems and suppliers. However, it is important even at this stage for healthcare providers to early establish their contacts with the local/OA medical and health coordinators to apprise them of the provider's status and anticipated needs. The reliance upon internal systems and suppliers would hold true until the impact of the situation overwhelmed the entities' normal support mechanisms or a local or state of emergency was declared.

Under these conditions, the specific entity's logistical functions would place their medical and health-related support or resource requests through the local jurisdictional medical and/or health coordinator. It is important to note that, during a declared local or state of emergency, private entities must direct their requests for medical and health support and resources through the SEMS process that often times utilizes Multi-Agency Coordinating Groups to coordinate activities and establish allocation of scarce resources among competing entities.

The local medical and health coordinator for the affected jurisdiction would identify the situation, contact the MHOAC if necessary, and request the resources that are needed based on the event. The MHOAC, in cooperation with the OES OA EOC, would attempt to acquire the needed resources within the OA.

At this point in the progression, a "healthcare surge" within the meaning of this document does not yet exist. However, a request for additional resources represents the first step in establishing the existence of surge. If the demands for resources become overwhelming at the local level, then the "healthcare surge" status of that OA would be changed to reflect that a surge exists in that OA.

The MHOAC can request mutual aid from other OAs, and contact the RDMHC for regional assistance. The RDMHC, in coordination with the Regional EOC, would attempt to acquire the needed resources within the region.

The Medical Health Branch Representative in the State Operations Center would be notified. The Medical and Health Branch Representative (either from CDHS or EMSA) would coordinate with the CDHS Department Operations Center (CDHS DOC), Emergency Medical Services Authority Department Operations Center (EMSA DOC) or when co-located, the Joint Emergency Operation Center (JEOC). The medical and health branch in the SOC would coordinate with unaffected regions. CDHS and EMSA would fill the request at the State level from resources under their control and would be responsible for processing the resource request(s) received via the SOC. If the request(s) cannot be filled from within the state, the State would then contact the Federal Emergency Management Agency (FEMA) to request deployment of federal resources.
At any point in this progression, a “local emergency” or “state of emergency” could be proclaimed. Once a state of emergency is proclaimed, even RDMHCs from unaffected regions can be utilized to coordinate the acquisition of requested mutual aid on behalf of the affected region.

Finally, if the Governor has determined that, despite all the mutual aid provided and the immunities available to professionals and facilities providing emergency care, extraordinary measures must be taken to suspend regulatory statutes under Government Code section 8571 in order to enable providers of medical care to render emergency aid to individuals who otherwise would not receive it. In addition, the Governor could issue orders and regulations to establish altered standards of care consistent with the ESA’s goal of preserving lives, or to commandeer property and personnel.

1.4.13 Termination of the Emergency

A local emergency proclaimed by a designated local official terminates by operation of law after seven days, unless the proclamation has been ratified by the local governing body.[156] If a local emergency has been proclaimed by the local governing body, the governing body must review the need for continuing the local emergency at it regularly scheduled meetings until the emergency is terminated.[157] The governing body must proclaim the termination of the local emergency at the earliest possible date that conditions warrant.[158]

Similarly, the Governor must proclaim the termination of a state of emergency at the earliest possible date that conditions warrant.[159] All of the powers granted to the Governor under the ESA for a state of emergency terminate upon the proclamation.[160] Thus, to the extent that the Governor has suspended regulatory statutes or altered standards of care by regulation, those suspensions and alterations would automatically end when the Governor proclaims the termination of the state of emergency.

2 Surge Capacity and Capability: An Overview

2.1 Community Based Surge Capacity and Capability

The concepts, ideas and content in this section are based on the discussions of the expert panel and references from a report by The CNA Corporation, *Medical Surge Capacity and Capability: A Management System for Integrating Medical and Health Resources during Large-Scale Emergencies*, August 2004.

Currently, patient care during emergencies or disasters is provided primarily at community-based hospitals, integrated healthcare systems, private physician offices, and other point-of-service medical facilities. The delivery of care is based on individual facility's preparedness, capacity and capability. However, this approach to response during a healthcare surge is sub-optimal from a population outcome perspective as well as from a scarce resource utilization perspective. In a mass casualty incident, healthcare facilities may lack the necessary resources and/or information to individually provide optimal patient care.

According to the CNA report, "research has shown that most individual healthcare facilities possess limited surge supplies, personnel, and equipment, and that vendors or anticipated “backup systems” for these critical assets are often shared among local and regional healthcare facilities. This “double counting” of resources diminishes the ability to meet individually projected surge demands across multiple institutions" during a healthcare surge.

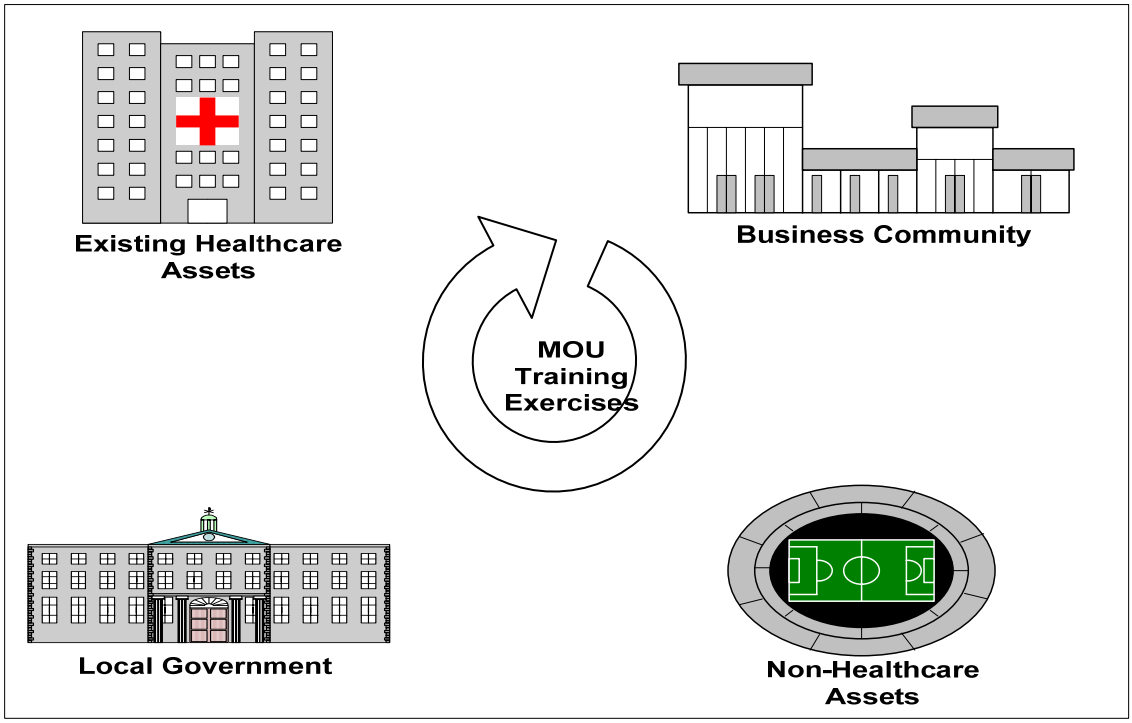
These community healthcare assets, therefore, must collaboratively develop community surge capacity and capability. This does not, however, preclude or diminish the need for individual healthcare facilities to have a comprehensive emergency management plan that addresses mitigation, preparedness, response, and recovery activities. However, 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. For example, communities should consider developing Memorandum of Understanding (MOU) for transfer of patients from hospitals to skilled nursing facilities (SNF). If SNFs and nursing homes can support the hospital or even hold their own then it will save a lot of hospital beds for the victims during a healthcare surge. Refer to the Appendix for Alameda County's MOU with SNFs and rehabilitation facilities to voluntarily coordinate mutual aid services during a disaster. Similarly, during a Pandemic Influenza, Home Health Care will play a critical role, especially when such patients are either infected or when hospitals are overwhelmed. Community based planning to define the role of home health care and availability of personnel to support such care will enable communities to better respond to an outbreak. Community based planning would allow existing healthcare resources in the public and private sectors as well as other non-healthcare assets to be optimally leveraged. Advantages of community based planning include, shared costs and funding, regulatory/standards compliance, purchasing coalitions, and shared knowledge. To encourage community based planning the government could consider tax breaks for participating members.

One of the challenges in creating a community surge capacity is the possible lack of buy-in from medical clinics, private physician offices, and other healthcare and non-healthcare assets. Because the private medical community is diverse, there are differences in capacity, capability, and constraints to implementing these processes. It is important to recognize that many community healthcare assets do not have the management infrastructure or personnel necessary to establish complex processes for incident preparedness and response. Thus, it is imperative that larger healthcare facilities in the community take a leadership role to initiate and maintain communication, develop trust and make the community planning effort inclusive.

The community based surge capacity and capability is composed of healthcare facilities and non-healthcare facilities to form a unified entity in a defined geographic area. During a surge, a unified entity facilitates effective communications and consistent information sharing with local government. While the community assets retain

their management autonomy during surge response, they coordinate and participate in information and asset sharing. A critical component of community based surge capacity and capability response is mutual aid—the sharing of personnel, facilities, equipment, or supplies. Since not all healthcare facilities, especially smaller hospitals and non-hospital facilities, participate in Hospital Preparedness Program (HPP) funded activities, mutual aid becomes critical for these clinics to be able to successfully participate in community based response plans. Mutual aid provides surge capacity and capability that is immediately operational, reliable, and cost-effective.

Community Based Surge Capacity & Capability



2.2 Community Participants

An important element of the community based capacity and capability is inclusion and integration of non-healthcare entities in the community. Below is a checklist of community members to consider for community based planning:

	Community Participant	Role
	Local Emergency Medical Services Authority	Local implementing arm of the Emergency Medical Systems Authority.
	Law Enforcement and Fire	Emergency first responders
	Public works & local Utility Companies	Essential services
	Communication Companies	Communication needs
	Major employers and business community, especially big-box retailers (e.g. Costco, Sam's Club)	Essential supplies and services
	Area Airports	Transportation
	Red Cross/Salvation Army and other non-profit organizations	Volunteers and Supplies Aid
	National Guard and Military Establishments	Transportation and infrastructure support
	Chamber of Commerce	Business community support
	Board of Realtors	Help coordinate additional space for healthcare facilities
	City Unified School District and Community Colleges	Alternate Care Sites
	Public transportation	Transportation
	Faith based organizations	Translation and funeral services
	Private security firms	Security services
	Mortuaries	Funeral services
	Community emergency response teams	Volunteers
	Medical Reserve Corps (MRC)	Volunteers
	Miscellaneous services	Financial, accounting, general services
	Vetrinary Shelters/Pet Boarding and Care	Pet care for workers/evacuees

The community based capacity and capability may include healthcare and non-healthcare assets from multiple jurisdictions. This may be desirable especially in rural areas, where health and medical assets are scattered. Since rural isolated facilities cannot rely on receipt of supplies, medications and durable medical equipment from Strategic National Stockpile in a timely manner, they have an even greater need to form a community based capacity and capability especially with private sector.

2.3 Community Based Surge Capacity and Capability Standards

The JCAHO's Environment of Care provides guidance on standards for community based surge capacity and capability. These standards will become effective January 1, 2008.

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

  An emergency in a health care organization or in its community can suddenly and significantly affect demand for its services or its ability to provide those services. The organization's Emergency Management Program defines a comprehensive approach to identifying risks and mobilizing an effective response within the organization and in collaboration with essential response partners in the community.

- EC.4.12: The organization develops and maintains an emergency operations plan.

  A successful response relies upon planning around the management of six critical areas: communications; resources and assets; safety and security; staffing; utilities; and clinical activities. While the Emergency Operations Plan can be formatted in a variety of ways, it must address these six critical functions to serve as a blueprint for managing care and safety during an emergency.
  Some emergencies can escalate unexpectedly, or strain not only the organization but the entire community. An organization cannot mitigate risks, plan thoroughly, and sustain an effective response and recovery without preparing its staff and collaborating with the community, suppliers and external response partners. Such an approach will aid the organization in developing a scalable response capability, and in defining the timing and criteria for decisions involving sheltering in place, patient transfer, facility closings, or evacuation.

- EC.4.14: The organization establishes strategies for managing resources and assets during emergencies.

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

The organization establishes processes to collaborate with health care organizations outside of the community in the event of a regional or prolonged disaster that requires resources and assets from outside the immediate geographic area.

The organization establishes processes to receive and care for evacuees from other communities consistent with the organization's role in the state or local emergency operations plan.

2.4 Surge Capacity Strategies

According to a report by Health Systems Research Inc., *Altered Standards of Care in Mass Casualty Events;* an AHRQ Publication, April 2005 and The Recommendations of the state Expert Panel on Inpatient and Outpatient Surge Capacity, *Guidelines for Managing Inpatient and Outpatient Surge Capacity*, state of Wisconsin, November 2005, if a facility determines they are experiencing a healthcare surge they are to use the following guidelines to assess and prepare for the need to increase patient care capacity:

- Rapid discharge of emergency department (ED) and other outpatients who can continue their care at home safely
- Cancellation of elective surgeries and procedures, with reassignment of surgical staff members and space
- Reduction of the usual use of imaging, laboratory testing, and other ancillary services
- Transfer of patients to other institutions in the state, interstate region, or nationally.
- Facilitation of home-based care for patients in cooperation with public health and home care agencies

- Facilities should consider cohorting surge capacity patients rather than spread them out. This cohorting will also be necessary for pediatric and adolescent patients.
- Specifically for hospitals:
  - Expansion of critical care capacity by placing select ventilated patients on monitored or step-down beds; using pulse oximetry (with high/low rate alarms) in lieu of cardiac monitors; or relying on ventilator alarms (which should alert for disconnect, high pressure, and apnea) for ventilated patients, with spot oximetry checks
  - Conversion of single rooms to double rooms or double rooms to triple rooms if possible
  - Designation of 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 of these areas to cohort those health care providers caring for contagious patients to minimize disease transmission to uninfected patients
  - Use of cots and beds in flat space areas (e.g., classrooms, gymnasiums, lobbies) within the hospital for non-critical patient care
  - Avert elective admissions at tertiary hospitals and discharge patients to rehab or a SNF or to home healthcare.
  - Obstetrics (OB) is to be considered as a “clean” unit (no infectious patients should be placed in OB), but may be filled with other “clean” patients only as a last resort.
  - Any unit that is used for immuno-suppressed patients should be treated in the same way as the OB unit and thus should not be counted as inpatient surge capacity beds.
  - Nursery beds are not to be considered as potential inpatient surge capacity beds even for infants, since these beds are used only for neonates <28 days. If an infant with an infectious disease or with trauma is brought in, the infant is to be placed in pediatrics (PEDS).

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

- Waiting Rooms
- Wings previously used as inpatient areas that can be reopened
- Conference Rooms
- Physical Therapy Gyms
- Medical Office Buildings
- Parking Lots
- Temporary shelters on facility premises (including cots in tents)

Obviously, there is a hierarchy among these rooms as to which would best and first be used as patient/inpatient surge capacity treatment areas. This selection of areas to be used for surge capacity can best take place when the facility has an understanding of the intensity of the incident and the resulting number of surge patients that it may receive. Collaboration and the establishment of alert protocols with Emergency Medical Services, First Responders and the Emergency Operations Center (EOC) will provide facilities with the necessary information to implement the appropriate number of patient/inpatient surge capacity.

2.5 Surge Capacity and Triage

There are two planning aspects that can augment surge capacity, the "what" and the "where". The "what" relates to the pre-event planning of sorting patient care capacity based on triage color codes (red, yellow, green or black).

Thus, a facility's surge capacity plan should consider identifying which patient care areas can best serve the needs of a type of patient. Whereas the "where" enables employing the right amount and types of resources based on the needs of the victims.

2.5.1 The What

The "what" relates to the pre-event planning of sorting patient care capacity based on triage color codes (red, yellow, green or black). Thus, a facility's surge capacity plan should consider identifying which patient care areas can best serve the needs of a type of patient.

Surge capacity could be initially designated by the following triage color codes. **Note the triage color codes are not the same as the surge color codes and are to be used as independent color codes for their respective context**:

- RED patient care areas are to be designated for the care of patients in need of immediate care. These RED patient care areas, which need to be similar to ED rooms with the required gases and equipment. Examples of such rooms are Post Anesthesia Care Unit PACU and Intensive Care Unit (ICU) rooms or, if necessary, a medical/surgical room.
- YELLOW patient care areas are to be designated for the care of patients, whose treatment can be delayed. These are medical/surgical areas that are in close proximity to existing medical/surgical rooms and also in close proximity to ancillary services and supplies.
- GREEN patient care areas are to be designated for care of patients that are ambulatory and thus their injuries may be of a minor nature. GREEN patients could be directly transported to outpatient treatment centers
- BLACK patient care areas are to be designated for the palliative or comfort care of patients and may be rooms that are more distant from the core acute care service areas.

Note, as in the field, all these patients will need to be constantly re-triaged. The color designation may change several times for these patients[161].

2.5.2 The Where

The "where" enables employing the right amount and types of resources based on the needs of the victims. An applicable model to look at would be the one used by military medical departments. The Health Service Support on Battlefield doctrine employs Echelons of Care. The term echelon is used to describe the phased system of health care delivery in the Theater of Operations (such as from the forward line of troops (FLOT) Echelon I, back to the continental United states (CONUS) Echelon V). Each higher echelon reflects an increase in medical capability while it retains the capabilities found in the lower echelons. At Echelon I, the medic makes medically substantiated decisions on the field (including triage decisions) as well as provides emergency medical treatment, while at Echelon V, facilities are staffed and equipped to provide care for all categories of casualties.

Employing Echelons of care, to field triage would ensure that victims are routed to the right types of care areas, from field to community clinics, surgery centers, acute care hospitals or even to hospice care centers and thus employing only appropriate level and amounts of scarce resources. A detailed discussion of Echelons of Care can be found at:
https://ccc.apgea.army.mil/sarea/products/textbook/Web_Version/chapters/chapter_13.htm#Unit%20level

2.6 Role of Clinics and other Outpatient Facilities

Community clinics, including Indian health clinics operated by tribal government entities, have a significant role in providing medical care to underserved urban and rural communities. While their capabilities are limited, they are likely to be significant points of convergence for ambulatory patients seeking care because:

- "Victims often seek medical care in settings they are familiar with, such as a personal physician's office;
- When medical surge demands severely challenge hospitals, patients may seek care at other healthcare facilities;
- Some victims' treatment requirements may be adequately managed in these smaller settings; and
- Certain events, such as a biological agent release, may be prolonged in duration and generate patients that can be safely evaluated in these settings, thus relieving some of the burden on larger healthcare facilities". (The CNA Corporation, *Medical Surge Capacity and Capability: A Management System for Integrating Medical and Health Resources During Large-Scale Emergencies*, August 2004)

According to California Emergency Medical Services Authority, *California Disaster Medical Response Plan*, January 24, 2007, the use of off site facilities, such as freestanding Outpatient Surgery Centers, for treatment of specified injuries (orthopedic or abrasion/lacerations which require more than first aid) will free up necessary resources at the hospital. Increasingly, licensing, accreditation, and funding agencies require community clinics to develop disaster response plans and perform hazard vulnerability assessments.

Urgent care centers, dialysis clinics, and other non-hospital facilities also provide essential medical services. Following a catastrophic disaster these facilities, along with community clinics, have several potential response roles and responsibilities:

- Protection of staff and patients.
- Stabilization of casualties who are injured on site or converge to the facility.
- Maintaining continuity of care to ambulatory patient base
- Creating a surge capacity resource for the treatment of stable, low priority incident and/or non- incident patients
- Creating a venue to establish specialty disaster services, such as blood donation stations, worried well centers, and mental health services.
- Participation, consistent with the organization's mission, capability and role as planned and provided for in the local system, in the OA's medical and health response.
- If unable to provide services, referring both usual patients and disaster victims to appropriate alternative sources of medical care.
- In addition to keeping the facility open, provide assistance with recruiting medical personnel or volunteers to augment staff at other health care facilities or service sites.
- Supporting OA medical response through language services and outreach and information dissemination to limited-English proficient and isolated communities.
- Rapid restoration of function to provide services to its usual patient population.

To meet these responsibilities, non-hospital facilities should:

- Develop and exercise disaster plans for internal and external emergencies both separately and simultaneously.
- Train staff in disaster operations including operating under Incident Command System (ICS).

- Establish communication and coordination links with their MHOAC and as specified in local plans.
- Prepare their facilities by mitigating non-structural hazards

California Primary Care Association's The Community Clinic & Health Center Emergency Operations Plan Template, 2004, provides extensive guidance to community clinics in the development of their emergency management plans and programs. The template contains sections for mitigation, preparedness, response and recovery. The appendix section contains extensive tools that enable planners to develop their emergency operations plan. The document can be accessed at: http://www.emsa.ca.gov/hbppc/hbppc.asp. The next update to the plans is expected to include Pandemic Influenza planning and an MOU template (see the draft version of the MOU template in Appendix SC 3).

3 The Workforce

The recommended guidelines and operational tools identified in this chapter can be used by non-licensed healthcare facility managers and planners to begin developing or adapting surge and disaster response plans as necessary to ensure appropriate and adequate personnel coverage during a surge. The primary goal of this content is to enable surge response through analysis of current standards and identification of waivers. To accomplish this, the content in this section covers the following five areas:

- **Scope of Practice and Professional Liability:** provides analysis for standards and guidelines related to professional liability and scope of practice as they pertain to personnel working during surge. This section specifically covers the liability issues associated with caregivers delivering care outside of their licensed scope of practice in order to ensure an optimal population outcome and identifies waivers and potential flexing of current standards that will enable staff members to work during surge with reduced liability. Additionally, this section provides staff coordinators with the ability to utilize staff in non-traditional roles that provide for the optimal outcome in an emergency.
- **Credentialing / Personnel Verification:** providers an overview of the current standards for the credentialing and privileging processes, how these may be streamlined during a surge, and what it entails for healthcare professionals.
- **Management and Organization of Personnel:** outlines how existing staffing regulations and staffing plans are affected once personnel are deployed to a facility, and what facilities' obligations are for their workforce. This section specifically addresses facilities' responsibility to develop plans to address key issues such as staffing regulations, staff assignments, and training, as well as to safeguard the health and safety of the workforce, provide support services such as dependent care, and ensure workforce resiliency.

3.1 Organizing Personnel

This section addresses non-licensed healthcare facilities' need to develop plans to address key issues such as staffing regulations, staff assignments and training. During a surge existing standards and regulations for these issues may be compromised and non-licensed healthcare facilities must be prepared to respond in not only an effective manner but also a timely one. Several tools are included in this section to facilitate the efficient organizing of personnel at a non-licensed healthcare facility.

3.1.1 Current Standards and Analysis

During a surge, there are two types of staffing regulations to be considered:

(1) A healthcare emergency may cause a significant volume change; therefore the non-licensed healthcare facility must demonstrate that prompt efforts were made to maintain required staffing levels.

(2) Business & Professions Code §3516 states that no physician shall supervise more than two physician assistants at any time. Additionally, Business & Professions Code §3502.5 allows for physician assistants, during a state of war emergency, state of emergency, or state of local emergency, to provide patient care regardless of whether the physician assistant's approved

supervising physician is available so long as a licensed physician is available to render the appropriate supervision.

Government Code §8571 states that during a state of war emergency or state of emergency the Governor may suspend any regulatory statute, or statute prescribing the procedure for conduct of state business, or the orders, rules or regulations of any state agency, including subdivision (d) of Section 1253 of the Unemployment Insurance Code, where the Governor determines and declares that strict compliance with any statute, order, rule or regulation would in any way prevent, hinder, or delay the mitigation of the effects of the emergency.

3.1.2 Guideline/ Recommendation

It is recommended that non-licensed healthcare facilities should plan for staffing for the first 72 hours of a mass casualty incident. During this time period, especially if other healthcare facilities are involved, there may not be the ability to call upon other organizations for assistance or to begin to recruit volunteers to assist, given the time necessary to implement these processes.

As such, it is recommended that:

- Staffing plans encompass not only clinical roles such as RNs and how they may be assigned to different duties based on the designated patient care levels, but also ancillary support staff.
- Matrices should be developed to assist staffing supervisors to identify specific staff types.

In preparing these staffing plans and matrices, it should be noted however, that "fewer ancillary staff would necessitate more nursing staff to accomplish tasks normally the responsibility of ancillary staff."[162]

The following tools present non-licensed healthcare facilities with various options in terms of surge staffing strategies and plans, staff utilization matrices (both for nursing and for ancillary support staff) as well as recommended medical staff bylaw language allowing licensed healthcare practitioners to provide care without supervision during a surge.

3.1.2.1 Staffing Strategy for RNs during Surge[163]

The following guidelines were developed for both inpatient and outpatient surge capacity. While it is recognized that not all the guidance is applicable to non-licensed healthcare facilities as they currently function, certain scenarios may require that facilities expand their capacity to meet the needs of the surge. Thus the guidelines in their entirety are included.

Outlined in the Guidelines for Managing Inpatient and Outpatient Surge Capacity, the Wisconsin State Expert Panel has developed the following staffing strategy to be used as a best practice for planning for surge staffing. As the most current guidance on this topic the Wisconsin Guidelines is referenced here as a model or sample for clinics.

In the first 72 hours of a surge, there will be limited additional staff therefore, the following staffing strategies have been identified to extend the staff capacity of a healthcare facility:

- **Strategy One**: Staffing ratios will need to be adapted to the need. Each of the designated patient care levels (Critical, Complex/Critical, Basic, and Supportive) will require different staffing ratios.
- **Strategy Two**: 8 hour shifts may be changed to 12 hour shifts.

- **Strategy Three**: Work tasks are to be prioritized so that only essential patient care tasks are provided by staff.
- **Strategy Four**: Healthcare facilities are to consider flexing scope of practice of staff to provide necessary care with available staff (when authorized by the Governor during a declared state of emergency to allow flexed scope of practice).
- **Strategy Five**: The healthcare facilities can use the media to contact volunteer health care workers or acquire staff through established MOUs and partnerships with other facilities and alternate labor sources such as MRCs, Community Emergency Response Teams (CERTS), etc.

Assignment of Staff to Designated Patient Care Levels

In a surge incident, non-licensed healthcare facility may need to supplement staffing of other facilities or accept higher acuity patients. The organization will need to assign available staff and volunteers to the designated care levels, based on the staff level and scope of practice. The following minimum skill sets that staff should have in order to provide patient care, based on the care level designation of the patient are recommended below:

1. Staff skills necessary to care for Critical patients: These are to be staff or volunteers, who are acute care RNs and Residents, who can perform primary and secondary assessment of critical care patients. The healthcare facility can also use acute care LVNs, technicians, PCAs and student nurses to assist these RNs and Residents; this will allow for increased productivity of these RNs and Residents.

2. Staff skills necessary to care for Complex/Critical patients: These are to be staff or volunteers, who are RNs and LVNs, who can perform initial and on-going assessment of patients and who are presently employed either in acute care settings or in non-healthcare facility work sites.

3. Staff skills necessary to care for Basic and Supportive patients: These are to be staff or volunteers, who are comfortable with death and dying, such as hospice volunteers, clergy, social workers, retired healthcare workers, healthcare facility volunteers, and members of service organizations such as the American Red Cross. It will be necessary to have a RN supervisor and Team Leader in each area to assess these staff, their skills and their stress and rehabilitation needs.

3.1.2.2 Ancillary Support Matrix

The following sample staff utilization matrix, is adapted from another example[163] set forth by the Wisconsin State Expert Panel in its guidance on surge capacity. It provides facilities with a template and guidelines for Ancillary staffing needs for a facility operating in surge. This document provides recommendations for maintenance of ancillary staff during a surge to maintain day-to-day operations as well as meet the expanded needs; sample matrices are provided. Ancillary staffing recommendations follow the matrices provided below.

The "Ancillary Support Matrix" is shown below. The complete tool can be found in the Operational Tools Manual.

Ancillary Support Matrix

The following sample staff utilization matrix, is adapted from another example[163] set forth by the Wisconsin State Expert Panel in its guidance on surge capacity. It provides both existing facilities and ACS(s) with a template and guidelines for Inpatient Ancillary staffing needs for a facility operating in surge. This document provides recommendations for maintenance of ancillary staff

during a surge to maintain day-to-day operations as well as meet the expanded needs; sample matrices are provided. Ancillary staffing recommendations follow the matrices provided below.

Ancillary 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			

Instructions for Use

Ancillary 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 or ACS with the surge of patients. The following ancillary departments are to complete their staffing plans (based on the template above) and strategies:

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

Each department is to complete its own staff utilization matrix but is to collaborate to determine which staff can be pulled from other departments to assist with these functions so that departments do not identify and depend upon the same staff.

3.2 Credentialing/ Personnel Verification

This section of the document provides an overview of the current standards for credentialing and the verification of qualifications of personnel ("personnel verification") as well as an analysis of how, or the extent to which, these standards may be flexed during a surge. Specific guidelines and processes (in the form of operational tools) as to how these processes may be streamlined during a surge are also provided, as appropriate.

3.2.1 Streamlined Credentialing and Privileging during Surge (Licensed Independent Practitioner)

3.2.1.1 Current Standards and Analysis

During a surge, healthcare professionals may opt to volunteer their services at a facility other than that which they normally work. For example, because of structural damage or denied access to transportation and highways (after an earthquake), a physician may decide to volunteer his/her services at a hospital at which he/she is not credentialed or privileged. In that instance, that physician will have to undergo a process known as "emergency credentialing" and be granted temporary disaster privileges, per JCAHO.

Standard MS.4.110 in the JCAHO Comprehensive Accreditation Manual for Hospitals (2007) states that an organization may grant disaster privileges to volunteers eligible to be licensed independent practitioners.

The Rationale for this standard further states that the organization may implement a modified credentialing and privileging process for eligible volunteer practitioners (in this case, licensed independent practitioners) when the disaster plan has been implemented and the immediate needs of the patients cannot be met. The usual process to credential and privilege practitioners would not allow a volunteer practitioner to provide immediate care, treatment and services in the event of a disaster due to the length of time it would take to complete the process.

While this standard allows for a method to streamline the credentialing and privileging process, safeguards must be in place to assure that volunteer practitioners are competent to provide safe and adequate care, treatment, and services. Even in a disaster, the integrity of two parts of the usual credentialing and privileging process must be maintained:

- Verification of licensure
- Oversight of the care, treatment, and services provided

JCHAO does not provide any formal procedure for carrying out this process, nor does it make any commitment to suspend accreditation requirements during a disaster. Healthcare providers retain the obligation to verify competency and maintain oversight of the practitioners and care delivered. If primary source verification cannot be obtained within 72 hours from the practitioner presenting to the facility, the provider must keep records of why it could not under the circumstances do the required verification check.

In order to implement this standard, organizations are held to the following criteria or performance expectations:

- Disaster privileges are granted only when the following two conditions are present: the emergency management plan has been activated, and the organization is unable to meet immediate patient needs.

- The individual(s) responsible for granting disaster privileges is identified.
- The medical staff describes in writing a mechanism (for example, direct observation, mentoring, and clinical record review) to oversee the professional performance of volunteer practitioners who receive disaster privileges.
- The organization has a mechanism to readily identify volunteer practitioners who have been granted disaster privileges.
- In order for volunteers to be considered eligible to act as licensed independent practitioners, the organization obtains for each volunteer practitioner at a minimum, a valid government-issued photo identification issued by a state or federal agency (e.g., driver's license or passport) and at least one of the following:
    - A current picture hospital or clinic ID card that clearly identifies professional designation
    - A current license to practice
    - Primary source verification of the license
    - Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), or Medical Reserve Corps (MRC), Emergency System for the Advanced Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal organizations or groups.
    - Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity)
    - Identification by current facility or medical staff member(s) who possesses personal knowledge regarding volunteer's ability to act as a licensed independent practitioner during a disaster.
- Primary source verification of licensure begins as soon as the immediate situation is under control, and is completed within 72 hours from the time the volunteer practitioner presents to the organization.
  Note: *In the extraordinary circumstance that primary source verification cannot be completed in 72 hours (e.g., no means of communication or a lack of resources), it is expected that it be done as soon as possible. In this extraordinary circumstance, there must be documentation of the following: why primary source verification could not be performed in the required time frame; evidence of a demonstrated ability to continue to provide adequate care, treatment, and services; and an attempt to rectify the situation as soon as possible.*
- The medical staff oversees the professional practice of volunteer licensed independent practitioners.
- The organization makes a decision (based on information obtained regarding the professional practice of the volunteer) within 72 hours related to the continuation of the disaster privileges initially granted.

3.2.2 Guideline/ Recommendation

An alternative to non-licensed healthcare facilities conducting their own credentialing process is the use of volunteers from ESAR-VHP and MRC. The credentials of volunteers registered with ESAR-VHP are validated prior to an emergency so that they may be deployed quickly to facilities in need. Similarly practitioners who are registered with MRCs may also have completed the credentialing process prior to the emergency; however the determination to offer this process is made at the local MRC Unit level. Since there is a fee associated with credential verification, it may be cost-prohibitive for some of the small Units.

Calling upon these volunteers may be a more feasible solution for facilities which do not conduct this process. Should a non-licensed healthcare facility decide to independently complete this process, certain considerations should be made. Additionally current policies and procedures should be updated to reflect that under a declared state of emergency the Governor has the

authority to waive certain requirements that would then allow facilities to call upon otherwise unavailable practitioners (e.g., physicians with inactive or retired licenses).

At this time, the credentialing process is disparate and may be duplicative between facilities. Should a practitioner volunteer at more than one location, and he/she is not registered with ESAR-VHP and MRC, the credentialing process would have to be repeated. As such, it is recommended that a centralized database for credentialing information be developed and made available for non-licensed healthcare facilities, other facilities, and public health (for purposes of an ACS).

It is recommended that facilities that do not have a standardized system to credential providers, such as non-hospital affiliated facilities, use the following operational tools as templates to streamline their credentialing and privileging process. The tools that have been drafted include:

- A recommended emergency credentialing policy
- Volunteer application form for healthcare practitioners (to be used as a credentialing form)
- A recommended credentialing matrix log to verify that all required identification has been obtained; and
- A process flow diagram to guide hospitals in their emergency credentialing process.

3.2.2.1 Tool - Recommended Policy for Emergency Credentialing and Privileging (Licensed Independent Practitioners)164

The "Recommended Policy for Emergency Credentialing and Privileging" is shown below. The complete tool can be found in the Operational Tools Manual.

Licensed independent practitioners (such as physicians, advanced practice nurses, and registered nurses) who request temporary disaster privileges during a period of officially declared emergency must be currently licensed.

Clinic medical staff bylaws/rules that address disaster credentialing should specify identification requirements for those practitioners requesting disaster privileging. At a minimum, identification should include a valid government-issued photo identification issued by a state or federal agency (e.g., driver’s license or passport) and at least one of the following:

- A current picture or healthcare facility identification card.
- A current license to practice and a valid picture identification issued by a state, federal, or regulatory agency.
- Identification indicating that the individual is a member of the California Medical Assistance Team (CalMAT) or of a Disaster Medical Assistance Team (DMAT).
- Documentation indicating that the individual has been granted authority to render patient care in disaster circumstances, such authority having been granted by a federal, state, or municipal entity.
- Presentation by current healthcare facility or hospital or medical staff member(s) with personal knowledge regarding the practitioner's identity.

Immediate temporary disaster privileges may be granted in accordance with the bylaws/rules of the medical staff. The individual responsible for granting such privileges must be delineated in writing in the medical staff bylaws/rules and referenced in the non-licensed healthcare facility's disaster (emergency preparedness) plan. The bylaws/rules should specify that this individual is not required to grant privileges to any requestor and is expected to make such decisions on a case-by-case basis at his or her discretion. The privileges should be effective immediately and

continue through the completion of the patient care needs or until the orderly transfer of the patient's care to another properly credentialed practitioner can be accomplished.

Following disaster credentialing, the practitioner should be provided and maintain on his or her person written verification of said privileges. The medical staff bylaws, rules and regulations should require that his or her notations in the medical record reflect that the practitioner is working under disaster privileges. For quality review purposes, a list of all patient encounters should be kept, if practical.

Allied Health Professionals (AHP) may be similarly considered for temporary privileges, and shall be subject to the same general conditions of supervision except that supervision may be performed by an AHP with current like privileges.

Emergency temporary privileges may be rescinded at any time, and there shall be no rights to any hearing or review, regardless of the reason for such termination.

Temporary disaster privileges are terminated at the end of the declared disaster.

A Volunteer Application for each practitioner must be completed and maintained on file at the facility.

3.2.2.2 Tool - Volunteer Application for Healthcare Practitioners

Upon presenting at a facility to provide services during a surge, healthcare professionals will be requested to complete an application form similar to the sample shown below. Its purpose is to give facilities a mechanism by which to collect the minimum necessary information to verify a practitioner's competency.

The "Volunteer Application for Healthcare Practitioners" is shown below. The complete tool can be found in the Operational Tools Manual.

Instructions for Use:

1. For each licensed independent practitioner (MD, DO, APN, or PA) who presents at a hospital to apply for emergency credentials, the Medical Staff office representative will provide him/her with the following application form.
2. Each licensed independent practitioner must present to the Medical Staff office representative with proper identification including a valid government-issued photo identification issued by a state or federal agency (e.g., driver's license or passport) and at least one of the following:

    - A current picture hospital identification card.
    - A current license to practice and a valid picture identification issued by a state, federal, or regulatory agency.
    - Identification indicating that the individual is a member of the California Medical Assistance Team (CalMAT) or of a Disaster Medical Assistance Team (DMAT).
    - Documentation indicating that the individual has been granted authority to render patient care in disaster circumstances, such authority having been granted by a federal, state, or municipal entity.
    - Presentation by current hospital or medical staff member(s) with personal knowledge regarding the practitioner's identity.

3. Completed application form is then given to the Medical Staff Director or other designated individual for review and determination of the practitioner's duties and area of assignment.

4. Concurrently, the Medical Staff Office representative will initiate the primary source verification process. This process must be completed within 72 hours from the time the practitioner presented to the organization.

VOLUNTEER APPLICATION (Licensed/Certified/Registered Professional)	
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*, please explain:	
Current Address: Street: City: State: Zip:	Previous Address: Street: City: State: Zip:
Phone number: ( )	Pager/ Cell Phone: ( )
Are you 18 years or older? ☐ No ☐ Yes	Social Security number:
Birth Date (mm/dd/yyyy):	Birth Place (City, State):

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

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

LICENSURE/ CERTIFICATION/ REGISTRATION INFORMATION		
Do you now have or have you previously had a health care 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

Please 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, please select below:

☐ ESAR-VHP ☐ Medical Reserve Corps (MRC) ☐ California Medical Assistance Team (CalMAT)
☐ Disaster Medical Assistance Team (DMAT) ☐ Other. Please 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*, please specify.

Age Specific Practice Criteria:
Please 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: (Please 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*, please identify which other language(s) and rate your proficiency in these languages:

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

VERIFICATION OF TRUTHFULNESS AND UNDERSTANDING REGARDING VOLUNTEER AGREEMENT

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

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

_____ Initials

Proper identification was verified and copied.

- ☐ Government issued photo identification (All Applicants)
- ☐ Clinical License (Licensed Personnel only)

If applicant unable to present license, 2 witnesses from applicants current place of practice may attest to applicant's qualifications to practice.

Witness 1 Signature _____ Date _____

Witness 2 Signature _____ Date _____

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

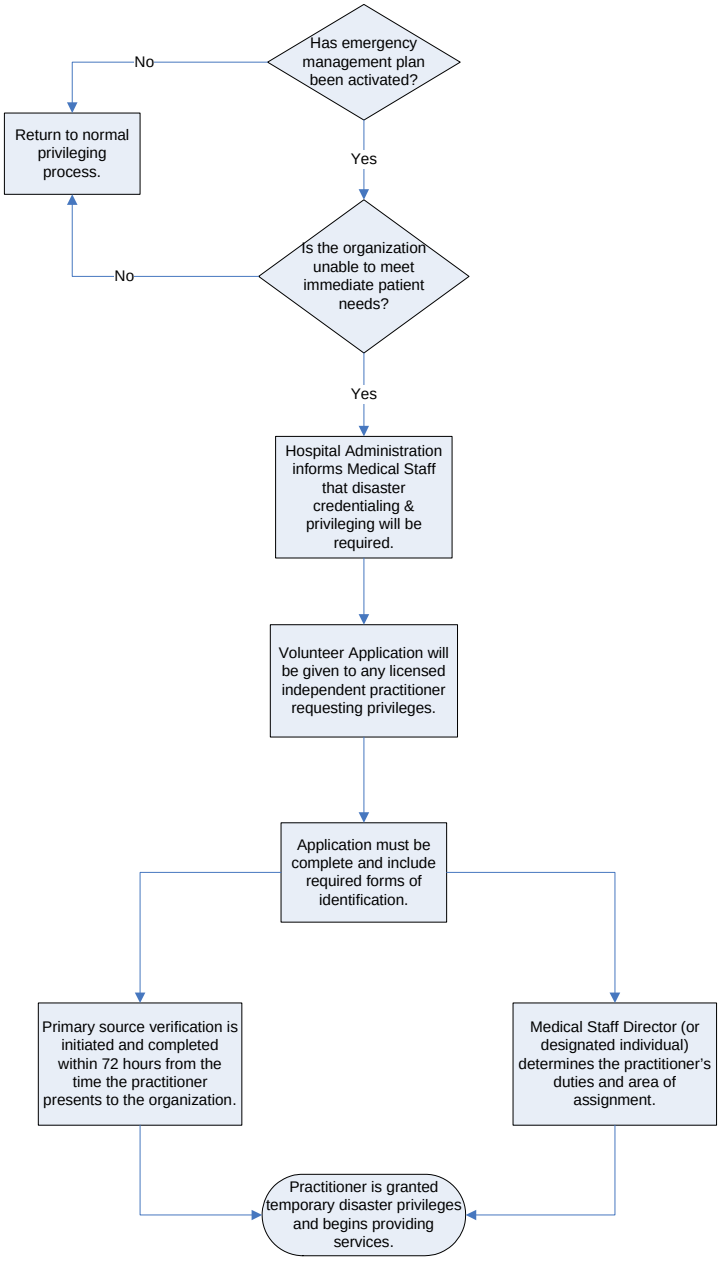
I authorize this individual to volunteer.

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

3.2.2.3 Tool - Temporary Disaster Privileging Process Flow Diagram

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

The "Temporary Disaster Privileging Process Flow Diagram" is shown below. The complete tool can be found in the Operational Tools Manual.


Has emergency management plan been activated?
No
Return to normal privileging process.
Yes
Is the organization unable to meet immediate patient needs?
No
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.
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.

3.3 Streamlined Personnel Verification for Surge

3.3.1 Current Standards and Analysis

For all other healthcare providers – other licensed, certified, or registered practitioners – and all other volunteers, processes should be in place to verify their qualifications and experience as well. To differentiate this process from that of credentialing, it will be referred to as "personnel verification". The (Office of Inspector General) OIG Compliance Program Guidance for Hospitals states that facilities should conduct a reasonable and prudent background investigation, including a reference check, as part of every such employment application. This is recommended as a best practice for all types of other healthcare facilities.

3.3.2 Guideline/ Recommendation

Similar to the recommendation made for credentialing above, non-licensed healthcare facilities are encouraged to consider the use of volunteer registries such as ESAR-VHP and volunteer organizations such as MRC and benefit from their pre-registration process which not only encompasses credentialing of licensed independent practitioners but may also fulfil requirements for personnel verification.

In order to assist non-licensed healthcare facilities in planning, the following tools and templates are included to address the process for personnel verification. Just as the credentialing tools may be customized, these personnel verification tools may be revised as well to best fit the needs of the facility or ACS.

Operational tools to implement a streamlined personnel verification process include:

- Recommended Policy for Personnel Verification (Other Licensed/ Certified/ Registered Practitioners and All Other Volunteers)
- Volunteer Application for Licensed/Certified/Registered Professionals and All Other Volunteers
- Personnel Verification Matrix for Other Licensed/ Certified/ Registered Practitioners and All Other Volunteers

3.3.2.1 Tool - Recommended Policy for Personnel Verification (Other Licensed/ Certified/ Registered Practitioners and All Other Volunteers)[165]

The "Recommended Policy for Personnel Verification (Other Licensed / Certified / Registered Practitioners and all Other Volunteers)" is shown below. The complete tool can be found in the Operational Tools Manual.

During a local emergency (as declared by local, state, or national officials) in which the emergency management plan has been activated and the organization is unable to meet immediate patient needs, licensed or certified personnel, who are not current employees of [Facility Name], [City, County] may be granted temporary working privileges as needed to assist in staffing during the emergency. The Administrator or Human Resource Director/Manager or their designees, (as identified under the Facility's Emergency Management Plan) will designate these non-employees to work at [Facility Name], [City, County].

Volunteers considered eligible to act as a licensed or certified personnel may also be considered upon approval from the Administrator, Human Resource Director/Manager or their designees.

Each non-employee and/or volunteer must present a valid government issued 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 current picture hospital ID card that clearly identifies professional designation
- A current license and/or certification to work
- Identification indicating that the individual is a member of the California Medical Assistance Team (CalMAT) or of a Disaster Medical Assessment Team (DMAT) or MRC, ESAR-VHP or other recognized state or federal organization or groups
- Documentation indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (if applicable)
- Identification by current hospital employee(s) who possesses personal knowledge regarding the non-employee/volunteer's ability to act as a licensed independent practitioner during a disaster (if applicable)

The Human Resource department will conduct a primary source verification of licensure (if applicable) as soon as the immediate situation is under control and is completed within 72 hours from the time the non-employee or volunteer presents to the organization.

The Labor Pool Unit Leader* shall determine the duties and area of assignment of those with emergency privileges.

The employee or volunteer will wear an [Facility Name] issued ID badges that indicate they have are a disaster volunteer. The Labor Pool Unit Leader will have the temporary badges and be responsible for distributing them to the identified personnel.

The Labor Pool Leader or designee will make a decision (based on information obtained regarding the license and/or certification of the non-employee/volunteer) within 72 hours related to the continuation of the disaster.

** - The Labor Pool Unit Leader is a designation under the Hospital Incident Command System (HICS). For the hospital to respond effectively to the demands associated with a disaster, support requirements will be coordinated by the Logistics Section. Under the Service Branch of the Logistics Section, the Labor Pool & Credentialing Unit is charged with acquiring and credentialing additional personnel. When activated, this unit is represented by the Labor Pool Unit Leader.*[166]

3.3.2.2 Volunteer Application for Licensed/Certified/Registered Professionals and All Other Volunteers

Upon presenting at a facility to provide services during a surge, all other healthcare professionals (not licensed independent practitioners) and volunteers will be requested to complete an application form similar to the sample shown below. Its purpose is to give facilities a mechanism by which to collect the minimum necessary information to verify a practitioner's competency.

The "Volunteer Application for Licensed/Certified/Registered Professionals and All Other Volunteers" is shown below. The complete tool can be found in the Operational Tools Manual.

Instructions for Use:

1. For all other licensed, certified, or registered professionals and all other volunteer who present at a hospital to provide service, the Human Resources department representative will 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 government issued 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 current picture hospital ID card that clearly identifies professional designation
   - A current license and/or certification to work
   - Identification indicating that the individual is a member of the California Medical Assistance Team (CalMAT) or of a Disaster Medical Assessment Team (DMAT) or MRC, ESAR-VHP or other recognized state or federal organization or groups
   - Documentation indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (if applicable)
   - Identification by current hospital employee(s) who possesses personal knowledge regarding the non-employee/volunteer's ability to act as a licensed independent practitioner 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 practitioner's duties and area of assignment.

VOLUNTEER APPLICATION (General 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*, please explain:	
Current Address: Street: City: State: Zip:	Previous Address: Street: City: State: Zip:
Phone number: ( )	Pager/ Cell Phone: ( )
Are you 18 years or older? ☐ No ☐ Yes	Social Security number:
Birth Date (mm/dd/yyyy):	Birth Place (City, State):
NEXT OF KIN & EMERGENCY CONTACT	
Give name, telephone number and relationship of two individuals who we may contact in the event of an emergency.	

Name	Telephone Number	Relationship
1.	( )	
2.	( )	

DEPENDENTS

Please list any dependents for which you are responsible.

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

AVAILABILITY, AFFILIATION, & EXPERIENCE

Please 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, please select below:

☐ ESAR-VHP ☐ Medical Reserve Corps (MRC) ☐ California Medical Assistance Team (CalMAT)
☐ Disaster Medical Assistance Team (DMAT) ☐ Other. Please specify _____

Please 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 – please 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*, please identify which other language(s) and rate your proficiency in these languages:

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

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

TO BE COMPLETED BY HUMAN RESOURCE - PERSONNEL VERIFICATION
_____ Initials 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:** / /

3.3.2.3 Tool - Personnel Verification Matrix for Other Licensed/ Certified/ Registered Practitioners and All Other Volunteers

The "Personnel Verification Matrix for Other Licensed/Certified/Registered Practitioners and All Other Volunteers" is shown below. The complete tool can be found in the Operational Tools Manual.

The following table is meant to provide non-licensed healthcare facilities that do not already have a tracking mechanism with a template to use to verify that non-employed licensed practitioners, as well as all other volunteers, have provided the appropriate, and required, documentation.

Qualification Requirements during Surge						
Individual Name	**Proposed Minimum Identification Requirements during Surge (Please select all applicable)**					**Allowed Scope of Practice**
	Govt-Issued Photo ID (Required)	Hospital ID	Current License & Picture	Volunteer (e.g., CalMAT, DMAT) ID	Other - Please specify	

Instructions for Use

For each licensed, certified, or registered practitioner, or any other volunteer, who presents at a hospital to provide service, the Human Resources department representative intakes the following information:

- The practitioner's/volunteer's full name
- The presence (by checking off the applicable box) of the identification requirements. A government-issued photo ID (e.g., a Drivers License) is required in order to qualify for emergency credentials.

- If the practitioner 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 ESAR-VHP) or presentation by current hospital or medical staff member(s) with personal knowledge regarding the practitioner's identity, these should be specified in the box labeled "Other".

Once the practitioner's identity and ability to practice has been verified, and the Labor Pool Leader determines the duties and area of assignment for each practitioner or volunteer, this information should be documented in the column labeled "Allowed Scope of Work/ Job Classification."

Sample Job Classification types includes but is not limited to: Housekeeping, Security, Food Services, Facilities Management, Laundry, Medical Records and Admissions.

3.4 Maintaining Personnel

This section of the document focuses on maintaining staff through the period of surge, including taking the necessary precautions to safeguard their health and safety, providing support services such as dependent care, and addressing issues surrounding workforce resiliency. Specific guidelines are outlined in this section along with recommended tools and templates to enable effective planning.

3.4.1 Workforce Health & Safety and Workers Rights – Current Standards and Analysis

Per the Occupational Safety Health (OSH) Act of 1970, Section 5, "each employer shall furnish to each of his employees employment and a place of employment which are free from recognized hazards that are causing or are likely to cause death or serious physical harm to his employees." Known as the "general duty clause" it very simply states employers' basic obligation to keep employees safe – a concept that could not be any more applicable than in a time of surge. State-specific CalOSHA regulations further detail this obligation, under Labor Code §6400. One of facilities' main priorities in planning for, and responding to a surge, is their overarching duty to safeguard the health and safety of their workforce. Without the workforce, there can be no response.

One of the methods by which facilities protect the health and safety of their workforce is in the provision of personal protective equipment (PPE). Under Labor Code §6401, "every employer shall furnish and use safety devices and safeguards, and shall adopt and use practices, means, methods, operations, and processes which are reasonably adequate to render such employment and place of employment safe and healthful." Additional specific guidance for the provision of PPE are outlined in CCR 8 §3380. CalOSHA requirements may not be waived, but in the event that a non-licensed healthcare facility is unable to meet this requirement, CalOSHA's response would be to assist the facility in meeting the standard under alternate means. Enforcement of CalOSHA requirements during the surge is handled through ICS, under which the focus is not on citation (or the issuance of tickets or violations) but in resolving the issue.

In conjunction with employers' obligation to safeguard the health and safety of their workforce is their responsibility to honor employees' rights. A healthcare surge would affect the way in which employers (in this case facilities or public health) would be able to address workers' rights, for example requiring staff and administrators to remain at a facility or report to work (after leave) during a disaster. The California Industrial Welfare Commission Order No. 4-2001, 3(B)(9)-(10)

outline the number of hours that healthcare personnel may work during a healthcare emergency and allows, after overall operational status has been considered, certain provisions to be made to extend overtime to staff during a disaster. Per CDHS Legal Counsel analysis, this order is subject to modification or waiver under the Governor's executive powers during a state of emergency.

To address employers' ability to have employees' return to work (from a leave) during a disaster, CCR 8 §9776.1 is referenced which discusses employers' general requirement of a return to work release with limitations and/or accommodations before returning an employee to work. This can be obtained from the workers compensation approved physician. In order to respond to a surge, this standard may be waived by authority of the Governor under the Emergency Services Act. Doing so would allow facilities to potentially return certain staff members to work in an expedited manner, thereby increasing the workforce pool.

3.4.2 Workforce Health & Safety and Workers Rights – Guideline and Recommendation

Based on the review of the above standards and the ability to flex these regulations and requirements during a surge, it was identified that mandates can be made for staff to comply with certain requirements as a condition of their employment. It is recommended that the standards discussed above, as well as the accompanying analysis, be incorporated into a Workforce Resiliency Policy. A sample of this recommendation is included in the following section.

3.4.2.1 Tool - Policy for Workforce Resilience during Disaster[167]

The "Policy for Workforce Resilience during Disaster" is shown below. The complete tool can be found in the Operational Tools Manual.

Purpose:
This policy offers guidelines for dealing with needs and training to optimize workforce resilience in the event of a disaster. This policy provides minimum standards for existing facilities to incorporate into current workforce resiliency policies. Alternate Care Sites will adopt a modified version of this policy based on staffing type and functional model. It is important that the intent of this policy is carried out when staffing ACS(s) in order to provide proper support, protections, and training to staff and volunteers. The term worker is used to refer to facility personnel during a time of 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, however, 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 we 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 worker too sick to be at work)

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

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

Emotional:
- Management will provide all workers with regular updates of status of disaster in community 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 stigmata that workers may face for working with victims. Stress control teams will be trained in infection control precautions.

Training

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

1. All employees will receive training in the following:

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

2. Department specific training will be developed by department managers as appropriate to the type of services provided.

3. If there are not enough behavioral health specialists available for response to staff needs in a disaster, __(Affiliate name)___ will provide basic counseling training to selected individuals to assist in meeting worker emotional needs.

4. ___(Affiliate name)___ has developed information packages 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 to 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 that 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

This policy offers guidelines for dealing with needs and training to optimize workforce resilience in the event of a disaster. This policy provides minimum standards for non-licensed healthcare facilities to incorporate into current workforce resiliency policies. The term worker is used to refer to facility personnel during a time of surge, which could consist of paid employees or volunteers.

3.4.3 Support Provisions for Staff – Current Standards and Analysis

Although there are no legal requirements for the provision of support to staff or dependents during an emergency, JCAHO standards under Environment of Care (EC) 4.10 state that facilities must address emergency management. In order to fulfil this standard, the non-licensed healthcare facility emergency plan must provide processes for managing the following elements under emergency conditions[168]:

- Activities related to care, treatment, and services (for example, scheduling, modifying, or discontinuing services; controlling information about patients; referrals; transporting patients)
- Staff support activities (for example, housing, transportation, incident stress debriefing)
- Staff family support activities
- Logistics relating to critical supplies (for example, pharmaceuticals, supplies, food, linen, water)
- Security (for example, access, crowd control, traffic control)
- Communication with news media

3.4.4 Support Provisions for Staff – Guideline and Recommendation

In regards to the provision of child care and dependent care (adults requiring supervision or support), it is recommended that facilities identify staff members who can provide child care and dependent care as needed during a surge. Using existing staff increases the likelihood that these individuals have undergone background checks as part of the employment process.

In addition, it may be beneficial to establish contracts with outside agencies or vendors who will be responsible for providing qualified and licensed professionals for child and dependent care. In the event where such contracts are not feasible or agencies are not accessible, additional community resources should be identified as part of surge planning. Community resources may include schools, religious organizations, or other service organizations.

It is also recommended that non-licensed healthcare facilities consider specific elements in developing a staff support provision plan – elements that include critical stress management and

workforce health and safety. It is also recommended that facilities develop and implement a dependent care policy. Samples of these recommendation tools are included in the sections that follow.

3.4.4.1 Tool - Considerations for Staff Support Provisions[163]

The "Considerations for Staff Support Provisions" is shown below. The complete tool can be found in the Operational Tools Manual.

As a starting point for planning, surge planners are encouraged to consider certain issues or components to providing support provisions for staff. The healthcare facility should consider the formation of Staff Disaster Support Committee or have its Human Resources Department pre-plan for the following (the list is not intended to be inclusive): Some of these issues include:

1. Some staff will not be able to report to work due to the fact that they or their loved ones may have been directly involved in the incident. In the absence of existing policies, it is recommended that a policy be developed or incorporated into current leave (sick time, medical leave, etc.) policies.

2. Some staff will refuse to report to work due to concerns about their own and their family members' safety and health. In the case of a biological incident, they may have fear of contracting the disease or bringing the disease home. In the absence of existing policies, it is recommended that a policy be developed or incorporated into current leave (sick time, medical leave, etc.) policies.

3. Many staff will have concerns about childcare. The normal childcare provider may not be able to provide these services in an incident. These same concerns apply to staff, which may be caring for their parents or others. There should be options available for childcare/eldercare so that staff are free to report to work. Title 42 - Termination if employees chose to volunteer for disaster work (Policy or guideline for protection of work, possibly consider waiver).

4. Some staff may have concerns about the shelter and care of their pets. Considerations should be made to plan for pet care during surge. Designated kennel or housing provisions should be part of the disaster preparedness plan and individual staff member plan.

5. The facility is to consider the provision of rooms for staff for rest and sleep and for personal hygiene needs (blankets, pillows, sheets, showers, towels, soap, shampoo, etc.). In the case of a biological incident, there may be the implementation of work quarantine in addition to staff working longer shifts or not being able to go home. The facility may also want to consider what is available in local hotels, churches, and other such organizations for sleeping accommodations and showers.

6. The facility is to consider areas for staff to eat and have refreshments.

7. Staff may be away from home for extended shifts and need to communicate with family members and other loved ones. The facility is to consider the availability of telephones to call home and computer access for email.

8. 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 so that this "Kit" is readily available.

9. Staff are to also have a “Family Plan” so that everyone in the family knows what will need to happen and who is responsible for various duties if a family member, who works at the healthcare facility, needs to work longer shifts or is quarantined at the facility.

10. The facility should also give consideration for back-up of essential services such as food services, laundry, housekeeping and other services, especially if these services are out-sourced and the incident affects the ability of the contractor to continue to provide these services and if the surge of patients and visitors overwhelms the capacity of these contractors.

11. Most facilities use “calling trees” to notify staff. The healthcare facility is to consider a back-up system for notifying staff should the telephone lines be down or the circuits busy.

12. The facility is to consider pre-identifying staff persons, who will manage and supervise volunteers and in which areas or departments the healthcare facility is likely to utilize volunteers.

13. The facility is also to consider that there may not be sufficient managers to supervise the staff in the surge capacity areas.

14. With staff being asked to work in the surge capacity areas, work in these areas may not necessarily involve their normal work responsibilities (duties as assigned). It is suggested that job descriptions be available for all positions so that staff can receive “just-in-time” training by reading the job descriptions.

Based on these recommendations, the following support provisions have been identified and should be considered by surge planners:

- Behavioral/Mental Healthcare care 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 Rest/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, etc.) staff store at the place of works
- Family Emergency Plan

3.4.4.2 Tool - Sample Policy for Dependent Care[169]

To address one of the issues regarding the provision of staff support services, it is recommended that facilities implement a policy for dependent care. Such a policy should address facilities’ commitment to shelter and feed staff and volunteer dependents during a surge.

The "Sample Policy for Dependent Care" is shown below. The complete tool can be found in the Operational Tools Manual.

Purpose:
This procedure outlines the process by which the Hospital Incident Command System (HICS) at [Hospital Name] provides for sheltering and feeding of 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 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.

Responsibilities:
The Dependent Care Unit Leader shall 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 of 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
    a. The Dependent Care Unit Leader will oversee other staff or volunteers requested from the Labor Pool, two clerical staff for registration, and a nurse to administer medications as needed.
    b. Staff and volunteers shall sign in and out when reporting to assist.
    c. Staff shall monitor the area continuously for safety issues and to respond to dependents' needs.
    d. 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
    a. Post signs indicating "Dependent Care Area – Responsible Adult Must Register Dependent."
    b. Assign each family a Family Number.
    c. 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.

d. Apply and armband to each dependent upon arrival with name and Department Number.
e. Take a picture of each dependent with person responsible for them, and attach to Dependent Care Registration form.
f. Special sign-in and sign-out procedures shall be provided for minor or incompetent dependents.
    i. Implement a positive ID system for all children cared for under 10 years of age.
    ii. Provide matching ID for retrieving guardian to show upon release of child.
g. Tag medications, bottles, food and other belongings with dependent's name and Dependent Number and store appropriately.
h. Assign each dependent to a dependent care provider and record on form.

G. Medications
    a. Assure that dependents taking medications have a supply to last during the estimated length of stay.
    b. 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 responding to specific incidents or individual needs.

I. Documentation
    a. Document all care provided to individual dependents, such as medications, psychological services, toileting or dressing.
    b. Document all other actions and decisions and report routinely to the Dependent Care Unit Leader.

J. Checking Out of Dependent Care Area
    a. When dependent leaves area, compare picture with dependent and responsible person.
    b. Check ID, verify name and obtain signature of responsible person picking up dependent.
    c. Retrieve and send all medications and personal items with dependent.
    d. Collect arm bands.

<u>Form 1</u>

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

Toileting **Medical Conditions**

Medications you brought:		
Name	**Dose**	**Times to be given**
Name	**Dose**	**Times to be given**

People who may pick up dependent	
Name	**Relationship**
Name	**Relationship**
Name	**Relationship**

For Dependent Care Area Staff Only:	
Dependent Care Staff: • Apply armband with name and registration number on each dependent. • Tag all medications, bottles, food and other belongings and store appropriately. • Photograph dependent with person responsible and attach photo to this form. • Use reverse side of this form to document care provided to this dependent. • Retain forms in Dependent Care Area until “All Clear” is announced, then route to Incident Command Center.	
Dependent Care Providers Assigned	
Name of person picking up dependent	
Signature of person picking up dependent	

Form 2

Dependent Name		**Dependent Number**
Date/ Time	**Type of Care Given**	**Notes**

3.5 Scope of Practice and Professional Liability

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

To the extent that flexibility is limited, or explicitly prohibited, professional liability, for both employed professionals and volunteers, needs to be clearly defined. Although this section focuses specifically on the practitioner's liability, the knowledge is essential to non-licensed healthcare facilities in determining the way in which they staff their facilities.

3.5.1 Scope of Practice - Current Standards and Analysis

To date, there is only one type of practitioner who is specifically allowed to provide services outside their licensed scope of practice during a surge: pharmacists.

Per Business & Professions Code §4062(b), under a declared emergency, the pharmacy board has the authority to waive the application of the act if it will aid in the protection of public health or the provision of patient care.

3.5.2 Scope of Practice - Guideline/Recommendation

The recommendation has been made that the Licensing Boards of each of the following practitioners be contacted to determine if flexibility currently exists within their scope of practice or could be drafted for approval.

- Physicians
- Registered Nurses
- Advanced Practice Nurses
- Physician Assistants
- Dentists
- Emergency Medical Technicians (EMTs) and Paramedics
- Pharmacists
- Respiratory Care Practitioner
- Respiratory Therapy Technician
- Cardiovascular Technologists and Technicians
- Radiologic Technologists and Technicians
- Surgical Technologists
- Medical and Clinical Laboratory Technologists
- Medical and Clinical Laboratory Technicians (Phlebotomists)
- Diagnostic Medical Sonographers
- Veterinarians
- Marriage and Family Therapists
- Medical and Public Health Social Workers
- Psychologists

- Mental Health Counselors
- Behavioral Health Professionals

This endeavour is currently underway as the California Department of Health Services has reached out to each of the Licensing Boards to obtain the information. The following table includes initial responses from the Licensing Boards identifying expected flexed scope of practice for various professional types that could be used to assign personnel during a surge to meet patient needs with the available staff.

3.5.2.1 California Healing Arts – Licensing Board Responses

The following table provides an overview of the responses received from the various 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.

The "California Healing Arts – Licensing Board Responses" is shown below. The complete tool can be found in the Operational Tools Manual.

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	N/A

Board	Current Scope of Practice	Scope of Practice/ Liability in an Emergency	Comments/ Recommendation
		assistant, so long as a licensed physician is available to render the appropriate supervision."	
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. 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	N/A

Board	Current Scope of Practice	Scope of Practice/ Liability in an Emergency	Comments/ Recommendation
		occurs outside both the place and the course of employment shall not be liable for any civil damages as the result of acts or omissions by the person in rendering the emergency care. This section does not grant immunity from civil damages when the person is grossly negligent.”	

3.5.2.2 Tool - Flexed Scope of Practice Plan

In order to provide essential services to patients and maintain facility daily operations, it may be necessary to flex the scope of practice for personnel to meet clinical and non-clinical needs. The following matrix is designed to assist staffing coordinators at non-licensed healthcare facilities in planning and allocation of personnel resources during surge. Examples of positions are provided to illustrate classification of staff.

The "Flexed Scope of Practice Plan" is shown below. The complete tool can be found in the Operational Tools Manual.

Flexed Scope of Practice Plan		
Position	**Competencies/ Skill Sets (Non-Surge)**	**Allowed Skill Sets (Surge)**
Credentialed Staff		
Dentist		
Non Credentialed Staff		
Nurse Practitioner		
In-State Volunteers (Other Facility, Registered Volunteer, Walk-In)		
Out-of-State Credentialed Volunteer*		
Psychiatrist		
Out-of-State Non-Credentialed Volunteers		
Certified Registered Nurse Anesthetist (CRNA)		

* Current analysis of standards and regulations relating to augmenting staff in the state of California during surge indicates that only during a state-wide declared emergency, in which current resources are unable to meet the demand for healthcare services, will out-of-state practitioners be allowed to provide care within California. Additionally, the Medical Director of EMSA will designate those specialties to be requested and location for deployment of service.

Instructions for Use:

Facilities' staffing coordinators or Medical Staff representatives may complete this table based on the information received from the California Licensing Boards. Allowed flexed scope of practice (e.g., the procedures each practitioner would be allowed to perform), per the Licensing Boards would be listed under the Allowed Skill Sets (Surge) column.

Under the Competencies/ Skill Sets (Non-Surge) column, each practitioner's "normal" privilege list would be indicated.

3.5.3 Professional Liability - Current Standards and Analysis

A resounding concern in planning for a surge response is that of professional liability, even more so when the discussion of flexing providers' scope of practice is involved. Protections for employed personnel as well as available protections for volunteers – under normal conditions - must be clarified as well as the extent to which they may be expanded during a surge.

Several statutes apply to the liability of healthcare professionals. To date, there are no statutes specific to liability and professional malpractice coverage if an injury occurs to a patient receiving care from a provider whose care is outside his or her scope.

- Government Code §8659, under the California Emergency Services Act states that any physician or surgeon (whether licensed in this state or any other state), hospital, pharmacist, nurse, or dentist who renders services during any state of war emergency, a state of emergency, or local emergency at the express or implied request of any responsible state or local official or agency shall have no liability for any injury sustained by any person by reason of such services, regardless of how or under what circumstances or by what cause such injuries are sustained; provided, however, that the immunity herein granted shall not apply in the event of a wilful act or omission.

Certain statutes and practices specifically address the liability of practitioners providing service outside the state by which they are licensed:

- Government Code §178, Article 5 provides that "no party state or its officers or employees rendering aid in another state pursuant to this compact shall be liable on account of any act or omission in good faith on the part of such forces while so engaged", the Governor's suspension authority runs only to "statutes" not parts of statutes. Additionally, this provision of the Interstate Civil Defense and Disaster Compact applies to the liability of out-of-state disaster workers and is not a regulatory statute or one for the conduct of state business.

Certain statutes specifically address the liability of volunteers while providing uncompensated care:

- The Volunteer Protection Act of 1997, Section 4(a) provides that a volunteer of a non-profit organization or government generally will be relieved of liability for harm if the volunteer was acting within the scope of his responsibilities if he was properly licensed, certified, or authorized for the activities (whenever such licensing, certification or authorization is appropriate or required).

  The Act pre-empts state law, but allows a State to apply its own law exclusively in any case that does not involve out-of-State parties. It does not protect volunteer organizations. And as it is a federal provision, it cannot be suspended or flexed by the Governor.

- The Good Samaritan Statutes under Business & Professions Codes §2395, 2395.5, 2396 and 2398 state that no licensee, who in good faith renders emergency care at the scene of an emergency, shall be liable for any civil damages as a result of any acts or omissions by such person in rendering the emergency care. "The scene of an emergency" as used in this section shall include, but not be limited to, the emergency rooms of hospitals in the event of a medical disaster. "Medical disaster" means a duly proclaimed state of emergency or local emergency declared pursuant to California Emergency Services act.

  As the Good Samaritan statutes are neither regulatory statutes nor statutes for the conduct of state business, they cannot be suspended.

- Per the Disaster Service Worker Volunteer Program Guidance[170], the Emergency Services Act (Government Code §8657) provides DSW volunteers with limited immunity from liability while providing disaster service as it is defined CCR 19 §§2570.2 and 2572.2. Additionally, the Volunteer Protection Act of 1997 also provides them with limited protection. Immunity from liability protects the political subdivision or political entity, and the DSW volunteer in any civil litigation resulting from acts of good faith made by the political subdivision or political entity, or the DSW volunteer, while providing disaster service (e.g., damage or destruction of property; injury or death of an individual). Immunity from liability does not apply in cases of wilful intent, unreasonable acts beyond the scope of DSW training, or if a criminal act is committed.

  Convergent volunteers (those who have not pre-registered, or been impressed into service) not listed as DSW volunteers, have some liability protection for disaster service under the Good Samaritan statutes. They are not, however, provided immunities to the extent as registered DSW volunteers and are not covered for workers' compensation insurance through the DSW Volunteer Program.

3.5.4 Professional Liability - Guideline and Recommendation

It is recommended that non-licensed healthcare facilities be provided with, and review, a list of qualified immunities to: (1) be aware of the liability protections that exist for various personnel and (2) to apply this knowledge in developing staffing plans and policies and procedures.

Additionally it is recommended that education of these liability protections be provided for personnel at all levels (e.g., management, practitioners, and support staff), hand-in-hand with education about the flexibility to provide "out of scope" services.

3.5.4.1 List of Qualified Immunities

To some extent, the Legislature has already recognized liability in an emergency. There are several statutes providing qualified immunity to persons rending aid during an emergency. These immunity provisions instruct the courts not to impose liability in specified emergency circumstances. Thus, if the immunity applies, there can be no liability. This, in turn, may reduce the need for a suspension of regulatory requirements, because the immunity already contemplates that the standard of care is altered in emergency circumstances.

Qualified immunities refer to the immunity from civil liability that is afforded within a certain range of circumstances, as by a requirement of good faith or due care. Below are the qualified immunities that would be applicable to volunteer and contracted personnel.

Qualified Immunities for Volunteer Personnel - The Volunteer Protection Act of 1997 states that no volunteer of a nonprofit organization or governmental entity shall be liable for harm caused by an act or omission of the volunteer on behalf of the organization or entity if: (1) the volunteer was acting within the scope of the volunteer's responsibilities...etc. (2) if appropriate or required, the volunteer was properly licensed, certified, or authorized by the appropriate authorities...etc. This statute is very broad and may apply in broad circumstances, so long as summoned by a proper authority, and possesses the required first aid and emergency care training; immunity from liability appears to exist for providing any service that could fall within the definition of emergency services. For the purposes of this statute, emergency services includes but is not limited to first aid and medical services, rescue procedures, and transportation or other related activities necessary to insure the safety of the victim who is the object of a search or rescue operation.

California Civil Code §§ 1714.2 and 1714.21 states that if trained in basic CPR by the AHA or ARC and in good faith renders CPR at the scene of an emergency is not liable for any civil damages unless grossly negligent. Not applicable to those expecting compensation (e.g., staff/volunteers trained in CPR who renders aid during duty hours). A person is not liable for any civil damages if rendered AED (defibrillator) at the scene of an emergency, if complied with applicable requirements of Health and Safety Code §1797.196.

Qualified Immunities for Contracted Services - Good Samaritan Statutes outline qualified immunities for contracted healthcare personnel providing services in an emergency situation. California Business & Professional Code § 1627.5 applies to dentists and states that no person licensed under this chapter **[dentists]**, who in good faith renders emergency care at the scene of an emergency occurring outside the place of that person's practice, or who, upon the request of another person so licensed, renders emergency care to a person for a complication arising from prior care of another person so licensed, shall be liable for any civil damages as a result of any acts or omissions by that person in rendering the emergency care.

California Business & Professional Code § 2395 applies to physicians and surgeons and states that no licensee, who in good faith renders emergency care at the scene of an emergency or during a medical disaster, shall be liable for any civil damages as a result of any acts or omissions by such person in rendering the emergency care. "The scene of an emergency" as used in this section shall include, but not be limited to, the emergency rooms of hospitals in the event of a medical disaster. "Medical disaster" means a duly proclaimed state of emergency or local emergency declared pursuant to the California Emergency Services Act (Chapter 7 (commencing with Section 8550) of Division 1 of Title 2 of the Government Code). Acts or omissions exempted from liability pursuant to this section shall include those acts or omissions which occur after the declaration of a medical disaster and those which occurred prior to such declaration but after the commencement of such medical disaster. The immunity granted in this section shall not apply in the event of a willful act or omission.

California Business & Professional Code § 2727.5 applies to nurses and states that a person licensed under this chapter **[nurse]** who in good faith renders emergency care at the scene of an emergency which occurs outside both the place and the course of that person's employment shall not be liable for any civil damages as the result of acts or omissions by that person in rendering the emergency care. This section shall not grant immunity from civil damages when the person is grossly negligent.

California Business & Professional Code § 2861.5 applies to licensed vocational nurses and states that a person licensed under this chapter **[licensed vocational nurse]** who in good faith renders emergency care at the scene of an emergency which occurs outside both the place and the course of his employment shall not be liable for any civil damages as the result of acts or omissions in rendering the emergency care. This section shall not be construed to grant immunity from civil damage to any person whose conduct in rendering emergency care is grossly negligent.

California Business & Professional Code § 3503.5 applies to physician's assistants and states that a person licensed under this chapter **[physician's assistant]** who in good faith renders emergency care at the scene of an emergency that occurs outside both the place and course of that person's employment shall not be liable for any civil damage as a result of any acts or omissions by that person in rendering the emergency care. This section shall not be construed to grant immunity from civil damages to any person whose conduct in rendering emergency care is grossly negligent. In addition to the immunity specified in subdivision (a), the provisions of Article 17 (commencing with Section 2395) of Chapter 5 shall apply to a person licensed under this chapter when acting pursuant to delegated authority from an approved supervising physician.

Qualified Immunities for Paid Personnel - Immunities for paid personnel would fall under the authority of the employer. Paid personnel are subject to the terms and conditions of the employment agreement between an employer and the employee.

4 Supplies, Pharmaceuticals and Equipment

Under non-surge conditions, there are existing processes for healthcare facilities to access, procure, store and distribute supplies, pharmaceuticals, and equipment. During a surge, these processes may be altered and new processes needed to ensure that each operational level can obtain potentially scarce resources in a timely manner. This chapter outlines processes for acquiring supplies, pharmaceuticals, and equipment pre-surge and during a surge, as well as the liability, licensing and regulatory implications for their distribution and deployment.

Key definitions for the purposes of this chapter are:

- Supplies are defined as durable and consumable goods which are essential in carrying out the treatment of a patient's illness or injury.
- Pharmaceuticals are any prescription medications, over the counter drugs and/or nutraceuticals administered to persons to diagnose, treat, or prevent disease or other abnormal conditions.
- Equipment is fixed or portable equipment used for diagnosis, treatment, monitoring and direct care of individuals.
- Acquisition is defined as the process of acquiring supplies, pharmaceuticals, and equipment from various sources via procurement, stockpiles, caches, and other sources.
- Procurement is the process of obtaining supplies, pharmaceuticals, and equipment via contracts, government requests, and mutual aid that includes an arrangement of payment. Procurement is considered a subset of access.

4.1 Acquisition of Pharmaceuticals

The following section on Pharmaceuticals offers non-licensed healthcare facilities a tool that can be used when preparing for pharmaceutical needs during a surge.

For facilities with on-site pharmacies, pharmacy inventory levels are closely scrutinized and the challenge is often to move as close as possible to just-in-time (JIT) to enhance financial performance. The pharmacy wholesalers support these JIT efforts by providing deliveries five to six days per week. Additionally, wholesalers provide pharmacies access to historical purchase data and software tools to easily establish par levels, reorder points and reorder quantities. "Par Levels are the maximum desirable number of pharmaceuticals determined. The reorder quantity equals the number of units below this predetermined number."[171] Despite the frequency of deliveries, pharmacies must plan for the gaps in delivery service, e.g., 24-48 hours at a minimum, and establish par levels accordingly, therefore creating a barrier to a true JIT system.

A limitation often seen with the calculation of par levels is that they are established using "averages", and therefore do not account for significant variations in utilization that are sometimes seen in facilities, e.g., a sudden increase in the use of an antimicrobial due to seasonality changes. To compensate for the gaps in delivery service and the limitations of par level calculations, pharmacies identify key pharmaceuticals that are critical to patient care and adjust par levels on these products accordingly.

The decision as how to utilize this tool is site dependent, based on the existing complexity of services offered, volume expectations during a surge, and the needs of the community. Due to

the financial impact, the decision to increase existing inventories and/or cache a supply a pharmaceuticals to accommodate a surge event should be made in conjunction with facility leadership with consideration given to the specific risks that the facility has identified in its Hazard Vulnerability Analysis (HVA) if one has been completed.

It will depend on the function of each facility to determine what specific pharmaceuticals are needed. There is current planning to have the use of caches and stockpiles available, but there are certain surge scenarios such as a pandemic outbreak that may warrant a facilities operating for an extended period of time. If that is the case, the ordering of types of pharmaceuticals at a non-licensed healthcare facility may have to be accomplished. A good reference to utilize when ordering types of drugs is the Disaster Medical Assistance Team (DMAT) Rx list. DMAT caches were utilized in Hurricane Katrina and the comprehensive nature assumes that a facility is starting with no resources. Due to the extensive nature of this list, existing facilities and public health officials can gain access to this list through their Local Health Officer (LHO).

When resources allow, or are available within the community, strong consideration should be given to involving key stakeholders in the planning process. The following list is not comprehensive.

- Clinical Pharmacists
- Disaster Coordinators
- Emergency Department Directors
- Emergency Department Physicians
- Respiratory Therapists
- Pulmonologists
- Critical Care Director
- Infectious Disease Physicians
- Poison Control Specialists
- Drug Information Specialists
- Radiologists
- Radiation Safety Officers
- Hospital Administrators
- Pediatric Specialists (Pediatric Critical Care / Emergency Medicine Physicians)
- Vendors and Distributors

4.1.1 Basic Inventory Approach – Pharmaceuticals

The Basic Inventory Approach is designed to build upon **existing** practices within pharmacy operations and develop a systematic approach to establishing baseline inventory levels to sustain normal operations for 72-96 hours. Because of existing gaps in delivery, many pharmacies may currently be operating at or near these levels. This approach helps create a baseline inventory for normal operations for 72-96 hours. The use of an “80/20 report” is recommended if possible. An 80/20 report is a commonly used report provided by pharmacy wholesalers. This report is often used to identify which of the top dollar volume drugs are driving changes in the drug expenses for the institution. The intent of the "80/20 report" is that 200-300 lines of drugs represent 80-90% of the total dollars expended. To use this approach, simply refer to the process flow below and refer to an 80/20 report for guidance.

Pharmaceuticals – Basic Inventory Approach

Step 1

Obtain an "80/20" report from the pharmacy wholesaler

DISTRIBUTION CENTER	NDC	ITEM #	DESCRIPTION	FORM	STR	GENERIC GROUP	NET QTY	NET SALES	CUM SALES	CUM % of Total Sales
RALEIGH (B)	00075062040	270884	LOVENOX 40MG PFS 10X0.4ML	PFS	40	ENOXAPARIN SODIUM S.C.	384	$71,527.91	$71,527.91	6%
RALEIGH (B)	00173044202	453928	ZOFRAN 2MG/ML SDV 5X2ML	SDV	2	ONDANSETRON HCL	818	$68,507.50	$140,035.41	11%
RALEIGH (B)	00004196401	098772	ROCEPHIN 1 GM VL 10X10ML	VL	1	CEFTRIAXONE SODIUM	309	$67,924.36	$207,959.77	16%
RALEIGH (B)	00075062300	533844	LOVENOX 100MG PFS 10X1ML	PFS	100	ENOXAPARIN SODIUM	71	$33,148.09	$241,107.86	19%
RALEIGH (B)	55513082310	445890	EPOGEN S40 40M UN/ML VL 10X1ML	VL		EPOETIN ALFA	6	$26,983.08	$268,090.94	21%
RALEIGH (B)	00075062280	532770	LOVENOX 80MG PFS 10X0.8ML	PFS	80	ENOXAPARIN SODIUM	68	$25,239.31	$293,330.25	23%
RALEIGH (B)	57894004002	595579	RETAVASE HALF KIT	KIT		RETEPLASE	21	$23,859.53	$317,189.78	25%
RALEIGH (B)	00310030022	748897	DIPRIVAN 10MG/ML VL 25X20ML	VL	10	PROPOFOL	83	$22,845.54	$340,035.32	27%
RALEIGH (B)	08290094110	934861	NORMAL SALINE 0.9% W/CANN SYG 30X10ML	SYG		SODIUM CHLORIDE	1,457	$22,013.42	$362,048.74	28%
RALEIGH (B)	00074445604	232207	ULTANE PEN BTL LIQ 250ML	LIQ		SEVOFLURANE	97	$21,482.84	$383,531.58	30%

Step 2

Identify the items on the "80/20" report that the organization believes would be impacted during a surge

Step 3

Based on historical data, establish 72-96 hours par levels for these items

Step 4

If sterile solutions are on the list (e.g. Lactated Ringers, are obtained from a different vendor) identify the items that the organization believes would be impacted during a surge

Step 5

Based on Historical Data and vendor lead time, establish 72-96 hour par levels for these items

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

4.2 Planning for the Acquisition of Supplies and Equipment

The stockpiling of supplies and medical equipment will be paramount in the ability to function in a disaster. Similar to pharmaceuticals, the decision as to which methodology to use is site dependent based on the existing complexity of services offered and volume expected during a surge. Information from the Hazards Vulnerability Assessment should be utilized to assist in understanding site specific needs.

When resources allow, or are available within the community, strong consideration should be given to involving key stakeholders in the planning process such as:

- Materials Manager / Procurement
- Disaster Coordinator
- Emergency Department Director
- Respiratory Therapists
- Facilities / Logistics
- Medical-Surge Coordinator
- Critical Care Coordinator
- Pediatric Specialists (Pediatric Critical Care / Emergency Medicine Physicians)
- Vendors and Distributors

4.2.1 Inventory Based – Detailed Supplies and Equipment List

The Inventory Based - Detailed Supplies and Equipment List tool encourages planners to utilize a detailed list to guide the ordering of specific supplies and equipment. It allows organizations the flexibility to define the classes of supplies and equipment and determine whether caches are better suited for their organization, or if increasing par levels of existing inventory is a better strategy. The contents and quantities of the Disaster Resource Center (DRC) caches were originally developed by the Los Angeles County EMS Agency. The State EMS Authority developed a recommendation for Casualty Collection Points in the 1990's. This information was used as the starting point for the medical cache contents. Subsequently, the DRC Coordinator group has worked with the EMS Agency to refine these caches and address the perceived needs that would arise in a disaster. The number of patients that could be treated varies based on the type and mix of patients.[172] 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 surge scenario.

Inventory Based –Detailed Supplies and Equipment

Steps to consider when determining supplies and equipment needed during a surge at a Clinic.

Step 1	**1. Determine what supplies and equipment are already in stock**
Step 2	**Based on the number of potential patients to be treated during a surge, calculate the supplies and equipment needs for 72-96 hours**
Step 3	**Determine if the supplies and equipment will be part of the existing inventory or cached**

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 facility'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 existing facility, what is the quantity that may be part of the facility's cache either on-site or nearby.

The "Detailed Supplies and Equipment List" is shown below. The complete tool can be found in the Operational Tools Manual.

Development of Standards and Guidelines for Healthcare Surge During Emergencies
Supplies and Equipment that May Be Required During a Surge

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

SURGICAL SUPPLIES	Current Supply	Total Potential Requiring Treatment	Package Size (if applicable)	Quantity / Cache
Scalpel with blade, disposable #10				
Scalpel with blade, disposable #15				
Sterile gloves, sizes 6.5, 7.0, 7.5, and 8.0				
Surgical scrub brushes with betadine				
Suture set (disposable)				

Suture removal kit				
Suture (Nylon sutures various sizes)				
ORTHOPEDIC SUPPLIES	**Current Supply**	**Total Potential Requiring Treatment**	**Package Size (if applicable)**	**Quantity / Cache**
Splint, cardboard 12”				
Splint, cardboard 18”				
Splint, cardboard 24”				
Splint, cardboard 34”				
Splint, fiberglass 3”				
Splint, fiberglass 4”				
Splint, fiberglass 5”				
IV SETS, NEEDLES AND SYRINGES	**Current Supply**	**Total Potential Requiring Treatment**	**Package Size (if applicable)**	**Quantity / Cache**
IV Start Kits				
IV catheter, 18 gauge				
IV catheter, 20 gauge				
IV catheter, 22 gauge				
IV catheter, 24 gauge				
IV administration set, adult				
IV administration set, pediatric				
IV piggyback tubing				
Needle disposable, 18 gauge				
Needle disposable, 22 gauge				
Needle disposable, 25 gauge				
Syringe, 1ml				
Syringe, 3 ml				
Syringe, 5 ml				
Syringe, 10 ml				
Syringe, 20 ml				

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

Nasal cannula, adult				
Nasal cannula, pediatric				
02 mask with tubing, pediatric				
02 mask with tubing, adult				
02 mask - non-rebreather, adult				
Nebulizers – hand held				
Nebulizers – masks				
Ventilator circuits				
Suction machine, portable				
Suction catheters 10 french				
Suction catheters 12 french				
Suction catheters 14 french				
Yankauer suction				
Suction tubing				
Suction Canisters				
NG Tubes				
Thoracostomy Tubes, assorted sizes				
Pleurivac & Heimlich valves				
INFECTION CONTROL SUPPLIES	**Current Supply**	**Total Potential Requiring Treatment**	**Package Size (if applicable)**	**Quantity / Cache**
Cover/Isolation gowns				
Splash guard for wound irrigation				
Masks surgical				
Face shield with eye shield				
Masks N-95				
Patient exam gloves, small				
Patient exam gloves, medium				
Patient exam gloves, large				
Shoe covers				
Surgical caps				
Wipes, disposable				

MISCELLANEOUS SUPPLIES	Current Supply	Total Potential Requiring Treatment	Package Size (if applicable)	Quantity / Cache
Bags, plastic 30 gallon, 8 mil				
Batteries, C for laryngoscope handle				
Batteries, D for flashlights				
Blankets lightweight				
Clipboards				
Diapers, disposable large				
Diapers, disposable medium				
Diapers, disposable small				
Diapers, disposable, large, peds				
Diapers, disposable, medium, peds				
Diapers, disposable, small, peds				
Emesis basins, plastic				
Facial tissues				
Flashlights				
Gloves work type leather/canvas				
OB kits, disposable				
Paper towels				
Patient ID bands				
Styrofoam cups				
Tongue depressors, non sterile				
NON-DISPOSABLE MEDICAL SUPPLIES	**Current Supply**	**Total Potential Requiring Treatment**	**Package Size (if applicable)**	**Quantity / Cache**
Blood Pressure multi-cuff kit with adult, pediatric, infant and thigh cuff				
Glucometer kit with lancets, test strips and battery				
Portable Otoscope/Ophthalmoscope set with				

batteries				
Pulse Oximetry, portable				
Stethoscope				
Tourniquets 1”				
Trauma/paramedic scissors				
MISCELLANEOUS Equipment	**Current Supply**	**Total Potential Requiring Treatment**	**Package Size (if applicable)**	**Quantity / Cache**
Ventilators - dual use Adult/Pediatric				
Portable/disposable vents				
Equipment Trailer				
18 X 24 Tent				
10 X 10 Tent				
Temps Beds				
Simpler Life Cots				
Junkin Cots				
Blankets/Sleeping Bags/Linen				
Tables				
Chairs				
Lights				
Portable Generator				
Heating System/Fan				
HEPA Filtration System				
Staff Noticiation/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 handwashing				
Outdoor Lighting				

EZ Up Shades				
Security Upgrades and hardening				
Post Decontamination clothing sets				
Pharmacy Cache				
CHEMPACK location site				
Medical/Surgical Supply Cache				
Prime Mover (tow vehicle)				
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 radiatin injury within a 24-hour period.** **The goal is to be able to expand hospital capacity by 20-25% in the first 24 hours.**				

There are specific supplies and equipment to be considered that are specific to the pediatric population. In the specific tool for this section, the pediatric population is referenced, but to find more detailed information on the emergency care of the pediatric population, please refer to http://www.emsa.ca.gov/def_comm/vii032807_a.asp.

4.3 Distribution and Deployment

This section looks at how liability, licensing and regulatory issues impact the distribution and deployment of pharmaceuticals. These issues include:

- Waivers.
- Expired medications.
- The liability for off-label drug usage.
- Determining what designated personnel are allowed to distribute and / or disperse mediations during a surge and what their liability is.
- The liability of pharmacists, intern pharmacists, or pharmacy technicians who are not licensed in California, but who are licensed in good standing in another state, including those presently serving military or civilian duty.
- The delivery of pharmaceuticals to licensed and un-licensed sites (e.g. delivery of medications to an un-licensed dispensing site).
- The liability of using supplies and equipment beyond the manufacturer's recommended use (e.g. PPE).
- The liability for Non-Governmental Organizations (NGOs) for the distribution of medical and health supplies.

4.3.1 The California State Board of Pharmacy Waiver

The California State Board of Pharmacy plays a large responsibility in the function of pharmacists who play an intricate role in patients receiving needed medications. In a recent response to the potential of a surge, the California State Board of Pharmacy created a Disaster Response Policy Statement in January 2007 to ensure proper preparation and an effective response to any local, state, or national disaster. The purpose of the policy statement and potential waivers as part of the California Business and Professions Code, section 4062, subdivision (b) is to encourage pharmacists to do everything possible to do the most good for the largest amount of people.

This policy highlights that in the event of declared disaster or emergency, the Board expects to utilize its authority under the California Business and Professions Code, including sections 4005(b) and 4062, to encourage and permit emergency provision of care to affected patients and areas, including by waiver of requirements that it may be implausible to meet under these circumstances.[173] This takes into account what would be otherwise normal operating procedures that may not be able to be addressed during a surge such as record-keeping requirements, labeling requirements, employee ratio requirements, consultation requirements and other standard pharmacy practices and duties that may interfere with the most efficient response to those affected.

How the Waiver is communicated
In the event of the waiver, the State of California Board of Pharmacy would communicate this information to the Office of Emergency Services (OES) for them to distribute the information. Information would also be posted on their website at www.pharmacy.ca.gov and communicated via phone @ (916) 574-7900.

The Board expects licensees to apply their judgment and training to provide medication to patients in the best interests of the patients with circumstances on the ground dictating the extent to which regulatory requirements can be met in affected areas. The Board also expects

that the highest standard of care possible will be provided, and once the emergency has dissipated, its licensees will return to practices conforming to state and federal requirements.[174]

4.3.1.1 Tool - California State Pharmacy Board Disaster Policy Statement

The "California State Board of Pharmacy Disaster Response Policy Statement" is shown below. The complete tool can be found in the Operational Tools Manual.

This tool can be used a reference to understand the purpose of the California State Pharmacy Board waiver and how it will be utilized in the event of a surge.

California State Board of Pharmacy Disaster Response Policy Statement
The California State Board of Pharmacy wishes to ensure complete preparation for, and effective response to, any local, state, or national disaster, state of emergency, or other circumstance requiring expedited health system and/or public response. Skills, training, and capacities of board licensees, including wholesalers, pharmacies, pharmacists, intern pharmacists, and pharmacy technicians, will be an invaluable resource to those affected and responding. The board also wishes to encourage an adequate response to any such circumstance affecting residents of California, by welcoming wholesalers, pharmacies, pharmacists, intern pharmacists, and pharmacy technicians licensed in October 25 and 26, 2006, Board Meeting Minutes - Page 13 of 52 pages good standing in other states to assist with health system and/or public response to residents of California.

The board encourages its licensees to volunteer and become involved in local, state, and national emergency and disaster preparedness efforts. City or county health departments, fire departments, or other first responders can provide information on local opportunities. The Emergency Preparedness Office of the California Department of Health Services is a lead agency overseeing emergency preparedness and response in California, particularly regarding health system response, drug distribution and dispensing, and/or immunization and prophylaxis in the event of an emergency. At the federal level, lead contact agencies include the Department of Health and Human Services, the Centers for Disease Control, and/or the Department of Homeland Security and its Federal Emergency Management Agency (FEMA). Potential volunteers are encouraged to register and get information at www.medicalvolunteer.ca.gov (California) and www.medicalreservecorps.gov (federal).

The board also continues to be actively involved in such planning efforts, at every level. The board further encourages its licensees to assist in any way they can in any emergency circumstance or disaster. Under such conditions, the priority must be protection of public health and provision of essential patient care by the most expeditious and efficient means. Where declared emergency conditions exist, the board recognizes that it may be difficult or impossible for licensees in affected areas to fully comply with regulatory requirements governing pharmacy practice or the distribution or dispensing of lifesaving medications.

In the event of a declared disaster or emergency, the board expects to utilize its authority under the California Business and Professions Code, including section 4062, subdivision (b) thereof, to encourage and permit emergency provision of care to affected patients and areas, including by waiver of requirements that it may be implausible to meet under these circumstances, such as prescription requirements, record-keeping requirements, labeling requirements, employee ratio requirements, consultation requirements, or other standard pharmacy practices and duties that may interfere with the most efficient response to those affected.1 The board encourages its licensees to assist, and follow directions from, local, state, and national health officials. The board expects licensees to apply their judgment and training to providing medication to patients in the best interests of the patients, with circumstances on the ground dictating the extent to which regulatory requirements can be met in affected areas. The board further expects that during such

emergency, the highest standard of care possible will be provided, and that once the emergency has dissipated, its licensees will return to practices conforming to state and federal requirements.

Furthermore, during a declared disaster or emergency affecting residents of California, the board hopes that persons outside of California will assist the residents of California. To facilitate such Expanded powers in the event of a disaster are also granted to the Governor and/or other chief executives or governing bodies within California by the California Emergency Services Act [Cal. Gov. Code, §§ 8550-8668] and the California Disaster Assistance Act [Cal. Gov. Code, §§ 8680-8690.7], among others. Section 8571 of the Government Code, for instance, permits the Governor to suspend any regulatory statute during a state of war or emergency where strict compliance therewith would prevent, hinder, or delay mitigation. October 25 and 26, 2006, Board Meeting Minutes - Page 14 of 52 pages assistance, in the event of a declared California disaster or emergency, the board expects to use its powers under the California Business and Professions Code, including section 900 and section 4062, subdivision (b) thereof, to allow any pharmacists, intern pharmacists, or pharmacy technicians, who are not licensed in California but who are licensed in good standing in another state, including those presently serving military or civilian duty, to provide emergency pharmacy services in California. The board also expects to allow nonresident pharmacies or wholesalers that are not licensed in California but that are licensed in good standing in another state to ship medications to pharmacies, health professionals or other wholesalers in California.

Finally, the board also expects to allow use of temporary facilities to facilitate drug distribution during a declared disaster or state of emergency. The board expects that its licensees will similarly respond outside of the state to disasters or emergencies affecting populations outside California, and will pursue whatever steps may be necessary to encourage that sort of licensee response.

[1]Expanded powers in the event of a disaster are also granted to the Governor and/or other chief executives or governing bodies within California by the California Emergency Services Act [Cal. Gov. Code, §§ 8550-8668] and the California Disaster Assistance Act [Cal. Gov. Code, §§ 8680-8690.7], among others. Section 8571 of the Government Code, for instance, permits the Governor to suspend any regulatory statute during a state of war or emergency where strict compliance therewith would prevent, hinder, or delay mitigation.
[2]See also the Interstate Civil Defense and Disaster Compact [Cal. Gov. Code, §§ 177-178], the Emergency Management Assistance Compact [Cal. Gov. Code, §§ 179-179.5], and the California Disaster and Civil Defense Master Mutual Aid Agreement [executed 1950], regarding cooperation among the states.

4.3.2 Use of Expired Medications

In a surge scenario, there is the potential for a shortage of appropriate medications. An example could be a pandemic flu outbreak. Specific virals and vaccines may be indicated and there may not be an adequate amount available for use. The government may prepare by stockpiling exactly for this type of situation and there is the possibility that the medications may become expired. This may become a dilemma if medical personnel have the indicated medication at their disposal, but question their liability in using the product and the efficacy of the medication to provide the desired results. Approved drugs are tested for stability and the expiration dates are based on those tests. Only the FDA can approve the use of expired medications. Restrictions on pharmacists dispensing expired drugs could be waived by the Pharmacy Board which will be situation dependent. An emergency proclamation changing the standard of care could also provide protection.

4.3.3 Off – Label Drug Use

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

There is no statutory or regulatory prohibition against off-label use of a drug by a physician. Consequently, pharmacists may dispense pharmaceuticals without being out of compliance. The only limitation on such off-label use is the law of medical malpractice. The more a drug is used for off-label purposes, the lower the likelihood that such use will be considered a breach of the standard of care owed to the patient. A proclamation of an emergency could include a provision making the standard of care the prevention of the greatest loss of life, which could allow some off label uses even if not generally accepted by the medical community, but consistent with the goal of saving a life.

4.3.4 Distribution and/or Dispensing of Pharmaceuticals by non-licensed Pharmacists

During a surge, there is a possibility that there may not be a licensed Pharmacist on-site to dispense pharmaceuticals or oversee the process from a liability perspective. The California Business and Professions Code, Section 4051 states that "it is unlawful for any person to manufacture, compound, furnish, sell, or dispense any dangerous device, or to dispense or compound any prescription pursuant to Section 4040 of a prescriber unless he or she is a pharmacist under this chapter." [175] Situations when a Pharmacist may authorize the initiation of a prescription to non-licensed pharmacists/healthcare providers:

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

To address this, the California State Board of Pharmacy may waive application of any provisions of this chapter or the regulations adopted if, in the Pharmacy Board's opinion, the waiver will aid in the protection of public health or the provision of patient care during a declared federal, state, or local emergency as noted in California Business and Professions Code, Sections 4005(b) and 4062." [175]

4.3.5 Licensing of Dispensing Sites and Sites External to Hospitals

As noted in the California Board of Pharmacy rules and regulations, Article 3, Section 4059.5.(a), drugs may be ordered by a licensed pharmacy and delivered to the licensed premises, and must be signed for by a pharmacist.[176] To the extent possible, Non-Licensed Healthcare Facilities are encouraged to work with the Board of Pharmacy to identify themselves as pharmaceutical dispensing sites if that is there purpose to expedite approval. This would minimize any potential delays in getting pharmaceuticals delivered to external sites in the event of a surge situation. A pharmacist's educational background and experience should be utilized in this situation to understand if the appropriate medications have been delivered in the correct quantities so they can then utilize the pharmaceuticals in the most efficient manner.

4.3.6 Out – of State Licensed Pharmacists, Intern Pharmacists and/or Pharmacy Technicians

With the possibility for limited Pharmacy staff in a surge scenario, many volunteers may present to any location where care is being provided (e.g. hospital, ACS, clinic, dispensing site) to assist in providing services that a Pharmacist, Intern Pharmacist and/or Pharmacy Technician would provide under normal operating procedures. To effectively utilize this type of volunteer it is essential to prepare for this situation and understand their potential capacity and liability.

The California State Board of Pharmacy encourages that persons outside of California will assist the residents of California. In the event of a declared disaster or emergency, the Board expects to use it powers under the California Business and Professions Code, including section 900 and sections 4005(b) and 4062 to allow any pharmacists, intern pharmacists, or pharmacy technicians, who are not licensed in California, but who are licensed in good standing in another state, including those presently serving military or civilian duty, to provide emergency pharmacy services in California.[177]

Nonresident pharmacies or wholesalers that are not licensed in California but that are licensed in good standing in another state are encouraged to ship medications to pharmacies, health professionals or other wholesalers in California.

4.3.7 Furnishing Medications without a Prescription

During a surge, there may be limited time to receive a prescription from a Physician. Therefore Section 4062, subdivision (a) states that a Pharmacist may in good faith, furnish a dangerous drug or dangerous device in reasonable quantities without a prescription during a federal, state or local emergency, to further the health and safety of the public.[178] This section states that a record containing the date, name, and address of the person to whom the drug or device is furnished, and the name, strength, and quantity of the drug or device furnished shall be maintained. The pharmacist shall communicate this information to the patient's attending physician as soon as possible.

4.3.8 The Use of Supplies and Equipment beyond the Manufacturers Recommended Use

In a surge scenario there is the possibility that medical supplies and equipment may be used in a different manner than its intended use which brings into consideration liability and reimbursement. An example is the use of an adult intubation kit on a pediatric patient.

The Federal Food, Drug & Cosmetic Act, Chapter V, Subchapter E, Sec. 564 [21 USC 360bbb-3] - Authorization for Medical Products for Use in Emergencies subdivision states that the Secretary may authorize the introduction into interstate commerce, during the effective period of a declaration under subsection (b), of a drug, device, or biological product intended for use in an actual or potential emergency (referred to in this section as an "emergency use").

5 Operations

This chapter focuses on six primary areas with respect to healthcare professionals and how their practice, the way in which they provide care at a non-licensed healthcare facility, will be affected during a healthcare surge. Topics discussed include:

(1) Regulations and standards that may present barriers to timely and effective delivery of care during a surge and any applicable liability protections.
(2) Surge capacity strategies including guidance for triage, discharge planning and case management.
(3) The methods by which the way professionals will manage and prioritize patients differ, all in an effort to switch in focus from patient-based outcomes to population-based outcomes.
(4) The way in which healthcare professionals will have to alter the way they document information in the patient's medical record;
(5) Considerations healthcare professionals must take with regards to patient tracking, and how this becomes integral in the healthcare surge response;
(6) The impact of HIPAA;
(7) Decontamination and infection control strategies.

5.1 Regulations, Standards and Liability Protection

During a healthcare surge, patient care capacity will be expanded to set up care areas for an influx of a large number of patients. This will mean that facilities may be unable to comply with certain regulatory and standards requirements, including those for:

- Scope of Practice and Treatment Methods
- Using non-clinical areas for clinical purposes
- Patient Management
- Patient Restraints
- Clinical Laboratory Improvement Act

This section provides an overview of the current compliance requirements for these areas as well as a list of any applicable waivers and available liability protections that may be available to facilities during surge.

5.1.1 Scope of Practice and Treatment Methods

Healthcare providers will be faced with extenuating circumstances during which they may have to provide patient care services for which they may not be licensed or treat patients using "non-traditional" treatment means. As a result, non-licensed healthcare facilities may need the following scope of practice for personnel and scope of services at facilities requirement to be flexed during a surge:

- Primary care clinics (per CCR 22 §75026) are to provide only those services for which it is organized, staffed and equipped.

To address the scope of services and treatment means compliance requirement mentioned above, non-licensed healthcare facilities should be aware of the following waiver for scope of services:

- The Governor – under Government Code §8571 – has the authority during a state of war emergency or a state of emergency to suspend any regulatory statute, or statute prescribing the procedure for conduct of state business, or the orders, rules, or regulations of any state agency, including subdivision (d) of Section 1253 of the Unemployment Insurance Code, where the Governor determines and declares that strict compliance with any statute, order, rule, or regulation would in any way prevent, hinder, or delay the mitigation of the effects of the emergency.

5.1.2 Non-Clinical Areas for Clinical Purposes

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

- The National Fire Protection Association (NFPA) standards (19.1.1.4.4) stipulate that for existing health care occupancies, a change from one health care occupancy sub-classification to another shall require compliance with the requirements for new construction. With respect to existing ambulatory health care facilities, sections of facilities shall be permitted to be classified as other occupancies, provided that they meet all of the following conditions: (1) they are not intended to serve ambulatory health care occupants for purposes of treatment or customary access by patients incapable of self-preservation and (2) they are separated from areas of ambulatory health care occupancies by construction having a fire resistance training of not less than 1 hour. (NFPA standards 21.1.2.1)

At this time, there is no known process to flex NFPA standards.

5.1.3 Patient Management

Standard of Care during a healthcare surge will necessitate managing patients in a manner that will save as many lives as possible. There are several regulatory/standards requirements that relate to managing patients:

5.1.3.1 JCAHO

As it relates to triage of patients during a healthcare surge for healthcare facilities, JCAHO's Environment of Care stipulates the following Standard: EC.4.18 - The organization establishes strategies for managing clinical activities during emergencies: The fundamental goal of emergency management planning is to protect life and prevent disability. The manner in which care, treatment and services are provided may vary by type of emergency. However, certain clinical activities are so fundamental to safe and effective care that the organization should determine how it will re-schedule or manage patient clinical needs even under the most dynamic situations or in the most austere care environments. (Note, these standards will be effective January 1, 2008) Non-licensed healthcare facilities can use JCAHO's guidance to develop strategies for managing clinical activities during emergencies. However, these standards are not applicable to these types of organizations.

The emergency triage process will typically result in patients being quickly treated and discharged, admitted for a longer stay, or transferred to a more appropriate source of care. It is especially important to identify and triage patients whose clinical needs are outside of the usual scope of service of the organization. A catastrophic emergency may result in the decision to keep all patients on the premises in the interest of safety, or conversely may result in the decision to

evacuate all patients because the facility is no longer safe. Planning for clinical services must address these situations accordingly.

Currently there is no authority to waive or flex JCAHO standards.

5.1.4 Patient Restraints

Certain circumstances could warrant the use of patient restraints for the safety of the patient, other patients and staff. Regulations that apply include:

- Welfare and Institutions Code, 5150: When any person, as a result of mental disorder, is a danger to others, or to himself or herself, or gravely disabled, a peace officer, member of the attending staff, as defined by regulation, of an evaluation facility designated by the county, designated members of a mobile crisis team provided by Section 5651.7, or other professional person designated by the county may, upon probable cause, take, or cause to be taken, the person into custody and place him or her in a facility designated by the county and approved by the state Department of Mental Health as a facility for 72-hour treatment and evaluation.

  Such facility shall require an application in writing stating the circumstances under which the person's condition was called to the attention of the officer, member of the attending staff, or professional person, and stating that the officer, member of the attending staff, or professional person has probable cause to believe that the person is, as a result of mental disorder, a danger to others, or to himself or herself, or gravely disabled. If the probable cause is based on the statement of a person other than the officer, member of the attending staff, or professional person, such person shall be liable in a civil action for intentionally giving a statement which he or she knows to be false.

- California Administrative Code, Title 13, Section 1103.2 - Ambulance Emergency Care Equipment and Supplies: Any equipment or supplies carried for use in providing emergency medical care must be maintained in clean condition and good working order. (a) Essential equipment and supplies to be carried shall include as a minimum: (2) Straps to secure the patient to the stretcher or ambulance cot, and means of securing the stretcher or ambulance cot in the vehicle.

- Health and Safety Code, Section 1798.6: (a) Authority for patient health care management in an emergency shall be vested in that licensed or certified health care professional, which may include any paramedic or other pre-hospital emergency personnel, at the scene of the emergency who is most medically qualified specific to the provision of rendering emergency medical care. If no licensed or certified health care professional is available, the authority shall be vested in the most appropriate medically qualified representative of public safety agencies who may have responded to the scene of the emergency. (b) If any county desires to establish a unified command structure for patient management at the scene of an emergency within that county, a committee may be established in that county comprised of representatives of the agency responsible for county emergency medical services, the county sheriff's department, the California Highway Patrol, public pre-hospital-care provider agencies serving the county, and public fire, police, and other affected emergency service agencies within the county. The membership and duties of the committee shall be established by an agreement for the joint exercise of powers under Chapter 5 (commencing with Section 6500) of Division 7 of Title 1 of the Government Code. (c) Notwithstanding subdivision (a), authority for the management of the scene of an emergency shall be vested in the appropriate public safety agency having primary investigative authority. The scene of an emergency shall be managed in a manner designed to minimize the risk of death or health impairment to the patient and to other persons who may be exposed to the risks as a result of the emergency condition, and priority shall be placed upon the interests of those persons exposed to the

more serious and immediate risks to life and health. Public safety officials shall consult emergency medical services personnel or other authoritative health care professionals at the scene in the determination of relevant risks.

- In addition to the above regulations, CCR, Title 22, Sections 1000075 & 1000159 apply.

- Guidance on policy and procedures associated with patient restraints can be obtained from San Diego County Division of Emergency Medical Services - Policy Procedure Protocol (Pg 48), July 2002. The document can be accessed via: http://www2.sdcounty.ca.gov/hhsa/documents/EMS-TreatmentProt2004Rev6_30_04Part3.pdf

5.1.5 Clinical Laboratory Improvement Act (CLIA)

Recognizing that not all non-licensed healthcare facilities will have the ability to setup a laboratory during a healthcare surge, the following guidance is included to assist those facilities that may be able to respond in this way during a surge.

- As it relates to a facility's ability to setup a laboratory during a healthcare surge, the CLIA statutes are very prescriptive and prohibit any facility from receiving or testing human specimens unless the facility is CLIA certified. Certification requirements include an application, assurances of compliance, and a site survey. A CLIA waiver requires pre-approval based on an application, and limited scope of testing (42 USC 263a(d)(2).) Since the effect of this necessitates pre-approval, it does not appear possible to secure a waiver prior to a declared emergency.

There are two suggested options that non-licensed healthcare facilities can utilize to prepare for a surge:

1. Have a CLIA waiver prepared and ready for submission in the event of a declared emergency. This would expedite things on the facility's end, but would still require time for federal processing to approve and issue the waiver.
2. Request via the Governor to the Secretary of Health and Human Services a temporary suspension of the requirements under CLIA to obtain a Certificate or a certificate of waiver to perform simple laboratory examinations and procedures. There is authority under 42 USC 247d for the Secretary to take appropriate action in the event of a public health emergency.

5.1.6 Liability Protection

Current legislation provides facilities with liability protection, including:

- *Government Code §8659* states that any physician or surgeon (whether licensed in this state or any other state), hospital, pharmacist, nurse, or dentist who renders services during any state of war emergency, a state of emergency, or a local emergency at the express or implied request of any responsible state or local official or agency shall have no liability for any injury sustained by any person by reason of such services, regardless of how or under what circumstances or by what cause such injuries are sustained; provided, however, that the immunity herein granted shall not apply in the event of a willful act or omission.

- *Civil Code §1714.5* which deems that there shall be no liability on the part of one, including the state of California, county, city and county, city or any other political subdivision of the state of California, who owns or maintains any building or premises which have been designated as a shelter from destructive operations or attacks by enemies of the United

states by any disaster council or any public office, body, or officer of this state or of the United states, or which have been designated or are used as mass care centers, first aid stations, temporary hospital annexes, or other necessary facilities for mitigating the effects of a natural, manmade, or war-caused emergency, for any injuries arising out of the use thereof for such purposes sustained by any person while in or upon said building or premises as a result of the condition of said building or premises or as a result of any act or omission, or in any way arising from the designation of such premises as a shelter, or the designation or use thereof as a mass care center, first aid station, temporary hospital annex, or other necessary facility for emergency purposes, except a willful act, of such owner or occupant or his servants, agents or employees when such person has entered or gone upon or into said building or premises for the purpose of seeking refuge, treatment, care, or assistance therein during destructive operations or attacks by enemies of the United states or during tests ordered by lawful authority or during a natural or manmade emergency. No disaster service worker who is performing disaster services ordered by lawful authority during a state of war emergency, a state of emergency, or a local emergency, as such emergencies are defined in Section 8558 of the Government Code**,** shall be liable for civil damages on account of personal injury to or death of any person or damage to property resulting from any act or omission in the line of duty, except one that is willful.

- *Civil Code §1714.6* states that the violation of any statute or ordinance shall not establish negligence as a matter of law where the act or omission involved was required in order to comply with an order or proclamation of any military commander who is authorized to issue such orders or proclamations; nor when the act or omission involved is required in order to comply with any regulation, directive, or order of the Governor promulgated under the California Emergency Services Act. No person shall be prosecuted for a violation of any statute or ordinance when violation of such statute or ordinance is required in order to comply with an order or proclamation of any military commander who is authorized to issue such orders or proclamations; nor shall any person be prosecuted for a violation of any statute or ordinance when violation of such statute or ordinance is required in order to comply with any regulation, directive, or order of the Governor promulgated under the California Emergency Services Act. The provisions of this section shall apply to such acts or omissions whether occurring prior to or after the effective date of this section.

- On a state level, limited liability protection is available through Health and Safety Code §1317 which states that no health facility, its employees, physician, dentist, clinical psychologist or podiatrist shall be liable in any action arising from refusing to render emergency care if based on a determination, exercising reasonable care, the person is not suffering from an emergency medical condition, or the health facility does not have the appropriate facilities or qualified personnel available to render those services. The same applies to any “rescue team” if resuscitation efforts are attempted and in good faith.

These protections only provide relief at the state level and for state-run programs. Thus, it is recommended that similar protection be afforded at a federal level.

It is further recommended that regulatory and compliance framework be flexible so that in the event of a healthcare surge, declaration of waivers leads surge response and affords healthcare providers the required flexibility and compliance and liability protection to provide care. Specifically:

- Expanding *Government Code §8659* to include all existing facilities as defined in this guide.
- Expanding *Government Code §8659* to include liability protection for facilities where volunteers present at facilities through informal channels. For example, for volunteers that are not sourced through ESAR-VHP,[179] instead those that directly present at facilities. Another option would be to federalize such volunteers, which means that such volunteers would be

considered employees of the federal government sourced through Department of Health Services.

- During most healthcare surge events, facilities will experience surge before a formal emergency is declared. In order to protect facilities, waivers accompanying the declaration should be retroactive to experience of surge.
- Waivers should not be specific to a certain set of regulations (for example, Title 22), but should be broad, yet appropriate for the circumstances. Facilities require a mechanism by which they can determine what level of care should be provided and what regulations should be complied with based on the type of declaration.
- Governor's request for waiver of federal requirements must be initiated for local as well as state emergencies.
- Waiver should be for suspension of regulations as well as enforcement.
- Beyond the waivers discussed in this manual, state should make available a list of specific laws and regulations that can and cannot be waived during a healthcare surge (for example, list of sections of Title 22 that might not be waived). In addition, waiving certain regulations might not be sufficient since providing care during a healthcare surge is likely to violate other related regulations. Facilities require specific guidance that provides them the necessary means to operate outside of license.
- Counties need to establish a formal surge mechanism which will have a measure of presumption or automatic confirmation that facilities are free to provide care during healthcare surges. Another option to consider would be a stand-by prior program flex approval conditioned upon declaration of disaster and compliance with as much as possible under the circumstances.

The occurrence of a healthcare surge will require significant changes in the way in which health and medical care is delivered. If the healthcare system is to optimize population outcomes, planning, education, and training efforts should be focused on the development and implementation of appropriate protocols for Standard of Care during a Healthcare Surge.

5.2 Minimum Requirements for Medical Record Documentation

During a disaster scenario it may be reasonable to expect that most healthcare resources will be devoted to patient care and that administrative functions may need to be reduced to minimum requirements. It is recommended that non-licensed healthcare facilities and the affiliated healthcare professional staff use their standard medical record documentation if the surge event does not impact the ability to complete medical record documentation. Alternatively, the following information recommends minimum requirements for medical record documentation during healthcare surge.

5.2.1.1 Tool - Sample Short Form Medical Record

The following sample short form is an example of the type of medical record that could be initiated for a patient during a surge as needed. The short form medical record can be initiated during a surge and should be utilized to capture pertinent assessment, diagnosis, and treatment information. This short form is not expected to meet existing medical records documentation requirements. Rather it serves as a recommended set of elements that can be considered as accepted documentation during healthcare surge.

The “Short Form Medical Record” is shown below. The complete tool can be found in the Operational Tools Module.

This document should be completed for victims seeking medical attention.

Demographic
Patient Demographic Information - include patient name, date of birth, parent/guardian, disaster incident number (DIN) 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 sticker could be affixed in place of handwriting the information.

History

- Chief Compliant - enter patient's primary complaint upon presenting for care
- Significant Medical History - enter notes on patient's medical history
- Glasgow Coma Scale - enter score for each area
- Field Triage Category - enter category
- Site Triage Category - enter category
- Pupil Size - enter pupil size
- Reactive - circle yes/no
- Pain - circle patient's level of pain
- Temp - indicate patient's temperature
- Pulse - indicate patient's pulse
- Respiration - enter patient's rate of respiration
- Blood Pressure - enter patient's systolic and diastolic blood pressure
- Intake - enter patient fluid intake
- Output - enter patient fluid output
- Special Dietary Needs - enter patient's special dietary needs
- Medications - indicate medications the patient is currently taking including name, dose, route, and time
- Last Menstrual Period - indicate last period
- Pregnancy Status - indicate status

Physical Exam

- Physical Exam - This section should be utilized to capture comments relative to the assessment of the patient's cardiovascular, pulmonary, and other body systems.

Re-Assessment

- This section is to be completed as a secondary assessment prior to a procedure. It includes a place for a set of vital signs and any lab results.

Procedure / Disposition

- This section of the form includes space to document the following:

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

Demographic

Patient Name:_____ DOB/Age:_____

Parent / Guardian:_____ Primary Physician:_____

DIN:_____ MRN:_____

Allergies:_____ ☐ NKA

History

Chief Complaint:_____

Significant Medical History:_____

Last Menstrual Period:_____ Pregnancy Status:_____

Glasgow Coma Scale	
Eye	
Motor	
Verbal	
Total	

Field Triage Category: _____ Site Triage Category:_____

Pupil Size L:_____ Reactive: ☐ Yes ☐ No

Pupil Size R:_____ Reactive: ☐ Yes ☐ No

Circle pain (Adult): 0 (no pain) 1 2 3 4 5 6 7 8 9 10 (worst pain)

Circle pain[1] (Child/Other

Time recorded:			
Temp:			
Pulse:			
Respiration:			
Blood Pressure:			

Notes:_____

Intake		Output	
Total		Total	

Special Dietary Needs:_____

Medications

Name	Route		Dose	Time Frequency

Physician initials: _____ Nurse initials:_____ Other initials:_____

Physical Exam

Cardiovascular:_____ Pulmonary:_____

Neurological:_____

Other Significant Findings:_____

Physician initials:_____

Re-Assessment

Date:_____ Time:_____

System Review: Temp:____ Pulse:____ Respiration:____ Blood Pressure:____

Lab Results:_____ X-ray Results:_____

Physician initials: _____ Nurse initials:_____ Other initials:_____

Procedure / Disposition

Pre-Procedure DX:_____ Post-Procedure DX:_____

Procedure:_____ Findings:_____

Condition of Patient Post Procedure: ☐ Critical ☐ Guarded ☐ Stable

Discharge Instructions (YES/NO): Written_____ Verbal_____

Diet: ☐ Regular ☐ Soft ☐ Liquid ☐ Other:_____

Activities: ☐ No Restrictions ☐ Restrictions as Follows:_____

Discharge Medications:_____

Follow-Up Visit: When_____ NA:_____

Condition at discharge: ___ Critical ___ Guarded ___ Stable ___ Fair ___Deceased

___ Temp ___Pulse ___Respiration ___Blood Pressure

Discharge: ☐ Home ☐ Shelter ☐ ACS ☐ SNF ☐ Deceased Date: _____

☐ Transfer:_____ ☐ Other:_____ Time: _____

Admitted: ☐ Time admitted:_____

Physician order:_____

_____

Notes: _____

_____

Physician initials: _____ Nurse initials:_____ Other initials:_____

Wong, DL, Hockenberry-Eaton M, Wilson D, Winkelstein ML, Schwartz P: *Wong's Essentials of Pediatric Nursing*, ed. 6, St. Louis, 2001, p.1301.

5.3 Patient Tracking

Although electronic tracking systems are preferred, in cases where electronic systems are unavailable, paper-based tracking could serve as a viable alternative. Suggestions are provided

for inter-facility tracking. The recommendations in this section are based on the following major concepts:

- *Collect minimum necessary data:* Given that an unanticipated disaster may severely limit the capability of the healthcare system to obtain and transfer information, a manual tracking system should be simple to use and focus on collecting minimum data elements.
- *Assign patients a unique identifier:* A fundamental component of an effective tracking system will be to establish a unique patient identifier or "disaster incident number" (DIN).
- *Allow healthcare facilities to focus on treatment:* It is recommended that the operational area MHOAC be responsible for collecting tracking information from the hospitals within its jurisdiction. The American Red Cross or other appropriate agency could then be responsible for collecting the information and making it available to the public. Treatment facilities would therefore be able to direct inquiries to these information sources and focus on delivering care to patients.
- *Patient tracking (vs. person tracking) is a priority:* Tracking persons who have sought treatment at healthcare system entry points (e.g. Existing Facilities, Alternate Care Sites, EMS) during surge is a priority versus 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. However, for the purposes of this section a focus on patient tracking is recommended.
- *Paper-based tracking is an essential contingency:* Although significant efforts are underway to develop robust electronic patient tracking systems for disaster and emergency purposes, manual back-up processes should be maintained in case of system outage. Additionally, 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.

The remaining portions of this section describe the critical components of paper-based patient tracking including the definition and use of a "disaster incident number", policies and procedures for patient tracking, and a sample patient tracking form.

5.3.1 Disaster Incident Number (DIN)

A disaster incident number is a unique identifier used to track patients during healthcare surge. The county Office of Emergency Services or Public Health is recommended to serve as the central source responsible for creating and disseminating DINs to public and private healthcare facilities including emergency medical services. Having a single entity responsible for creating DINs is essential to avoiding duplication.

A policy and form has been drafted that provides an example of the process and documentation that could be instituted at the county level for the purpose of tracking a patient during surge. Disaster Management Systems has created "all risk" triage tags for disaster purposes.[180] It is recommended that tags are modified to include space for DIN information including space for a DIN sticker label. Additionally, it is recommended that the DIN and Triage # be identical to reduce the identifying information being transferred.

The triage tags are included for sample viewing purposes only and are not meant to endorse Disaster Management Systems as a vendor.

The "Disaster Incident Number Policy and Label" are shown below. The complete tool can be found in the Operational Tools Manual.

Instructions:

1. Disaster Incident Number (DIN) would be 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 DIN would be comprised of 2 specific elements of identification:
    - The first 2 digits would be 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 would place a 0 in front of the first digit.
    - The second set of numbers would be a number from 1 to 9,999,999. That number would specifically identify that particular patient within that county.
    - Example: 01-0000025

3. The DIN could be assigned at any of the following entry points and/or locations:
    - Existing Facility - To be assigned at registration.
    - Alternate Care Site / Field Treatment Centers / Shelters - To be assigned at registration.
    - EMS (Field crew) - To be assigned upon pick up.

4. The DIN 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 DIN is initiated. When the DIN is initiated with EMS, condition, gender and destination are key data elements.
    - First Name - patient's first name
    - Last Name - patient's last name
    - Street Address - patient's home address
    - City - patient's city of residence
    - SSN - patient's social security number
    - Telephone - patient's home phone
    - Cell - patient's cell phone
    - Destination - place the patient is being triaged to
    - Condition (Minor compromise, Major compromise, No compromise, Shelter only)
    - Facility Name

5. The DIN form may include a bar code that would represent the number for that form.

6. Disaster Management Systems has created "all risk" triage tags for disaster purposes.[181] It is recommended that tags are modified to include space for DIN information including space for a DIN sticker label. Additionally, it is recommended that the DIN and Triage # be identical to reduce the identifying information being transferred.

Sample DIN label

First Name:	BAR CODE
Last Name:	
DIN:	BAR CODE
Street Address:	
City:	BAR CODE
SSN:	
Tel:	BAR CODE
Cell:	
Destination:	BAR CODE
Facility Name:	
Condition (indicate condition with check mark):	
Minor compromise: [ ]	Not compromised: [ ]
Major compromise: [ ]	Shelter only: [ ]

5.3.2 Patient Tracking Form[182]

The Disaster Victim/Patient Tracking Policy and Form is an example of the type of process and form that could be instituted at a long term facility for the purpose of tracking patients as they are transferred to other facilities when electronic systems are down. Additionally, this form could serve as a tool used to report facility census and bed capacity to the local incident command center.

The "Disaster Victim/Patient Tracking Form" is shown below. The complete tool along with the accompanying policy can be found in the Operational Tools Manual.

Policy:

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.
   - LAST NAME Record patient's last name
   - FIRST NAME Record patient's first name
   - DIN Disaster Identification Number is the unique identifier assigned to that patient for the surge
   - MR #/Triage # Medical record (MR) number and/or triage number assigned to patient at the facility
   - SEX Record "M" for male and "F" for female
   - 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.
   - 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.
   - AREA TRIAGED TO The area or zone a patient is triaged to
   - DISPOSITION The specific area, facility or location the patient is being transferred or discharged to
   - 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, upon arrival of the first patient and until the disposition of the last. Operational period is defined by the Medical Health Operational Area Coordinator (MHOAC).

DISASTER VICTIM / PATIENT TRACKING FORM

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

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

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

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

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

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

5.4 HIPAA Compliance

In order to effectively treat patients under healthcare surge conditions, covered entities may require flexibility to exercise professional discretion related to maintaining the privacy and security of protected health information (PHI). Waiver of existing HIPAA law during a disaster scenario is unlikely to be granted by the federal government and is not recommended due to the potential long-term effects of identify theft. However, as was demonstrated during Hurricane Katrina, the enforcement of HIPAA is unlikely so long as "…failure to comply is based on reasonable cause and is not due to willful neglect, and the failure to comply is cured within a 30-day period." [183, 184] The following information highlights provisions for covered entities under current HIPAA law that can be applied to disaster-related scenarios and healthcare surge.

5.4.1 Covered Entity

According to 45 CFR 160.103 covered entity means: (1) A health plan. (2) A health care clearinghouse. (3) A health care provider who transmits any health information in electronic form in connection with a transaction covered by this subchapter. Under this definition an Alternate Care Site is not a qualified covered entity. However, the practice by an Alternate Care Site may trigger it to be classified as a covered entity: The Alternate Care Site seeks reimbursement for services by billing electronically or engages in any other HIPAA electronic transaction such eligibility query and response.

5.4.2 Workforce Training

Covered entities should make reasonable efforts to maintain current training practices according to 45 CFR 164.530(a)(2) which states:

"A covered entity must train all members of its workforce on the policies and procedures with respect to protected health information required by this subpart, as necessary and appropriate for the members of the workforce to carry out their function within the covered entity."

5.4.3 Uses and Disclosures

HIPAA provides guidance related to uses and disclosures for disaster relief purposes but makes a qualified requirement that the covered entity obtain the patient's consent whenever possible, or rely on its professional judgment that disclosure is in the individual's best interest. According to 45 CFR 164.510(b)(4):

> "A covered entity may use or disclose protected health information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating with such entities the uses or disclosures permitted by paragraph (b)(1)(ii) of this section. The requirements in paragraphs (b)(2) and (3) of this section apply to such uses and disclosure to the extent that the covered entity, in the exercise of professional judgment, determines that the requirements do not interfere with the ability to respond to the emergency circumstances." [185]

In response to Hurricane Katrina the U.S. Office for Civil Rights released a bulletin to provide guidance around HIPAA Privacy and Disclosures in Emergency Situations. The bulletin states the following:

"Providers and health plans covered by the HIPAA Privacy Rule can share patient information in all the following ways:

TREATMENT. Health care providers can share patient information as necessary to provide treatment.

- Treatment includes:
  - sharing information with other providers (including non-licensed healthcare facilities and hospitals),
  - referring patients for treatment (including linking patients with available providers in areas where the patients have relocated), and
  - coordinating patient care with others (such as emergency relief workers or others that can help in finding patients appropriate health services).
    - Providers can also share patient information to the extent necessary to seek payment for these health care services.

NOTIFICATION. Health care providers can share patient information as necessary to identify, locate and notify family members, guardians, or anyone else responsible for the individual's care of the individual's location, general condition, or death.

- The health care provider should get verbal permission from individuals, when possible; but, if the individual is incapacitated or not available, providers may share information for these purposes if, in their professional judgment, doing so is in the patient's best interest.
  - Thus, when necessary, the non-licensed healthcare facility may notify the police, the press, or the public at large to the extent necessary to help locate, identify or otherwise notify family members and others as to the location and general condition of their loved ones.

  - In addition, when a health care provider is sharing information with disaster relief organizations that, like the American Red Cross, are authorized by law or by their charters to assist in disaster relief efforts, it is unnecessary to obtain a patient's permission to share the information if doing so would interfere with the organization's ability to respond to the emergency.

IMMINENT DANGER. Providers can share patient information with anyone as necessary to prevent or lessen a serious and imminent threat to the health and safety of a person or the public -- consistent with applicable law and the provider's standards of ethical conduct.

FACILITY DIRECTORY. Health care facilities maintaining a directory of patients can tell people who call or ask about individuals whether the individual is at the facility, their location in the facility, and general condition.

> Of course, the HIPAA Privacy Rule does not apply to disclosures if they are not made by entities covered by the Privacy Rule. Thus, for instance, the HIPAA Privacy Rule does not restrict the American Red Cross from sharing patient information." [186]

Permitted use and disclosure of PHI is stipulated for public health activities. Covered entities should make reasonable efforts to maintain required practice during surge according to 45 CFR 164.512 which states:

> "A covered entity may disclose protected health information for the public health activities and purposes described in this paragraph to: (i) A public health authority that is authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, including, but not limited to, the reporting of disease, injury, vital events such as birth or death, and the conduct of public health surveillance, public health

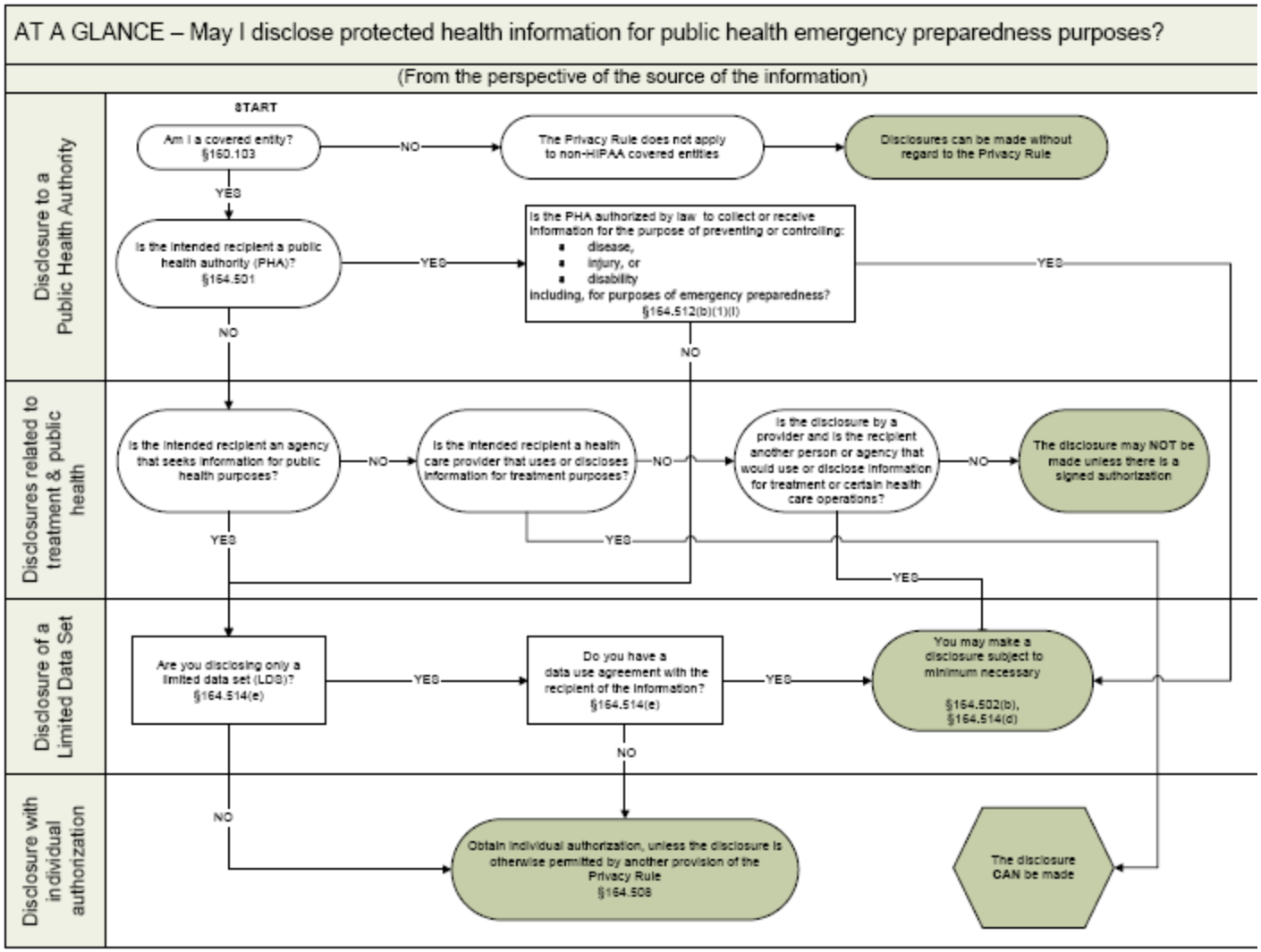
> investigations, and public health interventions; or, at the direction of a public health authority, to an official of a foreign government agency that is acting in collaboration with a public health authority; (ii) A public health authority or other appropriate government authority authorized by law to receive reports of child abuse or neglect; (iii) A person subject to the jurisdiction of the Food and Drug Administration (FDA) with respect to an FDA-regulated product or activity for which that person has responsibility, for the purpose of activities related to the quality, safety or effectiveness of such FDA-regulated product or activity."

Use and disclosure of PHI is permitted for cases related to averting threats to health or safety. There may be cases in which a covered entity may need to disclose PHI to a non-covered entity such as search and rescue. Under 45 CFR 164.512(j):

> "A covered entity may, consistent with applicable law and standards of ethical conduct, use or disclose protected health information, if the covered entity, in good faith, believes the use or disclosure: (i)(A) Is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public; and (B) Is to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat; or (ii) Is necessary for law enforcement authorities to identify or apprehend an individual: (A) Because of a statement by an individual admitting participation in a violent crime that the covered entity reasonably believes may have caused serious physical harm to the victim; or (B) Where it appears from all the circumstances that the individual has escaped from a correctional institution or from lawful custody, as those terms are defined in §164.501."

Finally, the U.S. Office for Civil Rights (OCR) published a decision tool related to the disclosure of protected health information during emergency. The tool includes a process flow which could be applied to healthcare surge.

The “Decision Making Tool for Disclosure of Protected Health Information (PHI)” is shown below. The tool can also be found in the Operational Tools Manual.


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
Disclosures related to treatment & public health
Disclosure of a Limited Data Set
Disclosure with individual authorization
START
Am I a covered entity? §160.103
NO
The Privacy Rule does not apply to non-HIPAA covered entities
Disclosures can be made without regard to the Privacy Rule
YES
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
NO
NO
Is the intended recipient an agency that seeks information for public health purposes?
NO
Is the intended recipient a health care provider that uses or discloses information for treatment purposes?
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?
NO
The disclosure may NOT be made unless there is a signed authorization
YES
YES
YES
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
Obtain individual authorization, unless the disclosure is otherwise permitted by another provision of the Privacy Rule §164.508
The disclosure CAN be made

5.4.4 California State Law Pertaining to Security of Information

California State law pertaining to security of information is expected to remain effective during healthcare surge. Entities covered under such laws should take reasonable steps to ensure the security of identity and health information. The list of relevant statutes includes but is not limited to the following:

- Confidentiality of Medical Information Act, California Civil Code 56 *et seq.*
- California Civil Code 1798.29
- California Civil Code 1798.81.5
- California Civil Code 1798.82
- California Civil Code 1798.83
- California Civil Code 1798.84
- California Civil Code 1798.85

Both covered entities under HIPAA may be covered by these State laws.

5.5 Facility Operations – Decontamination and Infection Control

Each non-licensed healthcare facility is expected to develop its own emergency management plan. While this section is not intended to serve as a template for an emergency management plan, it does provide guidelines and operational tools for key components of the preparedness and response phases. The section also reviews regulations, standards, waivers, and liability protection for facility operations and some key recommendations. Topics covered in this section include decontamination and infection control.

5.5.1 Decontamination

In addition to providing guidance on hazardous waste management, OSHA's publication "Best Practices for Hospital-Based First Receivers of Victims from Mass Casualty Incidents Involving the Release of Hazardous Substance" may also serve as the primary source for decontamination procedures. Additionally, the Hospital and Healthcare System Disaster Interest Group and The California Emergency Medical Services Authority, have developed *Patient Decontamination Recommendations For Hospitals*, July 2005. The document provides recommendations for protecting healthcare providers and managing patients in the event of a hazardous materials exposure. Specific algorithms for different contamination events have been included in the guide. The guide can be accessed at: http://www.emsa.ca.gov/aboutemsa/emsa233.pdf. Although this guide was developed for hospitals, non-licensed healthcare facilities can use these recommendations to customize their own emergency management plan to meet the unique decontamination needs of the facility and event.

Some of the recommendations include:

1. Facilities must regularly assess the risks to the community and perform a hazards vulnerability analysis. The level of equipment and staff protection must be based on this analysis.
2. Facilities are encouraged to establish relationships and notification procedures with appropriate local agencies (e.g. local EMS and public health) in order to:
    - Ensure communication between the field and facility to allow for preparation.

- Ensure that properly trained and equipped field/pre-facility responders decontaminate patients in the field in order to protect the facility as much as possible.
- Understand the local protocols and capabilities for field decontamination of patients.
- Ensure proper notification of an event to appropriate local agencies.

3. The primary role of a facility in a hazardous materials event is to triage, treat, decontaminate and medically screen patients as necessary.
    - An influx of contaminated patients will overwhelm any facility and therefore facilities must work collaboratively with the community and local government to meet the challenges of a surge of contaminated patients.
    - Facilities must be prepared for potentially contaminated patients who self-refer and present to the facility.
    - 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. Note the exception for Radiological decontamination in which emergency treatment takes precedence over Radiological decontamination.
        - 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 EMS 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.

5.5.2 Infection Control

Standards and Regulations

The JCAHO infection control standard requires accredited organizations to offer influenza vaccinations to staff, which includes volunteers, and licensed independent practitioners with close patient contact. The standard has become an accreditation requirement beginning January 1, 2007, for the Critical Access Hospital, Hospital and Long Term Care accreditation programs.

The JCAHO standard requires organizations to:

- Establish an annual influenza vaccination program that includes at least staff and licensed independent practitioners;
- Provide access to influenza vaccinations on-site;
- Educate staff and licensed independent practitioners about flu vaccination; non-vaccine control measures (such as the use of appropriate precautions); and diagnosis, transmission and potential impact of influenza;
- Annually evaluate vaccination rates and reasons for non-participation in the organization’s immunization program; and
- Implement enhancements to the program to increase participation.

CCR Title 8, Section 5193 – Bloodborne Pathogens: applies to all occupational exposure to blood or other potentially infectious materials.

The Public Health and Hospital Preparedness - Public Health and Hospital Preparedness, state of Wisconsin, *Wisconsin Hospital Emergency Preparedness Plan (WHEPP)*, Version 3, provides guidelines for Infection Control. These guidelines have been adapted for California and reproduced below.

<u>Definitions</u>

"Isolation rooms" are defined (California Mechanical Code Section 414.0) as negative air pressure airborne isolation rooms (hereinafter, "NPAir") with a minimum of 12 air exchanges per hour and direct exhaust to the outside, which is located at least 7 ft above roof and more than 25 feet from an air intake and from areas where people may pass. If air cannot be exhausted directly to the outside more than 25 feet from an air intake and from areas where people may pass, then air should be filtered through an appropriately installed and maintained HEPA filter. These rooms should be appropriately alarmed (CMC 414.0) and tested monthly (and daily when in use) to verify negative airflow.

"Pre-identified room": In facilities that do not have "NPAir" that meet the above criteria, an enclosed private room(s) should be pre-identified for "isolating" patients with fever and rash illnesses to minimize exposure to other patients and staff (e.g., an examination room at the end of a hallway). A transportation route from the Emergency Department to this pre-identified room also is to be established.

Most non-licensed healthcare facilities do not have established negative pressure isolation rooms. However, the Minnesota Department of Health, Emergency Preparedness, Response and Recovery website has an "Airborne Infectious Disease Management" guide that facilities can use to prepare appropriately. The guide was written to assist non-licensed healthcare facilities in developing strategies for temporary negative pressure isolation and provides instruction on the use of equipment used for airborne infectious disease management. Preventative maintenance schedules and a sample log for measuring particle counts are included for performance improvement planning. The guide can be found at:
http://www.health.state.mn.us/oep/training/bhpp/docs/AirborneWeb2_07Linked.pdf

Note: Guidelines from other states do not necessarily comply with California laws, regulations and standards. These references have been provided for informational purposes only.

6 Sources of Funds

This chapter focuses on what healthcare professionals should know about how the reimbursement landscape may be affected during and after a healthcare surge. During a catastrophic surge, the primary focus of the healthcare community is expected to be on responding to the event and caring for the ill and injured. However, the financial viability and stability of the healthcare system must be attended to as well in order to sustain operations at facilities and continue to provide medical care to the affected population. Ensuring this viability requires the healthcare community to recognize the kinds of financial challenges that may arise during a surge and to develop plans to respond accordingly. While there is a considerable amount of uncertainty in any surge, and especially with the financial implications of a surge, there are some practical planning tools and recommendations that healthcare providers can implement to mitigate some of the barriers and prepare for financial viability.

This chapter focuses on funding and reimbursement related to surge with consideration for preserving the financial viability of the existing healthcare system. As such, it is designed to identify financial barriers that may cause healthcare services to be interrupted during an emergent event and to compile recommendations for how these barriers can be addressed to facilitate access to and funding for delivery of care during a surge event. The contents of this chapter are assembled into two sections:

- **Preparing in Advance:** provides recommendations providers can adopt to prepare in advance for the financial considerations of a surge. Recommendations include:
  - Minimum elements for charge capture
  - Minimum required data elements for billing
  - Processes for advancing and expediting payment

- **Maintaining Revenue Stream & Financial Liquidity During a Surge:** outlines some of the ways in which providers can maintain their current revenue stream during a surge, including:
  - Existing laws and rules governing emergency provisions
  - Opportunities for waivers and declarations to address the possible barriers of the current funding and reimbursement system during a surge

6.1 Preparing in Advance

There are actions healthcare providers can focus on doing to preserve revenue and liquidity in advance of a disaster.

1. During contracting, negotiate a minimum data set for charge capture and billing purposes
2. Discuss various provisions ahead of time for advancing and accelerating payments

Sufficient planning and coordination between payers and providers will be essential to maintaining business continuity and sustaining operations at facilities providing medical care. Such coordination and planning may include creating new/modifying existing contracts to include disaster provisions such as minimum required data elements for reimbursement purposes during surge, third party vendors who may assist with billing on behalf of an existing facility during an extended surge, and creating policies to expedite cash flow during a declared surge.

The following section reviews these recommendations that providers can adopt to prepare in advance for the financial considerations of a surge.

6.1.1 Minimum Required Data Elements and Templates for Charge Capture

During a disaster scenario current methods of charge capture via electronic systems within existing facilities may be unavailable. Therefore, paper-based methods for capturing charges may be required. The following information recommends a list of minimally required data elements for charge capture. Maintaining accurate charge capture information will allow facilities to properly bill for services, receive reimbursement, and maintain cash flow and business continuity during an event. The following includes a list of recommended minimum data elements required for charge capture during healthcare surge. Sample templates are also included. The forms are not meant to replace existing forms at non-licensed healthcare facilities but rather to serve as samples to consider using during healthcare surge. Acceptance of charge capture elements will ultimately depend in private/ government payers agreeing to accept these recommended minimum data elements for billing purposes.

6.1.1.1 Charge Capture Standard Data Elements

The following information includes a list of standard charge capture elements.

Charge Detail
Medical Record Number (For Matching Purposes)
Patient Account Number (For Matching Purposes)
Service Code (CDM Item Number)
Date of Service
Posting Date
Charge Quantity
Posted Charge

Charge Description Master
Service Code (CDM Item Number)
Service Description
Medicare HCPCS
Additional CPT4 Codes
Revenue Code
Department
Service Price

6.1.1.2 Suggested Minimum Data List for Charge Capture

A Charge Capture form has been drafted to serve as a template for hospitals to consider using during healthcare surge and is based on the idea of capturing only minimum required data for charge capture.

The "Sample Charge Capture Form 1" is shown below. The tool can also be found in the Operational Tools Manual.

Instructions:

One form should be completed per patient.

Unique Patient Identifier: Enter patient disaster incident number or other identifier if available.[187]
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/CPT/HCPCS: 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.
DIN: Enter Disaster Incident Number

Unique Patient Identifier (#):	Patient Name (Last, First):
Provider Name:	DIN:

Service Description	Department	Units of Service or Quantity	Date of Service	To be completed by Billing		
				Code: Service / Revenue/ CPT/HCPCS	Service Price	Posted Charge
Total Charges						

The "Sample Charge Capture Form 2" is shown below. The tool can also be found in the Operational Tools Manual.

A set of forms (Acuity and Procedure forms) are presented as options for capture charges for service, medication, and supplies for individual patients.

Instructions:

One set of forms should be completed 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

RN Signature:_____ **Patient Disaster Incident Number:**_____

PROCEDURE CHARGE SHEET			
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	

Patient Disaster Incident Number:_____

6.1.2 Minimum Required Data Elements for Billing

During a surge, complete billing processes and data elements should be accomplished when possible. However, during a disaster scenario it may be reasonable to expect that most personnel will be devoted to patient care and that current electronic systems may be nonfunctional or unavailable. As such, administrative billing functions under surge conditions may need to be reduced to minimum requirements. A fundamental component of minimizing requirements will be to minimize the billing data that needs to be captured by providers and reported to payers. The following includes recommended data elements required for billing purposes during healthcare surge.

The following data elements for billing are included as recommendations and ultimately depend on private and pubic payers agreeing to accept these recommended minimum data elements for billing purposes. It is recommended that providers review these recommendations and incorporate them into contract negotiations with payers.

6.1.2.1 Recommended Minimum Required Data for Billing

The following list was derived from existing UB-04 (or CMS 1450) and CMS 1500 forms. Under normal conditions the UB-04 form is used by institutional providers (e.g. hospitals, skilled nursing facilities, hospices) to submit Medicare paper claims and the CMS 1500 form is used by non-institutional providers (e.g. physicians) to submit Medicare paper claims. It is recommended that private payers consider a similar list for providers to submit within their network.

UB-04 Data Elements	CMS 1500 Data Elements
• Subscriber ID/policy # • Time in, time out 1: Provider name, address, phone # 4: Type of bill 8b: Patient name 42: Revenue Codes 43: Revenue Description 44: HCPCS Rates/Codes 46: Units of Service 47: Total Charges 50: Payer 56: NPI 58: Insured's Name 67: Principal Diagnosis Code 69: Admitting Diagnosis 74: Principal Procedure Code 76: Attending 77: Operating	• Subscriber ID/policy # • Time in, time out 1:MEDICARE / MEDICAID / CHAMPUS / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER 1a: Insured's I.D. Number 2: Patient Name 3: Patient's Birth Date 5: Patient's Address 21: Diagnosis or nature of illness or injury 24 A-G: Date of service, Place of service, Type of service, Procedures/services/supplies, Diagnosis code, $ Charges, Days or units 24K: Use space to include condition code 25: Federal Tax I.D. Number 27: Accept Assignment? (yes/no) 28: Total Charge 33: Physician's, Supplier's Billing Name, Address, Zip Code & Phone #

Additional guidance regarding billing and coding during a disaster is provided in the following research:

6.1.2.2 Administrative Simplification Compliance Act Waiver Application[188]

"There are also some situations when this electronic billing requirement could be waived for some or all claims, however a provider must obtain Medicare pre-approval to submit paper claims in these situations:

- Any situation where a provider can demonstrate that the applicable adopted HIPAA claim standard does not permit submission of a particular type of claim electronically;
- Disability of all members of a provider's staff prevents use of a computer for electronic submission of claims;
- Other rare situations that cannot be anticipated by CMS where a provider can establish that due to conditions outside of their control, it would be against equity and good conscience for CMS to enforce this requirement.

  A request for this type of waiver must be sent by letter to the Medicare contractor to which a provider submits claims."

6.1.2.3 National Modifier and Condition Code To Be Used To Identify Disaster Related Claims[189]

"In order to track and facilitate processing of claims for disaster victims, a national modifier has been established for providers' use on claims.

Policy
In order to facilitate claims processing and track services and items provided to victims of Hurricane Katrina and any future disasters, a new modifier and condition code have been established for providers to use on disaster related claims. The new modifier and condition code are effective for dates of service on and after August 21, 2005. The new modifier is CR (Catastrophe/Disaster Related). The new condition code is DR (Disaster Related). The new modifier and/or condition code can be used by providers submitting claims for beneficiaries who are Katrina disaster patients in any part of the country.

For physicians or suppliers billing their local carrier or DMERC, only the modifier (CR) may be reported and not the condition code. A condition code is used in fiscal intermediary billing. For institutional billing, either the modifier or condition code may be reported. The condition code would identify claims that are or may be impacted by specific payer policies related to a national or regional disaster, while the modifier would indicate a specific Part B service that may be impacted by policy related to the disaster."

6.1.2.4 ICD-9-CM Coding Advice for Healthcare Encounters in the Hurricane Aftermath Introduction[190]

"To be used as a guide to help coding professionals when coding healthcare encounters of those individuals affected by the hurricane. This coding advice has been approved by the four Cooperating Parties – American Health Information Management Association, American Hospital Association, Centers for Medicare & Medicaid Services, and National Center for Health Statistics. It is recommended that State of CA stakeholders work with these organizations to develop additional codes specific to other disasters such as pandemic flu.

Use of E Codes
An External Cause code (E code) should be assigned to identify the cause of an injury(ies) incurred as a result of the hurricane. The use of E codes is supplemental to the application of ICD-9-CM diagnosis codes. E codes are never to be recorded as principal diagnoses (first-listed in non-inpatient setting). The appropriate injury code should be sequenced before any E codes.

The use of E codes is limited to injuries, adverse effects, and poisonings. They should not be assigned for encounters to treat hurricane victims' medical conditions when no injury, adverse effect, or poisoning is involved.

E codes should be assigned for each encounter for care and treatment of the injury. Note that this advice is an exception to the *ICD-9-CM Official Guidelines for Coding and Reporting* and applies only to healthcare encounters resulting from the hurricane. E codes may be assigned in all healthcare settings. For the purpose of capturing complete and accurate ICD-9- CM data in the aftermath of the hurricane, a healthcare setting should be considered any location where medical care is provided by licensed healthcare professionals.

Sequencing of E Codes
Cataclysmic events, such as hurricanes, take priority over all other E codes except child and adult abuse and terrorism and should be sequenced before other E codes. Assign as many E codes as necessary to fully explain each cause. For example, if an injury occurs as a result of a building collapsing during the hurricane, E codes for both the hurricane and the building collapse should be assigned with the E code for hurricane being sequenced as the first E code.

For injuries incurred as a direct result of the hurricane, assign the appropriate code(s) for the injuries, followed by code E908.0, Hurricane, and any other applicable E codes. Code E908.0 should be assigned when an injury is incurred as a result of flooding caused by a levee breaking. Code E909.3, Collapse of dam or man-made structure, should not be assigned when the cause is a hurricane. Code E909.3 is limited to collapses of man-made structures due to earth surface movements, and tidal surges caused by storm action are excluded from category E909."

6.1.3 Advancing and Expediting Payment

In some surge situations, cash flow may present a challenge for large, small and independent providers. As such, the following tool outlines possible opportunities for advancing and expediting payment from a range of payers. In many cases, there is no formalized policy or procedure for advancing or expediting payments, but there is an established practice for doing so on an "as needed" basis. Providers in need of expedited or advanced payment options will likely need to contact their plan or program representative directly to discuss advancing and expediting payments and establish memorandum of understanding (MOUs) and protocols in advance or at the time funds are needed.

The following table summarizes some of the options available by payer type with respect to 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. In the past, intermediaries have been asked to immediately process any requests for accelerated payments or increases in PIP for providers. The 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-

Payer	Option Available	Examples
		by-case basis.[191]
Medicare Part B	Advance Payments	Cash flow problems can be resolved through advance payments rather than through suspension of the mandatory payment floor. In the past, intermediaries have been asked to process immediately any requests for accelerated payments or increases in PIP for providers. The 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.[191]
Medi-Cal	Advance Payments	Medi-Cal has a process in place for advancing payment to participating providers. This interim payment process can be used in instances when providers are experiencing cash flow inadequacies, where Medi-Cal is experiencing payment delays, or when a provider's business operations are temporarily challenged. However, 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 provider has claims pending in the State system, the State can issue an interim payment and will reconcile 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 provider. The provider 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 provider's cash flow positive until business operations can resume to normal. Medi-Cal can issue this advance by either valuing the claims that are currently in the State processing system or run a report of a provider's claim payment history and issue an advance in lieu of receiving claims. Should the State issue an advance without having evidence of claims in the payment system, they cannot qualify for the Federal match. Claims must be submitted as proof of loss in order for the State to establish that they have a liability to pay. In circumstances where claims have not been received the Deputy Director of Medical Care Services, Department of Health Services 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 it would take some time to orchestrate given the number of providers that may be requesting it.[192]
Private Payer		Private payers 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 provider's business operations are temporarily challenged. The amount of the advance can vary depending on provider need, provider volume, previous payment history, contractual parameters, and

Payer	Option Available	Examples
		re-payment factors. Upon provider request, private payers will typically offer one of two options: 1) Advance a lump sum amount for a specified period of time to be re-paid in full when the agreed period elapses, or 2) Advance an agreed amount based upon previous payment history and provider need to be reconciled against future claim submissions. Contracted providers in good standing in need of expedited or advanced payment options will likely need to contact their plan or program representative directly to discuss advancing and expediting payments and establish memorandum of understanding (MOUs) and protocols in advance or at the time funds are needed.

6.2 Maintaining Revenue Stream and Liquidity during a Surge Event

During a surge, the enforcement of certain rules and requirements may preclude the effective and timely care of patients affected by the event and the prompt reimbursement of that care. To ensure that care is delivered to meet the healthcare needs during a surge, certain rules and requirements may need to be flexed and/or waived during these events. The specific rules and requirements addressed in this document are:

- Physician / Network Requirements
- Facility Reimbursement
- Pre-Authorization
- Pharmaceutical Coverage
- Co-Pay Requirements
- Non-Payment of Premiums and Coverage Continuity
- Claims Management
- Insurance Questions and Coverage Verification

The following sections outline how some of these rules and regulations may be addressed during surge, reducing some of the barriers to maintaining revenue stream and liquidity during a surge event.

6.2.1 Opportunities for Waivers and Declarations to Address Rules, Requirements and Other Barriers

While US Code 42 and California Civil Codes 22 and 28 provide some regulation guidance on emergency provisions, they do not fully address all of the funding and reimbursement issues that may arise during a surge. As such, the opportunity exists for the issuance of waivers and declarations to further address these barriers. The following section outlines the opportunities to address these rules and requirements for public and private payers. The section begins with a matrix summarizing these opportunities and continues into brief overviews of the Section 1135 Waivers impacting programs managed by the Centers for Medicare and Medicaid, Section 1115 Demonstration Waivers affecting Medicaid.

6.2.1.1 Waiver and Declaration Matrix

The following matrix summarizes the key waivers and declarations that may be issued in response to a surge that would impact the reimbursement process to providers. While providers serve to benefit from the flexed rules and requirements that these waivers and declaration would implement, they have little influence over their issuance. However, this tool helps illustrate the kinds of financial response that may occur following a surge. This table can be used by providers to identify the rules that may pose a challenge and how they may be responded to during an event in California, giving providers some context for how they may provide care during a surge. It also highlights to those who are in a position to influence the release of these waivers and declarations the relative impact of such actions. This table is also useful as it highlights the waivers and declarations that best serve the healthcare system, indicating the areas that key influencers and persons of authority should focus their attention. Most notably, the Section 1135 offer the most financial impact with the least amount of effort and time, whereas the 1115

Demonstration Waivers are more cumbersome with less likelihood of significant and timely impact.

The "Waiver and Declaration Matrix" Tool is shown below. The complete tool can be found in the Operational Tools Manual.

Key Influencer[1]	Waiver or Declaration Name	Issued By	Rules / Requirements Potentially Addressed	Relative Potential Impact[2]	Relative Effort to Enact[3]	Expected Time To Enact[4]
Healthcare Providers and State	Waiver Under Section 1135 of the Social Security Act	Secretary of Health and Human Services	• Conditions of Participation • Pre-Approval Requirements • State Licensure Requirements • Out-of-Network Providers	$$$$	Low	
State	Disaster Relief Emergency Medicaid Waiver Section 1115 Model Waiver	Secretary of Health and Human Services	• Simplified Eligibility Chart • 5 Months Temporary Eligibility • Simplified Application and Self-Attestation • Uncompensated Care Pool • Simplified, expedited patient enrollment • Expanded eligibility guidelines	$	High	

[1]Key Influencer – Entity who can influence the development and implementation of applicable waiver or declaration
[2]Relative potential impact - Relative impact on the revenue amounts and flow in the system
[3]Effort - Relative measure of complexity, skills and resources to get waiver or declaration approved
[4]Time - Relative expected time from application initiation to fund initiation

6.2.1.2 Section 1135 Waivers

One mechanism to address rules and requirements that may present a financial barrier during a surge is the Section 1135 Waiver. Under 42 U.S.C. § 1320b-5 (section 1135 of the Social Security Act), the Secretary of Health and Human Services has the authority to waive certain requirements of CMS programs in an emergency area during a federal emergency period.[193] These waivers are known as Section 1135 Waivers. As documented in the Federal Register, "the stated purpose of section 1135 of the Social Security Act (the Act) is to enable the Secretary to ensure, to the maximum extent feasible, in any emergency area and during an emergency period, that sufficient health care items and services are available to meet the needs of enrollees in Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP)."[194]

The purpose of section 1135 of the Social Security Act also ensures "that health care providers (as defined in subsection (g)(2)) that furnish such items and services in good faith, but that are unable to comply with one or more requirements described in subsection (b), may be reimbursed for such items and services and exempted from sanctions for such non-compliance, absent any determination of fraud or abuse."[195]

These waivers or modifications can "be made retroactive to the beginning of the emergency period or any subsequent date in such period specified by the Secretary" at the Secretary's discretion[196] and are issued in response to specific events and defined for a designated time and place. These waivers provide general flexibility to the Secretary of Health and Human Services, but some of the key elements that can be addressed by these waivers are:

- Conditions of Participation

- Physician State Licensure Requirements
- EMTALA
- Physician Referral Limitations
- HIPAA
- Medicare Advantage Payment Limitations
- Deadlines and Timetables[197]

As the Section 1135 Waiver is a key mechanism for addressing the financial barriers that public program rules and requirements may pose during a surge, it is helpful for healthcare professionals to be familiar with its existence and opportunity for issuance. While these waivers are situational and cannot be relied on to be issued in response to a surge event in California, they do provide a significant opportunity to address the financial barriers some of the CMS rules and requirements may present during a surge. The Detail of Previously Issued Waivers and Declarations by Rule / Requirement table outlines in more detail how these waivers have been used in the past and may be used to address specific issues that the California healthcare system may face during a surge. Additional information can also be found in the Appendix on Funding Deployed and Waiver Examples from Katrina.

For full text of the Section 1135 Waiver under 42 U.S.C. § 1320b-5, please see the Appendix.

6.2.1.3 Section 1115 Demonstration Waivers

In addition to the Section 1135 Waivers addressing Medicare, Medicaid and SCHIP, Section 1115 Demonstration Waivers provide another mechanism to make modifications to the Medicaid program. These waivers are generally more cumbersome and time consuming and should not be depended upon to provide primary relief during a surge.

According to CRS Report RL33083, "Section 1115 of the Social Security Act…authorizes the Secretary [of Health and Human Services] to waive certain statutory requirements for conducting demonstration projects that further the goals of Titles XIX (Medicaid) and XXI (SCHIP)." Section 1115 waiver programs "serve as a precedent for federal and state officials who wish to make temporary changes to the Medicaid program in response to the unique circumstances resulting from events such as the devastation of Hurricane Katrina."[198]

Under current law, Section 1115 waivers allow states to

- provide services to individuals not traditionally eligible for Medicaid
- cover non-Medicaid services
- limit benefit packages for certain groups
- adapt their programs to the special needs of particular geographic areas or groups of recipients
- accomplish a policy goal such as to temporarily provide Medicaid assistance in the aftermath of a disaster.[198]

Although health professionals will likely not be involved in the development of any Section 1115 waivers during a healthcare surge, it is useful for those involved in the delivery of care to be aware of this opportunity for addressing some of the financial barriers that may present itself during a surge.

6.2.2 Previous Financial Responses

One of the challenges with preparing for the financial consequences of a surge is the highly situational nature of any surge response. As such, it may be helpful to review in more depth the kinds of responses that have occurred in the past as a reference for the kinds of responses that *may* occur in the future. The following table, 'Detail of Previously Issued Waivers and Declarations By Rule / Requirement' outlines the rules and requirements for each administrative

rule and requirement by payer, with relevant examples or potential applications to waive or flex these rules. This table serves as a tool for providers to identify how specific rules or requirements may be addressed by various payers, giving providers additional context for how they may provide care during a surge and how that care may be reimbursed.

6.2.2.1 Detail of Previously Issued Waivers and Declarations By Rule / Requirement

The expanded table below outlines the rules and requirements for each administrative rule and requirement by payer, with relevant examples or potential applications to waive or flex these rules. This expanded table serves as a tool for providers to identify how specific rules or requirements may be addressed by various payers, giving providers additional context for how they may provide care during a surge.

This tool addresses the following rules / requirements / issues by private payers, Traditional Medicare, Medicare Advantage and Medi-Cal:

- Physician / Network Requirements
- Facility Reimbursement
- Pre-Authorization
- Pharmaceutical Coverage
- Co-Pay Requirements
- Non-Payment of Premiums and Coverage Continuity
- Claims Management
- Insurance Questions and Coverage Verification

The "Detail of Previously Issued Waivers and Declarations By Rule / Requirement" Tool is shown below. The complete tool can be found in the Operational Tools Manual.

Physician / Network Requirements	
A. Payer / Organization	**Private Payers**
B. Pertinent Regulations	(1) Emergency health care services which shall be available and accessible to enrollees on a twenty-four hour a day, seven days a week, basis within the health care service plan area. Emergency health care services shall include ambulance services for the area served by the plan to transport the enrollee to the nearest twenty-four hour emergency facility with physician coverage, designated by the Health Care Service Plan. (2) Coverage and payment for out-of-area emergencies or urgently needed services involving enrollees shall be provided on a reimbursement or fee-for-service basis and instructions to enrollees must be clear regarding procedures to be followed in securing such services or benefits. Emergency services defined in section 1317.1 include active labor. "Urgently needed services" are those services necessary to prevent serious deterioration of the health of an enrollee, resulting from an unforeseen illness, injury, or complication of an existing condition, including pregnancy, for which treatment cannot be delayed until the enrollee returns to the plan's service area. "Urgently needed services" includes maternity services necessary to prevent serious deterioration of the health of the enrollee or the enrollee's fetus, based on the enrollee's reasonable belief that she has a pregnancy-related condition for which treatment cannot be delayed until the enrollee returns to the plan's service area.[199] No health care service plan contract executed or amended on or after the effective date of this regulation shall limit or exclude health care services based on a determination that the need for the health care service arose as a result of an Act of War. The term "Act of War" includes any act or conduct, or the prevention of an act or conduct, resulting from war, declared or undeclared, terrorism, or warlike action by any individual, government, military, sovereign group, terrorist or other organization.[200] Basic health services (and only such supplemental health services as members have contracted for) shall within the area served by the health maintenance organization be available and accessible to each of its members with reasonable promptness and in a manner which assures continuity, and when medically necessary be available and accessible twenty-four hours a day and seven days a week, except that a health maintenance organization which has a service area located wholly in a non-metropolitan area may make a basic health service available outside its service area if that basic health service is not a primary care or emergency health care service and if there is an insufficient number of providers of that basic health service within the service area who will provide such service to members of the health maintenance organization. A member of a health maintenance organization shall be reimbursed by the organization for his expenses in securing basic and supplemental health services other than through the organization if the services were medically

Physician / Network Requirements	
A. Payer / Organization	**Private Payers**
	necessary and immediately required because of an unforeseen illness, injury, or condition.[201] To the extent that a natural disaster, war, riot, civil insurrection, or any other similar event not within the control of a health maintenance organization (as determined under regulations of the Secretary) results in the facilities, personnel, or financial resources of a health maintenance organization not being available to provide or arrange for the provision of a basic or supplemental health service in accordance with the requirements of paragraphs (1) through (4) of this subsection, such requirements only require the organization to make a good-faith effort to provide or arrange for the provision of such service within such limitation on its facilities, personnel, or resources.[202] **California - Legislation (CA Statutes) California Business And Professions Code** **Chapter 1.5. Exemption From Licensure § 900 Bus. & Prof.** (a) Nothing in this division applies to a health care practitioner licensed in another state or territory of the United States who offers or provides health care for which he or she is licensed, if the health care is provided only during a state of emergency as defined in subdivision (b) of Section 8558 of the Government Code, which emergency overwhelms the response capabilities of California health care practitioners and only upon the request of the Director of the Emergency Medical Services Authority. (b) The director shall be the medical control and shall designate the licensure and specialty health care practitioners required for the specific emergency and shall designate the areas to which they may be deployed. (c) Health care practitioners shall provide, upon request, a valid copy of a professional license and a photograph identification issued by the state in which the practitioner holds licensure before being deployed by the director. (d) Health care practitioners deployed pursuant to this chapter shall provide the appropriate California licensing authority with verification of licensure upon request. (e) Health care practitioners providing health care pursuant to this chapter shall have immunity from liability for services rendered as specified in Section 8659 of the Government Code. (f) For the purposes of this chapter, "health care practitioner" means any person who engages in acts which are the subject of

Physician / Network Requirements	
A. Payer / Organization	**Private Payers**
	licensure or regulation under this division or under any initiative act referred to in this division. (g) For purposes of this chapter, "director" means the Director of the Emergency Medical Services Authority who shall have the powers specified in Division 2.5 (commencing with Section 1797) of the Health and Safety Code. [203] **California - Legislation (CA Statutes) California Business And Professions Code** **Chapter 1.6. Health Care Professional Disaster Response Act § 921 Bus. & Prof.** The Legislature finds and declares the following: (1) In times of national or state disasters, a shortage of qualified health care practitioners may exist in areas throughout the state where they are desperately required to respond to public health emergencies. (2) Health care practitioners with lapsed or inactive licenses could potentially serve in those areas where a shortage of qualified health care practitioners exists, if licensing requirements were streamlined and fees curtailed. (b) It is, therefore, the intent of the Legislature to address these matters through the provisions of the Health Care Professional Disaster Response Act.[204]
C. Previous	Under the authority of the Governor of Louisiana's numerous Emergency Declarations and Executive Orders, the

Physician / Network Requirements	
A. Payer / Organization	**Private Payers**
Response Example, Pertinent Waivers or other Application During a Surge	Commissioner of Insurance for the state of Louisiana issued Emergency Rules 15, 17, 19 and 20. • These Emergency Rules suspended certain statutes and regulations regarding health insurance in Louisiana.[205] • These rules applied to primary and limited secondary parishes in Louisiana affected by the hurricanes over specific time periods.[206,207] • These rules applied only to products regulated by the Louisiana Department of Insurance. • These rules waived all restrictions relative to out-of-network access. Along with the Governor's Emergency Rules: • Aetna implemented policies for its members to receive in-network benefits for care out of their network in any state, and seek care from providers, including dentists, other than their designated primary care physicians.[208] • United Healthcare provided emergency transportation and treated all area hospitals as participating network hospitals under existing emergency benefit provisions.[209] • Members from the affected disaster areas who could not access CIGNA participating physicians, hospitals or other providers for the dates of service from August 27, 2005 to September 30, 2005 were able to seek care as needed, for which in-network benefits applied. If members were unable to see their primary care physician, they sought care as needed from any available medical professional.[210] • Blue Cross of California made revisions that applied to members who were living in Alabama, Louisiana and Mississippi at the time of the disaster that: o Allowed the affected members to see any physician necessary to provide access to care. o Blue Cross of California paid all claims as in-network, regardless of whether or not the health care provider was in network.[211]

7 Endnotes

[1] Govt. Code, §§8550, et seq.
[2] Depending upon the jurisdiction, the designated official may be the director of emergency services, the director or medical director of the local emergency medical services agency, or medical health operational area coordinator. A description of these officials is provided later in this document.
[162] Adapted from Medical Board of California, Division of Licensing, Standard of Care for California Licensed Midwives. *Midwifery Standards of Care* (September 15, 2005). http://www.mbc.ca.gov/MW_Standards.pdf
[163] Virginia Jury Instructions, Civil Instruction No. 35.000. Steven D. Gravely, Troutman Sanders LLP. *Altered Standards of Care: An Overview.*
http://www.vdh.state.va.us/EPR/pdf/Health_and_Medical_Subpanel.pdf
Note: In The Supreme Court Of The State Of Hawaii, In the Matter of the Publication and Distribution of the Hawai`i Standard Civil Jury Instructions, Instruction No. 14.2: Standard Of Care:
"It is the duty of a [physician/nurse/specialty] to have the knowledge and skill ordinarily possessed, and to exercise the care and skill ordinarily used, by a [physician/nurse/specialty] practicing in the same field under similar circumstances. A failure to perform any one of these duties is a breach of the standard of care".
[164] The Agency for Healthcare Research and Quality
[3] Health & Saf. Code, §1276.
[4] Govt. Code, §8571.
[5] Govt. Code, §8567. Local governing bodies have similar authority under a local emergency to enact ordinances, but these ordinances would be subordinate to state statutes, regulations, and orders of the Governor.
[6] 22 Cal. Code Reg., §70217. This regulation does allow for some flexibility where a healthcare emergency (i.e., an unpredictable or unavoidable occurrence at unscheduled or unpredictable intervals relating to healthcare delivery requiring immediate medical interventions and care) causes a change in the number of patients on a hospital unit. However, the hospital must demonstrate that prompt efforts were made to maintain required staffing levels.
[7] See Govt. Code, §8550.
[8] Civil Code, §1714.
[9] Government Code, §8659.
[10] *Burciaga v. St. John's Hospital* (1986) 187 Cal.App.3d 710.
[11] *Bryant v. Bakshandeh* (1991) 226 Cal.App.3d 1241
[12] *Calatayud v. State of California* (1998) 18 Cal. 4th 1057, 1064.
[13] Bus. & Prof. Code, §2727.5
[14] Bus. & Prof. Code, §1627.5.
[15] Bus. & Prof. Code, §2861.5.
[16] Bus. & Prof. Code, §3503.5
[17] Health & Saf. Code, §1799.102.
[18] Health & Saf. Code, §1799.104.
[19] Health & Saf. Code, §1799.106.
[20] Health & Saf. Code, §1799.107.
[21] See, e.g. Bus. & Prof. Code, §2727.5, applying to nurses.
[22] Health & Saf. Code, §1799.102, applying to any person outside of an emergency room or place where care is usually offered.
[23] Bus. & Prof. Code, §2397.
[24] See Govt. Code, §204; "The State may require services of persons, with or without compensation: . . . in protecting life and property from fire, pestilence, wreck and flood."
[25] Govt. Code, §8599.
[26] Govt. Code, §3101.
[27] Govt. Code, §3100.
[28] See Labor Code, §3600.6, §§3211.9-3211.93a, and §§4350-4355; 19 Cal. Code Reg. 2570, et seq.
[29] 19 Cal. Code Reg. 2570.2.
[30] Govt. Code 8657.
[31] Civil Code, §1714.5; the exception here is essentially identical to the Good Samaritan exception for physicians, and the exception to the specific provider immunity in a declared emergency under Govt. Code section 8659, discussed above.
[32] 19 Cal. Code Reg. 2572.1(j).
[33] Civil Code, §1714.5.
[34] Health & Saf. Code, §1317(a).
[35] Health & Saf. Code, §1317(c).
[36] Health & Saf. Code, §1317(g).
[37] Govt. Code, §8665.
[38] Civil Code, §1714.6.
[39] Civil Code, §1714.6.
[40] There is an immunity from liability for refusal to treat based on a determination that the health facility does not have the appropriate facilities or qualified personnel available to render those services. (Health & Saf. Code, §1317(c)).
[41] Hospitals with emergency departments are required under the Emergency Medical Treatment and Labor Act (EMTALA) to provide a screening and stabilization within the abilities of the staff and facilities available prior to transferring the

patient to another facility. (42 U.S.C. 1395dd.) This federal requirement can be waived by the Secretary for Health and Human Services under 42 U.S.C. 1320b-5(b)(3).
[42] See, e.g., Business & Profs. Code, §§1627.5, 2395, 2727.5, 2861.5, and 3503.5.
[43] At present, no standby orders suspending healthcare standards exist.
[44] Health & Saf. Code, §1276.
[45] Govt. Code, §8567.
[46] Govt. Code, §8665.
[47] Govt. Code, §8567b.
[48] A local health officer may take preventive measures to protect public health, including protective step that may be taken against any public health hazard that is caused by a disaster and affects the public health. This could, in limited circumstances, include control over vaccine distribution, but not commandeering of either the vaccine or personnel to administer it.
[49] Govt. Code, §8567.
[50] Govt. Code, §§8550, et seq.
[51] Govt. Code, §8550.
[52] Govt. Code, §8567.
[53] Govt. Code, §8571.
[54] Govt. Code, §8572.
[55] There are three types of emergencies under the ESA; state of war emergency, state of emergency, and local emergency. (See Govt. Code, §8558.)
[56] Govt. Code, §8627.
[57] Govt. Code, §8628.
[58] Govt. Code, §8575, et seq.
[59] Govt. Code, §8579(b)(1).
[60] Govt Code, §8549.10.
[61] Govt Code, §8549.13.
[62] Govt. Code, §8585.
[63] Govt. Code, §8586.
[64] Govt. Code, §8587.
[65] Ibid.
[66] California State Emergency Plan, 2005, pp. 8, 9.
[67] Govt. Code, §8569.
[68] Govt. Code, §8568.
[69] Govt. Code, §8595.
[70] Govt. Code, §8570.
[71] Govt. Code, §8572.
[72] Health & Saf. Code, §§1797.100, et seq.
[73] Health & Saf. Code, §§1797.150.
[74] California State Emergency Plan, 2005, p. 58.
[75] California State Emergency Plan, 2005, p. 56.
[76] Health & Saf. Code, §1797.160.
[77] Ibid.
[78] Health & Saf. 100100, et seq.; effective July 1, 2007, the public health duties of the State Department of Health Services are transferred to the new State Department of Public Health, Health & Saf. Code, §131000, et seq.
[79] California State Emergency Plan, 2005, p. 58.
[80] California State Emergency Plan, 2005, p. 56.
[81] Health & Saf. Code, §§1200, et seq.
[82] Health & Saf. Code, §1276.
[83] Govt. Code, §6502.
[84] Govt. Code, §8615.
[85] Govt. Code, §§8617, 8561.
[86] California Disaster and Civil Defense Master Mutual Aid Agreement, ¶1.
[87] Govt. Code, §8615.
[88] Govt. Code, §8600.
[89] Govt. Code, §8559(a).
[90] California State Emergency Plan, 2005, pp. 8, 10.
[91] Health & Saf., §1797.152(a).
[92] Health & Saf., §1797.152(b).
[93] Govt. Code, §8619.
[94] Govt. Code, §§178, et seq.
[95] Govt. Code, §179.5, et seq.; inoperative effective March 1, 2007; for proposed extension of operability, see AB 1564 (Nava), 2007-2008 Session.
[96] Robert T. Stafford Disaster Relief and Emergency Assistance Act, P.L. 93-288,100-707, and 106-390, 42 U.S.C. §5121, et seq.
[97] Govt. Code, §8560.
[98] Govt. Code, §8616.
[99] Govt. Code, §8610.
[100] Ibid.
[101] Ibid.

[102] Govt. Code, §8585.5.
[103] 19 Cal. Code Reg. 2570.2
[104] Govt. Code, §8612; 19 Cal. Code Reg. §2571.
[105] Labor Code, §3211.92.
[106] Govt. Code, §8610.
[107] Govt. Code, §8610.
[108] Govt. Code, §8614.
[109] In a letter dated September 28, 2006, the Director of OES certified to the federal Department of Homeland Security the compliance of SEMS with the National Incident Management System (NIMS) for fiscal year 2006.
[110] 19 Cal. Code Reg., §2400, et seq.
[111] Govt. Code, §8607(d).
[112] Govt. Code, §8607(e).
[113] Govt. Code, §8607(a)(1); Cal.Code Reg., §§2401, 2402(l), and 2405.
[114] Govt. Code, §8607(a)(2); 19 Cal.Code Reg., §2401, 2402(n).
[115] Govt. Code, §8607(a)(3); 19 Cal. Code Reg., §2415; See *Emergency Management in California*, OES, 2003, p. 8.
[116] Govt. Code, §8618.
[117] Govt. Code, §§8559(b), 8605, and 8607(a)(4);
[118] Govt. Code, §§8559(b), 8605.
[119] Govt. Code, §8605.
[120] 19 Cal. Code Reg., §2402(f).
[121] 19 Cal. Code Reg., §2402(c).
[122] Health & Saf. Code, §1797.153.
[123] Health & Saf. Code, §1797.153(c).
[124] Under the proposed tool, such a declaration could occur at surge levels Orange, Red or Black.
[125] Govt. Code, §8630.
[126] Govt. Code, §8631.
[127] Govt. Code, §8632.
[128] Govt. Code, §8634.
[129] Govt. Code, §26620.
[130] Govt. Code, §26621.
[131] Health & Saf. Code, §1797.200.
[132] Health & Saf. Code, §1797.202(a).
[133] Health & Saf. Code, §101000.
[134] Health & Saf. Code, §101030.
[135] Health & Saf. Code, §101460.
[136] Health & Saf. Code, §101375.
[137] Health & Saf. Code, §101175.
[138] See, generally, *Health Officer's Practice Guide for Communicable Disease Control*, 2007, DPH.
[139] Health & Saf. Code, §120176.
[140] Health & Saf. Code, §§101040, 101475.
[141] Govt. Code, §8630.
[142] Health & Saf. Code, § 101080.
[143] Health & Saf. Code, §101085(c).
[144] Health & Saf. Code, §101085(b).
[145] Health & Saf. Code, §101085(a)(2), (3).
[146] Health & Saf. Code, §101080.2(a).
[147] Health & Saf. Code, §101275.
[148] Health & Saf. Code, §101310.
[149] Health & Saf. Code, §1797.153.
[150] Health & Saf. Code, §1797.153(d).
[151] See Govt. Code, §§24000, 24010, and 24300.
[152] Govt. Code, §§27460, et seq.
[153] Govt. Code, §§27490, et seq. and 27520, et seq.
[154] Coroners Mutual Aid Plan, OES, 2006, p. 11.
[155] Coroners Mutual Aid Plan, OES, 2006, p. 16.
[156] Govt. Code, §8630(b).
[157] Govt. Code, §8630(c).
[158] Govt. Code, §8630(d).
[159] Govt. Code, §8629.
[160] Govt. Code, §8629.
[161] Adapted from: The Recommendations of the state Expert Panel on Inpatient and Outpatient Surge Capacity, *Guidelines for Managing Inpatient and Outpatient Surge Capacity*, state of Wisconsin, November 2005.
[162] Agency for Healthcare Research and Quality *Reopening Shuttered Hospitals to Expand Surge Capacity*. AHRQ Publication No. 06-0029, Rockville, MD: February 2006. http://www.ahrq.gov/research/shuttered/shuthosp.htm
[163] 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.
[164] Sutter Medical Center, Sacramento – Medical Staff Rules
[165] Sutter Health Affiliate – Circumstances for Granting Emergency Privileges in a Disaster

[166] California Emergency Medical Services Authority. Hospital Incident Command System Guidebook. 2006. http://www.emsa.ca.gov/hics/hics%20guidebook%20and%20glossary.pdf
[167] Sutter Health System.
[168] The JCAHO. *Comprehensive Accreditation Manual for Hospitals*. Oakbrook Terrace: JCAHO Resources. 2007
[169] Scripps Health, San Diego. July 2006.
[170] California Governor's Office of Emergency Services. *Disaster Service Worker Volunteer Program (DSWVP) Guidance*. April 2001.
[171] Patent Storm, United States Patent 5537313, "Point of supply use distribution process and apparatus," http://www.patentstorm.us/patents/5537313-description.html
[172] Kay Fruhwirth, County of Los Angeles, Emergency Medical Services Agency (EMSA).
[173] California Emergency Services Act [Cal. Gov. Code §§ 8550-8668] and the California Disaster Assistance Act [Cal. Gov. Code §§ 8680-8690.7].
[174] California Business and Professions Code, Section 4062, subdivision (b).
[175] California Business and Professions Code, Section 4051.
[176] California Business and Professions Code, Section 4059.5, Section 3, subdivision(a)
[177] California Business and Professions Code, section 900 and section 4062.
[178] California Business and Professions Code, Section 4062, subdivision (a).
[179] Emergency System for Advance Registration of Volunteer Health Professionals
[180] www.triagetags.com
[181] www.triagetags.com
[182] Adapted from Treating facility Incident Command System, http://www.emsa.ca.gov/hics/hics.asp
[183] U.S. Social Security Act 1176(b)
[184] http://www.hhs.gov/ocr/hipaa/EnforcementStatement.pdf
[185] 45 CFR 164.510(b)(4)
[186] http://www.hhs.gov/ocr/hipaa/KATRINAnHIPAA.pdf
[187] A disaster incident number is a unique identifier established at the county level for persons being treated at facilities during healthcare surge.
[188] http://www.cms.hhs.gov/ElectronicBillingEDITrans/07_ASCAWaiver.asp#TopOfPage
[189] http://www.nubc.org/R1810TN.pdf
[190] http://www.ahacentraloffice.com/ahacentraloffice/images/Katrina_coding%20advice.pdf
[191] 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
[192] Information gleaned from interviews with representatives from Medi-Cal, May 2007.
[193] MA Influenza Pandemic Preparedness Plan, "Section 10: Legal Considerations For Pandemic Influenza," October 2006
[194] Federal Register Vol. 71, No. 129, page 38264, July 6, 2006, http://a257.g.akamaitech.net/7/257/2422/01jan20061800/edocket.access.gpo.gov/2006/pdf/06-6029.pdf
[195] 42 U.S.C. § 1320b-5 (a)(2)
[196] 42 U.S.C. § 1320b-5 (c)
[197] 42 U.S.C. § 1320b-5 (b)
[198] Baumrucker, Evelyne , April Grady, Jean Hearne, Elicia Herz, Richard Rimkunas, Julie Stone, and Karen Tritz. "Hurricane Katrina: Medicaid Issues", *CRS Report RL33083 for Congress*, September 15, 2005
[199] 28 CCR 1300.67 (g)(1) and (2)
[200] 28 CCR § 1300.67.05.
[201] US Code 42, Chapter 6a, Subchapter XI, §300e Section b4
[202] US Code 42, Chapter 6a, Subchapter XI, §300e Section b5
[203] California - Legislation (CA Statutes) California Business And Professions Code Chapter 1.5. Exemption From Licensure § 900 Bus. & Prof.
[204] California - Legislation (CA Statutes) California Business And Professions Code Chapter 1.6. Health Care Professional Disaster Response Act § 921 Bus. & Prof.
[205] Louisiana State Medical Society, "Louisiana Department of Insurance's Final Emergency Rules and Directives relative to Suspension
of Certain Health Insurance Laws and Regulations Governing Louisiana Licensed Health Insurers
Post Hurricane Katrina and Rita" http://www.lsms.org/Hurricanes/2005%20Emergency%20Rules%20%20Directives.pdf
[206] Louisiana Title 37, Insurance, Part XI Chapter 27: Emergency Rule 15 and 17
[207] Louisiana Department of Insurance, "Hurricanes Katrina and Rita Health Insurance Protections," http://www.ldi.state.la.us/Documents/Health/LHCC/2006_HealthCareConference/HealthInsuranceProtectionsPrintFile.ppt.
[208] "Aetna Lifts Policy Requirements to Help Members in Hurricane Katrina's Wake" http://www.aetna.com/news/2005/pr_20050902.htm
[209] United Healthcare Responds to Support Hurricane Victims, August 31, 2005. http://www.unitedhealthgroup.com/news/rel2005/0831Hurricane.htm
[210] America's Health Insurance Plans (AHIP), "Hurricane Katrina Disaster Response", http://www.ahip.org/HurricaneResponse/cigna.htm
[211] America's Health Insurance Plans (AHIP), "Hurricane Katrina Disaster Response", http://www.ahip.org/HurricaneResponse/cigna.htm