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# Development of Standards and Guidelines for Healthcare Surge during Emergencies

## Alternate Care Sites

## ALTERNATE CARE SITES

2 **NOTE:** This document was developed with input from a broad group of stakeholders representing  
3 constituent organizations with diverse perspectives and technical expertise. The purpose of  
4 eliciting a wide range of input was to ensure the information contained in this document was as  
5 comprehensive and as sound as possible.  
6  
7 Although the individuals referenced and the organizations they represent have provided many  
8 constructive comments, information and suggestions, they were neither asked nor did they agree  
9 to endorse the conclusions or recommendations represented here or in subsequent iterations.  
10

11 **Background**

12 Providing healthcare during a large scale public health emergency presents significant challenges for  
13 healthcare facilities, licensed healthcare professionals, and communities. During emergency events,  
14 healthcare systems must convert quickly from their existing patient capacity to “surge capacity” - a  
15 significant increase beyond usual capacity - to rapidly respond to the needs of affected individuals. The  
16 demands of the emergency may prevent compliance with the existing healthcare standards. Just as  
17 California has healthcare standards for use with a normal operations, it is essential that California provide  
18 guidelines that identify the extent to which existing standards can be flexed or waived for healthcare  
19 delivery during emergencies.

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21 Surge planning for the healthcare system is a substantial and complex challenge. In a time of significant  
22 disaster, a successful plan must provide flexibility to address capacity (volumes of patients) and  
23 capabilities that emerge above baseline requirements. The issues addressed are diverse and include  
24 standards of practice during an emergency, liability of hospitals and licensed healthcare professionals,  
25 reimbursement of care provided during an emergency, operating alternate care sites, and planning  
26 considerations for surge operations at individual hospitals.

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28 Upon completion of this project, stakeholders will have access to a *Standards and Guidelines Manual* that  
29 will serve as a reference manual on existing statutory and regulatory requirements identifying what will be  
30 flexed or modified under different emergencies; *Operational Tools* that include forms, checklists and  
31 templates to facilitate and guide the adoption and implementation of statutory and regulatory  
32 requirements outlined in the *Standards and Guidelines Manual*; and a *Training Curriculum* outlining  
33 intended audience, means of delivery and frequency of training that will enable adherence to the policies  
34 and overall readiness of the healthcare delivery system.

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36 The deliverables will serve as the basis for planning and operations of healthcare facilities, providers and  
37 communities during an unexpected increase in demand for healthcare services. The deliverable will  
38 focus on eight areas: (1) Declaration and Triggers; (2) Existing Facilities; (3) Alternate Care Sites; (4)  
39 Personnel; (5) Supplies, Pharmaceuticals and Equipment; (6) Funding Sources; (7) Administrative; and  
40 (8) Population Rights.

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## Executive Summary

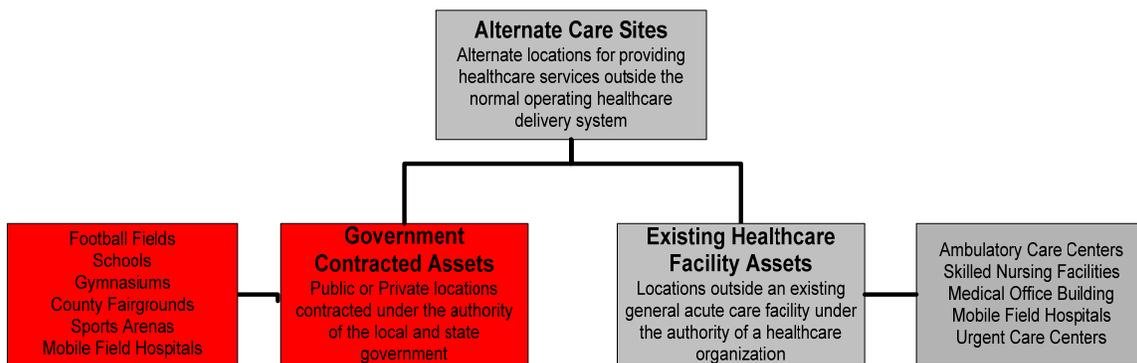
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Designing a healthcare delivery system to care for thousands or even hundreds of thousands of patients or victims when the local healthcare system is overwhelmed poses a daunting task for community or regional planners. America's healthcare system, in both urban and rural areas, is at or near capacity, with little ability to expand to respond to an unusually large mass casualty or surge event. Hospitals in many cities not only are at virtually 100% capacity but also must frequently close their emergency departments to new patients.<sup>1</sup> The State of California is no exception.

Under expected patient surge associated with pandemic influenza, California may require the ability to treat 58,723 patients above existing daily staffed bed capacity, with the majority requiring intensive care.<sup>2</sup> Given this gap, it is important that the California Healthcare System have a coordinated plan to convert quickly from their current patient capacity to surge capacity.

Existing healthcare facilities will need to expand to accommodate as many patients as possible to respond to population needs during a catastrophic event. At some point, the patient demand may exceed the existing healthcare facility capacity. Such patient demand will require a change in the healthcare delivery system and as a last resort may include the establishment of an alternate care site (ACS) contracted under government authority to mitigate the effects of the event.

Existing literature defines an ACS broadly as "a site to provide event-specific management of unique considerations that might arise in the context of catastrophic mass casualty events, including the delivery of chronic care; the distribution of vaccines or medical countermeasures; or the quarantine, cohorting, or sequestration of potentially infected patients in the context of an easily transmissible infectious disease." For purposes of this document, ACS(s) have been separated into two types: 1) the expansion under the license of an existing healthcare facility (see Existing Facility Work Group Output) and 2) ACS(s) contracted under local or state government authority. The focus of this document is on the government contracted ACS(s), as depicted below in red.



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An Alternate Care Site is a location that is not currently providing healthcare services and will be converted to enable the provisions of healthcare services to support, at a minimum, outpatient and inpatient care required during a surge event. Outpatient and inpatient care will vary based on resource availability and event-specific patient needs and may be structured differently than typically seen in existing facilities. These specific sites are not part of the assets of an existing facility (i.e. extensions of a general acute care hospitals), but rather are contracted under the authority of the local and state government.

<sup>1</sup> <http://www.bu.edu/bridge/archive/2002/01-18/in-the-news.html>

<sup>2</sup> State of California Medical Care and Public Health Surge Plan, All Hazards Response to Disasters, DRAFT REPORT: November 2006

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84 The California Emergency Services Act recognizes the role of the State and its political subdivisions to  
85 mitigate the effects of an emergency. Under this authority, local governments can contract with local  
86 public and private entities to establish an ACS in efforts to mitigate the effects of man-made or natural  
87 catastrophic disasters. Further, under the CDHS Pandemic Influenza Response Plan, local health  
88 departments (LHD) are responsible for identifying and planning for the operations of government  
89 contracted ACS(s). CDHS acknowledges that most local health departments are not currently providing  
90 direct patient care, and that successful planning for and operation of government contracted ACS(s) is a  
91 community planning responsibility dependent on the expertise of existing healthcare providers, local law  
92 enforcement, and other government and private resources.

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94 The Alternate Care Site (ACS) model in this document was developed to assist current local community  
95 healthcare systems and local health departments in better preparing for and responding to a surge event.  
96 The ACS model described in following pages focuses specifically on government contracted ACS(s)  
97 under the authority of the local health department. The model includes recommended considerations for  
98 the planning, organization, operational execution, and the logistical requirements that must be evaluated  
99 when establishing an ACS.

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101 The objective of this document is to provide a basic understanding of the core considerations for  
102 establishing and operating a government contracted ACS. As such, the document is divided into four  
103 sections:

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- 106 • **Section I. Definition and Description of an ACS.** This section gives the definition of an  
107 alternate care sites, and outlines criteria for consideration when describing three types of  
108 alternate care sites: Medical Shelters, Outpatient/Inpatient Facilities, and Mobile Field Hospitals.
  - 109 • **Section II. Planning for Healthcare Surge.** This section outlines the authority for establishing a  
110 government contracted ACS(s) and considerations for planners as they develop a plan to  
111 establish an ACS in a local community.
  - 112 • **Section III. Execution during Surge.** This section provides a framework for understanding the  
113 facility continuum for patient flow once a surge event is declared within a local community and the  
114 considerations for "ramp up" and operations of a government contracted ACS.
  - 115 • **Section IV. Post Surge Considerations.** This section describes considerations for the closure  
116 of an ACS.

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118 NOTE: This document is intended as a starting point for local planning and can be tailored for individual  
119 community application. Current local healthcare delivery systems and local health departments should  
120 coordinate to develop plans, relationships, and procedures specific to community needs with the  
121 overarching objective of providing a caring and safe environment for patients during a surge event. In  
122 truth, there is no "one size fits all" model for alternate care sites. It is recommended that local health  
123 departments in conjunction with community healthcare leaders develop plans for the establishment of  
124 alternate care sites that use available resources to meet patient needs during a declared surge event.

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126 The ACS Work Group has adopted a great deal of the thought leadership put forward forth in the AHRQ  
127 publication *Reopening Shuttered Hospitals to Expand Surge Capacity*. (AHRQ Publication No. 06-0029,  
128 February 2006). As such, the recommendations put forth by the publication are cited throughout this  
document.

# 1 Definition and Description of Alternate Care Sites

*Definition of an ACS - An Alternate Care Site is a location that is not currently providing healthcare services and will be converted to enable the provisions of healthcare services to support, at a minimum, outpatient and inpatient care required during a surge event. These specific sites are not part of the assets of an existing facility (i.e. extensions of a general acute care hospitals), but rather are government contracted assets, under the authority of the local and state government.*

An ACS can further be described by its medical surge capability, which is descriptive of the types of services that can be offered/provided to patients during times when the health care system is experiencing a surge of patients.<sup>3</sup> Medical surge capability encompasses the ability to manage patients requiring care in light of the supplies, resources and personnel available at the time.

Although the target patient populations and scope of care to be delivered at an ACS may be event specific, there is one common objective for establishing a government contracted ACS: absorb the patient load until the local healthcare system recovers from a surge. During planning, it is important to consider event-specific needs for patient care to understand the types of ACS(s) that will need to be established. There are three basic criteria to consider that will drive the medical surge capability of an ACS: patient types, scope of care and facility type.

While it is simply impossible to predict the types of patients that will be presenting at an ACS, general assumptions can be made based on the type of mass casualty event. A biological event may result in patients that present at an ACS with isolation requirements; a chemical, radiological, or a nuclear event may result in patients that require decontamination. However, in either scenario, there will be basic patient care requirements of an ACS based on the types of patients that present. These requirements can be classified by three patient types:

- **Outpatient/Inpatient:** Patient presents with general outpatient care requirements or with inpatient care requirements and is not well enough to go home.
- **Supportive:** Patient presents with palliative care requirements or an existing condition with maintenance care requirements (e.g. renal failure, diabetes, etc.)
- **Critical Complex:** Patient presents complex critical care requirements, such as surgery or ICU needs.

The scope of care in an ACS will be driven by resource availability and event-specific patient needs. It is recommended that ACS(s), at a minimum, have the ability to provide outpatient and inpatient healthcare services in order to alleviate the increase in patient demand in the existing healthcare system during a surge. By providing basic inpatient and outpatient services, existing facilities can offload less ill patients from nearby hospitals creating capacity for the more critical. However, it is important to distinguish that the outpatient and inpatient care services at an ACS will be structured differently than typically seen in existing facilities.

ACS(s) can also be established to care for patients with supportive and critical complex needs. The ACS(s) established to treat these types of patients will have specific scopes of care and will need to be assessed based on patient need during a surge. Some considerations for scope of care for supportive patients are dialysis care and palliative care; for critical complex patients considerations for scope of care include surgery and ICU services.

The selection of a potential facility to use as an ACS is an imprecise science and may vary based on the nature of the event.<sup>4</sup> When selecting an ACS facility, it is essential to consider the patient type and scope

<sup>3</sup> 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](http://www.vdh.state.va.us/EPR/pdf/Health_and_Medical_Subpanel.pdf)

<sup>4</sup> AHRQ. Pub No. 07-0001, "Mass Medical Care with Scarce Resources. A Community Planning Guide." Feb 2007

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179 of care as this will drive the facility requirements for providing care. For purposes of government  
180 contracted ACS(s), suggested facilities for ACS(s) providing care for outpatients and inpatients include,  
181 but are not limited to arenas, football fields, churches, gyms, community centers, parking lots and county  
182 fairgrounds. Suggested facilities for providing care to supportive patients are medical shelters, and  
183 suggested facilities for providing care for critical complex patients are mobile field hospitals. (For more  
184 information on mobile field hospital, please contact the California Emergency Medical Service Authority.)  
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Patient Type	Scope of Care	ACS Facility Type
Outpatient/ Inpatient	Patient presents with general outpatient care requirements or patient presents with inpatient care requirements and is not well enough to go home	Parking lot, football fields, Gym, Churches, Community Center
Supportive	Patient presents with palliative care requirements or an existing condition with maintenance care requirements (e.g. renal failure, diabetes, etc.)	Medical Shelters
Critical Complex	Patient presents complex critical care requirements	Mobile Field Hospitals

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## 2 Planning for Healthcare Surge

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Mass casualty events create demand for healthcare services, or a healthcare surge, that often exceed the infrastructure of the affected community. The concept of a surge forms the basis of preparedness and planning efforts for mass casualty events. It is important, therefore, to define Surge Event and Surge Capacity as referenced in this guide.

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<sup>5</sup>, 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.

Surge Capacity: is the patient care capacity under the control of existing healthcare organizational asset base which can be flexed to comply with the Standard of Care for a Healthcare Surge arising out of emergencies. "Healthcare Emergency consists of an unpredictable or unavoidable occurrence at unscheduled intervals relating to healthcare delivery, requiring immediate action"<sup>6</sup> (Industrial Welfare Commission Order).

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 surge as referenced in this guide specifically relates to mass casualty or catastrophic events that overwhelm the healthcare delivery system.

### 2.1 Event-Specific Planning Considerations

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To respond effectively to a mass casualty event, advance planning is critical. A collaborative planning effort between the local health department and community planners (from municipal agencies, including public safety, and emergency management as well as representatives from local health care organizations or institutions) must conceive a plan for how the government contracted ACS(s) would deliver wide-ranging medical services to the population in need. This planning must be done with existing healthcare facilities and home care entities. Planners must delineate the specific medical functions and treatment objectives that the ACS facility would need to accomplish.<sup>7</sup>

Successful establishment of an ACS will require planners to consider the type of mass casualty event and ensure that an ACS has adequate medical surge capabilities to meet the event-specific patient care needs. The planning considerations in this document take an 'all-hazards' approach, outlining the basic considerations for the establishment and execution of an ACS. These include:

- Basic human needs (shelter, heat, food, water)

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<sup>5</sup> 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.

<sup>6</sup> Industrial Welfare Commission Order No. 5-2001 Regulating Wages, Hours And Working Conditions In The Public Housekeeping Industry (Definitions): [http://www.dir.ca.gov/IWC/WageOrder5\\_010102.html](http://www.dir.ca.gov/IWC/WageOrder5_010102.html)

<sup>7</sup> Hassol A, Zane R. *Reopening Shuttered Hospitals to Expand Surge Capacity*. Prepared by Abt Associates Inc., under IDSRN Task Order No. 8. AHRQ Publication No. 06-0029. Rockville, MD: Agency for Healthcare Research and Quality. February 2006.

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- 235 • Basic medical care (beds, medical staff (at least one physician and two nurses), medical  
236 equipment and supplies, medications, electricity)
- 237 • Maintenance of sanitary conditions and management of wastes (plumbing, sanitizable surfaces,  
238 linens, means of waste disposal)
- 239 • Ancillary patient needs (social services, family waiting areas)
- 240 • Communications, safety, and security (fixed and portable communication devices, site and  
241 building access control devices, security staff)<sup>7</sup>

242 It is recommended that event specific considerations are built into the ACS plans to ensure that in  
243 addition to the basic considerations for establishment, the event-specific considerations are included for  
244 the implementing the establishment of an ACS.

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246 In the AHRQ Publication No. 06-0029, "Reopening Shuttered Hospitals to Expand Surge Capacity" the  
247 following planning considerations for a generic mass casualty event scenario and an infectious agent or  
248 communicable disease epidemic (e.g. smallpox, flu, SARS) scenario are suggested.

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250 **Scenario One: A generic mass casualty event (conventional terrorism or war, weapon of mass  
251 destruction, or natural disaster) in which hundreds of ambulatory medical/surgical patients need  
252 to be transferred from tertiary care hospital to make capacity for mass casualty victims.** In this  
253 scenario, every possible patient at the major tertiary hospitals would be transferred to other settings of  
254 care and all elective non-urgent admissions and procedures would be delayed; if this still did not reduce  
255 demand sufficiently, the surge facility would be open. The most critically ill patients would remain in the  
256 tertiary care facilities, and the most medically stable patients would be relocated to the surge facility. It is  
257 also conceivable that there would be a domino effect, in which patients from tertiary care setting would be  
258 transferred to community hospital and then less acutely ill patients in the community hospital would be  
259 transferred to the surge facility.<sup>4</sup>

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261 **Scenario Two: An infection agent or communicable disease epidemic (e.g., small pox, flu, SARS)  
262 that requires the creation of an infectious-disease/isolation or quarantine hospital as the surge  
263 facility.** Special considerations for a surge facility under an isolation scenario such as this include:  
264 willingness of facility owners to allow this use at their facility, prophylaxis of staff working at the surge  
265 facility, security and perimeter control, infectious waste removal and treatment, isolation air handling,  
266 negative pressure room wards, laundering and contaminated linens, and (possibly) body disposal.<sup>4</sup>

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268 *General Planning Assumptions*<sup>8</sup>  
269 The successful establishment and operations of an ACS is, by its very nature, a complex undertaking with  
270 a variety of issues to be addressed. As is the case with all aspects of emergency preparedness, these  
271 issues are best vetted and investigated well before an event that necessitates their implementation. As  
272 such, the following general planning assumptions should be considered by planners, regardless of the  
273 type of mass casualty event, when developing initial plans for establishing a government contracted ACS:

- 274 1. Community planning requires significant cross service planning to establish a government contracted  
275 ACS based on an all-hazards approach.
- 276 2. Lifesaving response will be performed by local emergency responders and citizens in the impacted  
277 area regardless of the efficiency of state and federal response systems.
- 278 3. Seriously injured victims will require medical care quickly.
- 279 4. Government contracted ACS(s) will operate in an uncertain environment:
  - 280 • The number, type and location of casualties; the status of roads and the emergency  
281 transportation system; and other factors such as weather, day of the week, time of day, etc.  
282 cannot be predicted. These factors will strongly influence not only the demand for medical  
283 care but also the availability of medical resources.
  - 284 • The magnitude of the disaster and disruptions to communications systems will require  
285 decision-makers to act without complete information about the number, type, and location of  
286 casualties and impact on health facilities.
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<sup>8</sup> Adapted from The California Emergency Medical Services Authority (EMSA)

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- 288 5. Affected populations will adopt strategies that appear most effective for obtaining medical care. This  
289 will result in convergence to known medical facilities, such as hospitals and clinics regardless of their  
290 operational status. Affected populations will also converge on government contracted ACS(s) if their  
291 location is known to the public.
- 292 6. Government contracted ACS(s) require significant logistic and personnel support from the Public  
293 Health DOC, and the City or OA EOC for support from law enforcement, fire, public works,  
294 purchasing, and social services. Medical, hospital, public health personnel, volunteers and disaster  
295 service workers cannot set up and operate a government contracted ACS without this assistance.
- 296 7. Government contracted ACS(s) should be viewed as a last resort in the medical response to a  
297 disaster because:
- 298 • Government contracted ACS(s) require large numbers of personnel and material resources to  
299 establish and operate.
  - 300 • Government contracted ACS(s) are not part of the usual health care system and their  
301 operation is not routinely practiced and refined.
  - 302 • Government contracted ACS(s) require a high-degree of interagency function and cooperation
- 303 8. Local existing healthcare facilities have plans in place to cope with dramatically increased capacity for  
304 to 72 hours. Therefore, it is assumed that a government contracted ACS would need to open within  
305 3-7 days after a declared surge event. Government contracted ACS(s) would need to operate for a  
306 range of 2-8 weeks, depending on the nature of the surge event and the patient needs. There is no  
307 maximum operational period.  
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## 309 2.2 Establishing a Government Contracted ACS

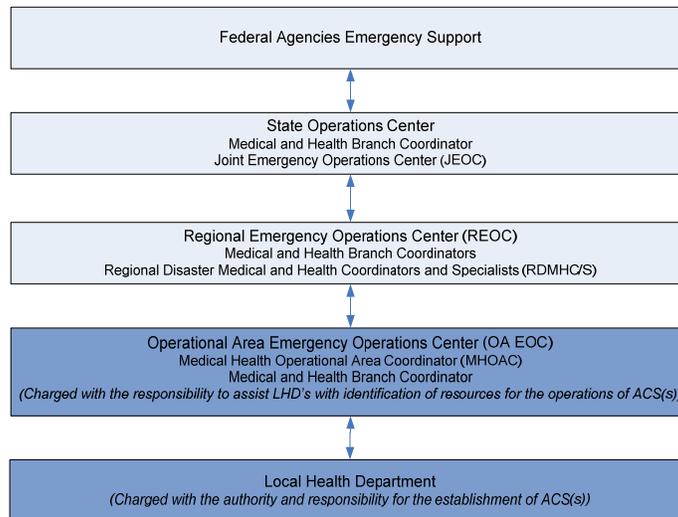
### 310 2.2.1 Authority

311 Currently, patient care during emergencies or disasters is provided primarily at community-based  
312 hospitals, integrated healthcare systems, private physician offices, and other point-of-service medical  
313 facilities. The delivery of care is based on individual facility's preparedness, capacity and capability.  
314 However, this approach to response during a healthcare surge is sub-optimal from a population outcome  
315 perspective and a scarce resource utilization perspective. In a mass casualty incident, healthcare  
316 facilities may lack the necessary resources and/or information to individually provide optimal patient care.  
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318 Therefore, community healthcare assets must collaboratively develop community surge capacity and  
319 capability plans. This does not, however, preclude or diminish the need for individual healthcare facilities  
320 to have a comprehensive emergency management plan that addresses mitigation, preparedness,  
321 response, and recovery activities. However, efforts must extend beyond optimizing internal emergency  
322 management plans and focus on integrating with other healthcare and non-healthcare assets in the  
323 community, public and private.  
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325 Under the CDHS Pandemic Influenza Response Plan, responsibility for identifying and planning for  
326 government contracted ACS(s) resides with the local health department (LHD). However, this task  
327 cannot be completed without local, regional and state collaboration. A recommended structure for the  
328 government authority and responsibility for the establishment an ACS using the Standardized Emergency  
329 Management System (SEMS) emergency response structure is depicted below.  
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Although the LHD has the authorization to set up and operate an ACS, it is expected that the Operational Area Emergency Operations Center (OA EOC) will provide support for the operational requirements for the establishment of an ACS. The medical/health branch of the OA EOC is led by the Medical Health Operational Area Coordinator (MHOAC) and has the resources to support the operations of an ACS. As such, it is recommended that the OA EOC assist the LHD to identify resources for the management and operations of an ACS.

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A substantial amount of advance preparation must take place before a disaster arises that necessitates the opening of an ACS. If LHD(s) choose to pursue the use of a location as an ACS, key local authorities will need to come together to ensure the individuals responsible for the operations of an ACS are clearly identified. LHD(s) should consider identifying who will be responsible for the ACS and for getting it up and running; and who will be in charge of operating the ACS when it is needed.<sup>4</sup>

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It is recommended that LHD(s) formalize an ACS Planning and Management Team to establish the minimum planning and operational requirements for establishing an ACS in a local community. The team should have a designated team leader with responsibility for maintaining contact with the team, arranging meetings, and representing the team as needed to take on the responsibility for establishing an ACS. Expertise in the following areas is needed, with preference for those with knowledge about operating under emergency conditions:

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- Disaster response/emergency management coordination (management, coordination of work with involvement of multiple entities).
- Hospital staffing
- Facilities
- Security
- Patient transport
- Patient information management
- Coordination of supplies, equipment and pharmaceuticals

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The ACS Planning and Management Team should engage in community based planning efforts in the preparation for the establishment of a government contracted ACS. The inclusion and integration of non-healthcare entities in the community is an important element of the community based capacity and capability. Below is a checklist of community members for consideration as the ACS Planning and Management Team begin to plan for the establishment and execution of government contracted ACS.

	Community Participant	Role
<input type="checkbox"/>	Local Emergency Medical Services Authority	Local implementing arm of the Emergency Medical Systems Authority.

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	Community Participant	Role
<input type="checkbox"/>	Law Enforcement and Fire	Emergency first responders
<input type="checkbox"/>	Public works & Local Utility Companies	Essential services
<input type="checkbox"/>	Communication Companies	Communication needs
<input type="checkbox"/>	Major employers and business community, especially big-box retailers	Essential supplies and services
<input type="checkbox"/>	Area Airports	Transportation
<input type="checkbox"/>	Red Cross / Salvation Army and other non-profit organizations	Volunteers and Supplies Aid
<input type="checkbox"/>	National Guard and Military Establishments	Transportation and infrastructure support
<input type="checkbox"/>	Chamber of Commerce	Business community support
<input type="checkbox"/>	Board of Realtors	Help coordinate additional space for healthcare facilities
<input type="checkbox"/>	City Unified School District and Community Colleges	Alternate Care Sites
<input type="checkbox"/>	Public transportation	Transportation
<input type="checkbox"/>	Faith based organizations	Translation and funeral services
<input type="checkbox"/>	Private security firms	Security services
<input type="checkbox"/>	Mortuaries	Funeral services
<input type="checkbox"/>	Neighborhood emergency response centers	Volunteers

### 367 2.2.2 Contract Considerations

#### 368 Facility

369 The first and foremost contract requirement for a government contracted ACS is the contract for securing  
 370 premises and operating an ACS on a private, public or tribal property. The ACS Planning and  
 371 Management Team should enter into contractual agreements for the acquisition of facility locations to be  
 372 under the authority of local or state government in the event of a declared surge. A sample Memorandum  
 373 for Use of Facilities in the Event of a Mass Medical Emergency is included in Appendix A.

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#### 375 Non-Clinical/Clinical Supplies & Equipment and Pharmaceuticals

376 In addition to facility contracts, the ACS Planning and Management Team should decide which items or  
 377 services will be contracted for or outsourced and which will not. Planners should examine the potential  
 378 for borrowing from other hospitals in the operational area, and also consider goods and services that  
 379 may be available under a disaster declaration from State and Federal authorities, including the Strategic  
 380 National Stockpile. Once the ACS location has been secured, the ACS Planning and Management Team  
 381 should undertake a detailed analysis of available services in the area.<sup>4</sup>

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383 National equipment and supply vendors provide a host of services. Regional vendors may be more  
 384 specialized and only provide one or two necessary services. Some contracting arrangements can be  
 385 made in advance on a 'contingency' basis so that contracts can be implemented rapidly when an  
 386 emergency occurs. In the preplanning stages, it is possible to develop contracts, purchase orders,  
 387 vendor relationships and inventory reallocation plans. Not everything needs to be contracted for in  
 388 advance, however, as many vendors report being able to meet the new demand at virtually any time. If  
 389 the entire equipment and supply process is to be arranged under a comprehensive service contract, the  
 390 facility assessment itself could perhaps include someone from the selected contractor who will be  
 391 responsible for so much of the time-sensitive ramp-up during the week prior to opening. Using an  
 392 existing contract at a major medical center as the contractual 'vehicle' would promote even faster  
 393 procurement.<sup>4</sup>

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395 *(See also Supplies, Pharmaceuticals and Equipment work group output document for licensing of*  
396 *dispensing at an ACS.)*

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### 398 **Security Services - Personnel and Equipment**

399 In some cases, private security personnel may need to be contracted for services at an ACS. A contract  
400 would have to be set up in advance with a firm, to specify the following:

- 401 • Number of security personnel needed and by when. (It should be readily feasible to get up to  
402 10 security personnel from a private firm within 24 hours.)
- 403 • Security protocols to be followed and exact parameters of responsibility.
- 404 • Level of training needed.
- 405 • Gear and equipment specifications.
- 406 • Number of personnel who need to be armed.
- 407 • Chain of command guidance.

408 The firm under contract should specify how (and how quickly) personnel will be made available given the  
409 needs of their permanent client list and should assess if they can truly deliver the needed staff.

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411 *(See also Personnel work group output document for augmenting workforce at an ACS.)*

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### 413 **Environmental Services - Personnel and Equipment**

414 Environmental service personnel and equipment may need to be contracted for an ACS. Planners may  
415 choose to pre-establish executable contracts for disaster remediation and pest control, general waste  
416 management, hazardous waste disposal, and laundry services. Many organizations provide these  
417 services and they tend to be local. Waste disposal is almost always outsourced, and, in the absence of  
418 on-site laundry machines, it would be wise to outsource laundry services as well. Environmental services  
419 personnel contracts should include specific language around the following tasks:

- 420 • General cleaning of surfaces and walls within patient areas, including wet/dry methods,  
421 timing to repetition, appropriate materials, and detergents/disinfectants.
- 422 • Mitigation of the use of mists, aerosols, and fumigants in patient areas and cleaning methods  
423 that disturb and distribute dust into patient areas.
- 424 • Cleaning areas with immunocompromised patients.
- 425 • Cleaning spills of bodily fluids.
- 426 • Special care of carpeting and other cloth furnishings.

427

428 *(See also Personnel work group output document for augmenting workforce at an ACS.)*

429

### 430 **Food Services - Personnel and Meals**

431 Food service personnel and meals may need to be contracted for an ACS. Planners may choose to pre-  
432 establish executable contracts for food service personnel and meal supply.

433

434 *(See also Personnel work group output document for augmenting workforce at an ACS.)*

## 435 **2.2.3 Facility Assessment**

436 The selection of the ACS location is critical for the successful operations of the ACS. A thorough facility  
437 assessment should be conducted early to select the proper facility for ACS operations. The ACS Planning  
438 and Management Team should determine the appropriate individuals to participate in the facility  
439 assessment. Some considerations include, but are not limited to security professionals, supply and  
440 equipment contractor and environmental engineers.

441

442 The following are considerations for the planners as they assess potential ACS locations.<sup>9</sup>

443

### 444 **Location Selection**

---

<sup>9</sup> ACS Site Criteria adapted from Federal Medical Station Site Selection and Support Requirements. (From D. Boyd, ACS Work Team Member)

## ALTERNATE CARE SITES

445 Optimally, ACS planners should locate and determine the suitability of an existing facility or structure that  
446 can be utilized to support the ACS, consistent with its intended purpose for the specific incident.

447

### 448 **Roadway Access and Security**

449 ACS(s) should have access to at least two-roads. This would provide continued access to the ACS in  
450 the event that one roadway became blocked or inaccessible. These roadways should connect directly to  
451 the ACS property. This would allow for easy set up of traffic stop points to limit access and check  
452 personnel identification or vehicles if needed during surge use.

453

### 454 **Building Size Considerations**

455 The building size is also a very important factor when selecting an ACS structure. The building should be  
456 large enough to effectively care for the patients. The exact allocation of space will be largely determined  
457 by the facility design; however, for reference the minimum building size of a functional ACS that can  
458 incorporate the 250-bed capacity is approximately 40,000 square feet. The minimum sized building  
459 required for either a 50-bed Quarantine and Shelter ACS or a 50-bed Non-Acute Care ACS is  
460 approximately 9,000 square feet. An open area of approximately 50,000 sq ft is considered optimum for  
461 an 250 bed ACS; 40 sq. ft per bed, per person.<sup>6</sup> The total size and number of beds will be directly  
462 influenced by factors such as facility layout (should not let the building dictate the support requirement),  
463 number of patients, patient acuity, and the medical logistics support.

464

### 465 **Building Security**

466 ACS(s) should have a limited number of building entranceways (approximately a half dozen or fewer) that  
467 are readily controllable for security purposes. In addition, it should be capable of being secured and  
468 providing secure storage for controlled substances and other sensitive medical materials.

469

## ALTERNATE CARE SITES

### 470 **Additional Facility Selection Consideration**

471 Below are additional suggested considerations for facility selection that can assist planners in selecting  
472 an ACS facility.

- 473 • Close proximity to its supporting hospital for ease of transferring patients and sharing of  
474 resources, such as laboratories and diagnostic capabilities
- 475 • Sufficient number and types of existing communications (hard wire telephones and high  
476 speed internet ports)
- 477 • Adequate parking and loading ramps
- 478 • Utilities: electrical power (back-up generator capability is highly desirable); ventilation; heating;  
479 air conditioning; water and plumbing systems
- 480 • Separate rooms with large floor space for patient care or ability to partition open space to  
481 create private patient care rooms
- 482 • Nursing stations
- 483 • Bathrooms with shower capabilities for patients
- 484 • Kitchen facilities
- 485 • Rooms for registration and family waiting area
- 486 • Climate control
- 487 • Waste removal capabilities
- 488 • Area for hand-washing stations and other safe hygiene techniques
- 489 • Staff support / rest break areas
- 490 • Adequate staging areas for supplies and storage
- 491 • Isolation areas for mental health patients
- 492 • Adequate HVAC for proper ventilation throughout facility
- 493 • Wheelchair access
- 494 • Fire protection safety and equipment (e.g., fire extinguishers, fire alarms, etc)
- 495 • Refrigeration capabilities for safe storage of medical supplies and food, if needed

496

### 497 **Clinical Considerations**

498 When selecting an ACS, it is important to evaluate the clinical care requirements for treating patients.  
499 Listed below are considerations for providing care at the ACS:

500

- 501 • Triage focused areas for patients requiring various levels of care
- 502 • Pharmacy area that provides pharmaceuticals necessary for patient care
- 503 • Laboratory / blood testing capabilities
- 504 • Isolation and decontamination capabilities
- 505 • Sufficient equipment support for clinical care, including medical gases
- 506 • On-site imaging capabilities
- 507 • Oxygen supply and cylinder refill capability
- 508 • Mortuary support

509

### 510 **Recommended Facilities**

511 Recommended existing structures suitable for use as an ACS include: National Guard armories,  
512 gymnasiums, civic sports centers, schools, hotel conference rooms, health clubs, convention centers, and  
513 community centers. Large tents or similar "soft" structures can also be used. One factor that makes  
514 National Guard armories and schools attractive is the fact that they are generally publicly owned  
515 structures, making it easier for emergency coordinators to rapidly secure them in the event of a disaster.

516

517 An Alternate Care Site Assessment Tool is included in Appendix B to assist planners in identifying  
518 potential locations that can serve as an ACS and the minimum physical requirements for operations of an  
519 ACS. The tool will assist in determining the criteria/requirements/standards for a particular ACS location  
520 as it relates to:

521

## ALTERNATE CARE SITES

- 522 • Location considerations for an ACS: airports/hangers, non-operating hospitals, arenas &  
523 stadiums, fairgrounds/parks, schools, churches, gyms, community centers, football fields,  
524 government buildings, hotels/motels, meeting halls and warehouses
- 525 • Clinical Care Requirements: What are the minimum clinical requirements to provide patient  
526 care?
- 527 • Infrastructure: Is there sufficient square footage to provide space for patient cots or mats and  
528 space for work area for healthcare providers, ancillary workers and support staff? Is there  
529 space to store supplies? Can access to the building be safely controlled? Is the building  
530 environmentally safe for patients and workers?
- 531 • Total space and layout: Is there an area where patients can easily be transferred from  
532 ambulances into the building? Is there ample parking for workers and patient families? Is there  
533 adequate space to safely store contaminated waste until pick up?
- 534 • Utilities: Does the building have a system of back up power? Electrical outlets? Sanitary  
535 facilities? Running water?
- 536 • Communication: Can multiple phone lines and internet connections quickly be activated at the  
537 site? Who do they need to serve? Is the wiring sufficient to support phone lines and internet  
538 connections?
- 539 • Other services: Is there an area where food can be prepared safely or received from a  
540 catering service?

### 541 2.2.4 Non-Clinical Operational Considerations

#### 542 **Security Services<sup>4</sup>**

543 Safety and security is the most essential operational requirement of an ACS. Without proper safety and  
544 security measures at an ACS, the lives of patients and personnel will be in jeopardy.

545 It is recommended that an ACS be open to the public ONLY IF an armed guard is present at the time of  
546 opening.

547  
548 Security needs and goals at the ACS would be comparable to those at any hospital under normal  
549 conditions of operations. These include general safety of patients, staff, and visitors, and protection of  
550 pharmaceuticals and other assets. However, typical measures to achieve security would be more  
551 complex for an ACS due to the following reasons:<sup>4</sup>

- 552 • Since this is a temporary ACS facility; the facility itself and security procedures will be  
553 unfamiliar and not yet routine to the security staff. Therefore, protocols will be more difficult to  
554 maintain and unusual events will be more difficult to identify
- 555 • ACS personnel will not be known to security staff or to one another, therefore unauthorized  
556 persons will be more difficult to identify
- 557 • Mechanical and electronic security controls would be quickly retrofitted onto the ACS structure  
558 and may not be of optimal design and function for this facility
- 559 • All personnel, patients, and visitors will be under heightened stress due to the catastrophic  
560 event that necessitated opening of the ACS
- 561 • Protestors and demonstrators (for example, animal rights activists) may target the ACS  
562

563 During an infectious agent or communicable disease epidemic scenario, there are significant additional  
564 security concerns and risks beyond those mentioned above. If the ACS is to serve as an  
565 isolation/quarantine facility for infectious patients, there could be a strong not-in-my-backyard reaction  
566 from the community surrounding the surge facility, generated by fear of the infectious agent. This could  
567 cause community members to object and try to prevent the facility from opening and receiving patients,  
568 and might lead to disruption of facility operations. If there is widespread perceived risk from the infectious  
569 agent, and if vaccinations and medical prevention and treatment are in short supply, there could be  
570 aggressive attempts to obtain or steal medications from the surge facility. These are serious and real  
571 security risks, and they will be difficult to manage under the conditions of a quickly opened temporary  
572 surge facility. The following additional measures should be considered:

- 573 • Providing security for incoming and outgoing vehicles (for roadways between site perimeter  
574 and major corridors through the community), in particular those transporting infected patients.

## ALTERNATE CARE SITES

- 575 • Controlling access to the grounds.
- 576 • Heightened access control into and around the building.
- 577 • More stringent identification and tracking of patients, staff, and visitors.

578

### 579 *Access Control*

580 Control of access to the site and the building would be achieved through security personnel, physical  
581 barriers such as fencing and Jersey knees, and mechanical and electronic devices such as locks, card  
582 reader systems on doors, and security cameras. There is a strong interplay between these security  
583 methods. As an example, if doorways cannot be locked or secured with electronic card readers,  
584 additional security staff will be needed at each doorway.

585

### 586 *Controlling Site Access*

587 ACS(s) should have access to at least two-roadways. This would provide continued access to the ACS in  
588 the event that one roadway became blocked or inaccessible. These roadways should connect directly to  
589 the ACS property. This would allow for easy set up of traffic stop points to limit access and check  
590 personnel identification or vehicles if needed during surge use. In particularly difficult security situations,  
591 roadways except one could be blocked with Jersey knees or other barriers, and traffic access could be  
592 limited to one checkpoint using physical traffic barriers plus security staff. Facility access roadways are  
593 also wide enough to create zigzag pathways to prevent a hostile vehicle from approaching the facility at  
594 high enough speeds to cause damage. For ACS(s) with large, open land areas with no fencing or other  
595 barriers, significant installation of physical barriers as well as security staff would be needed to control  
596 access onto the site.

597

### 598 *Controlling Building Access*

599 The exterior windows, doors, and other structural components of the ACS building should be in place with  
600 no breach in the building envelope allowing for building access other than in normal doorway entrances.  
601 Locks on doors and windows should be in place and functional. A limited number of building  
602 entranceways (approximately a half dozen or fewer) should be established. Exterior doorways should be  
603 controlled with locks and if possible electronic card readers. If not, security experts estimate that three to  
604 four security personnel would be needed per shift to control building access and monitor the building. If  
605 doorways could not be secured via use of such technology, additional security personnel would be  
606 needed to control these doorways.

607

### 608 *Securing Pharmaceuticals*

609 ACS(s) should have a lockable pharmacy area. Aside from the lockable doors, there should be security  
610 personnel and if possible, alarms and cameras. Installation of some of these additional security controls  
611 may be needed to protect the pharmacy area under the isolation/quarantine scenario if there is a general  
612 shortage of vaccines or preventive or curative medications as described in the introduction.

613

614 *(Also see Supplies, Pharmaceutical and Equipment work group document for additional information on*  
615 *considerations for securing pharmaceuticals.)*

616

### 617 *Identification and Tracking of Patients, Staff and Visitors*

618 Comprehensive identification and tracking efforts will be needed and security experts recommend  
619 issuance of staff identification badges, use of security personnel for identification and tracking or limitation  
620 of visitors. This identification and tracking would be conducted in concert with other access control  
621 measures as described above.

622

623 *(See Administrative work group output document for additional patient and valuables tracking*  
624 *considerations.)*

625

### 626 *Monitoring and Prevention*

627 Regular patrols by security personnel would be needed to continually identify and de-escalate potential  
628 security problems. In an infectious agent or communicable disease epidemic scenario, significant  
629 monitoring efforts would be needed as the security risks are much greater. Ideally, remote security

## ALTERNATE CARE SITES

630 monitoring devices such as door alarms and security cameras would be used in combination with  
631 patrolling security personnel. If remote monitoring is not feasible, a significantly higher number of security  
632 personnel will be needed.

633

### 634 *Security Communications*

635 Effective execution of security protocols will require that on-site security personnel be able communicate  
636 with one another and be able to call in outside emergency personnel if needed. During surge, security  
637 teams will need to communicate with each other, possibly with existing facilities and with the local police  
638 department.

639

### 640 *Security Management and Protocols*

641 It is recommended that a comprehensive security management plan and action protocols be developed  
642 by security experts for any planned government contracted ACS use.

643

### 644 *Security Staffing*

645 In a generic mass casualty event (conventional terrorism or war, weapon of mass destruction, or natural  
646 disaster), approximately four to six security staff per shift would be needed, and perhaps more at a larger  
647 facility. This includes three to four staff for building access control and security, and one to two staff for  
648 site access control and security. This level of staffing assumes that a reasonable level of physical barriers  
649 and mechanical and electronic security controls can be installed so that doors can all be locked and that  
650 physical traffic barriers are in place. If this is not the case, additional staffing will be needed. For example,  
651 an additional security staff person would be needed at each entrance door that could not be locked or  
652 otherwise secured.

653

654 In an infectious agent or communicable disease epidemic scenario, a higher level of staffing will be  
655 needed as security risks are greater. Approximately 8 to 12 security staff would be needed, 4 to 6 each  
656 for both building access control and security and site access control and security. Again, this level of  
657 staffing assumes that physical and mechanical controls can be installed for site and building access  
658 control. If these controls cannot be put in place, a higher level of staffing would be needed, including two  
659 to four additional security staff per shift to patrol and secure the site perimeter.

660

### 661 *Sources of Security Staff*

662 A possible option for security staff would be to contract with a private security firm; these exist in every  
663 city. Some of these firms specialize in the types of emergencies that would necessitate opening a surge  
664 facility. A contract would have to be set up in advance with a firm. In addition, it may be possible to hire  
665 officers from the local community police department in the town where the surge facility is located to serve  
666 as paid police details. This cannot be set up in advance or guaranteed. Depending on what else is  
667 happening in the community, all officers may be fully utilized conducting their regular duties and will only  
668 be available to respond to active security or civil unrest situations.

669

670 Security personnel may also be called in from public police or military entities such as: local police, State  
671 police, National Guard, military police, or security members of Federal DMATs or DMRTs (only under a  
672 Federal emergency). Personnel from these organizations cannot be arranged for in advance, but can only  
673 be called in to respond to an existing emergency situation.

674

675 In an infectious agent or communicable disease epidemic scenario it may be more difficult to obtain  
676 security personnel, as many will not wish to serve at an isolation/quarantine facility. Armed security staff  
677 may be needed under this scenario if civil unrest threatens to disrupt facility operations. Staff might also  
678 need protective gear against the infectious agent, such as respirators for which medical screening,  
679 training, and fit testing are required. Private security firms and/or their staff will likely be unwilling to serve  
680 at the isolation/quarantine surge facility. Local police officers might have the necessary skills and training  
681 and are likely to be fitted with respirators under DHS preparedness efforts (powered air-purifying  
682 respirator or air-purifying respirator fitted with HEPA cartridges at a minimum are recommended) but may  
683 be unwilling to serve at the isolation/quarantine surge facility.

684

## ALTERNATE CARE SITES

### 685 **Environmental Services<sup>4</sup>**

686 With hazardous and infectious materials and exceptionally strict occupational and facility cleanliness  
687 standards for patient safety, environmental engineering at an ACS is a science in itself. The several  
688 hundred page *Guidelines for Environmental Infection Control in Health Care Facilities* by the Centers for  
689 Disease Control and Prevention document is specifically aimed at environmental controls that decrease  
690 patient illness from common hospital infections at all phases of care, and can be used as guidance for the  
691 environmental service requirements at an ACS. Staff and/or contractors will be needed for the following  
692 functions:

- 693 • Cleaning the surge facility to bring it to sanitary standards before admitting patients
- 694 • Maintaining sanitary water, air, and other environment throughout the course of surge facility  
695 operation
- 696 • Laundering uniforms, bedding, and other cloth goods
- 697 • Disposing of hazardous materials under strict Environmental Protection Agency (EPA)  
698 guidelines
- 699 • Disposing of medical and other waste (both solid and liquid)

700

701 In addition to staffing, the following environmental services equipment will need to be purchased or  
702 procured:

- 703 • EPA certified detergents, disinfectants, and chemical sterilants (including tuberculoids and  
704 germicides)
- 705 • Disposable mops, cleaning cloths, sponges, and other cleaning apparatus
- 706 • Floor buffer/polisher and carpet shampooer
- 707 • Sweeping apparatus (note: recommendations from EPA suggest minimizing the use of such  
708 tools as they may disturb and distribute dust into the air – use wet mops whenever possible)
- 709 • Industrial strength vacuum with HEPA filter (and replacement)
- 710 • Containers and labels for hazardous waste
- 711 • General waste containers
- 712 • Cleaning carts and cleaning material storage shelving

713

714 During the planning phase, environmental engineers should accompany the team on the assessment of  
715 the selected surge facility. They should take note of the facility's current condition from a sanitation  
716 perspective. If pests or rodents are noted, planners may wish to fumigate the facility using appropriate  
717 hospital procedures prior to any declaration of surge need. Patient areas must be free of chemical  
718 residue; therefore, special precautions, specific techniques, and time must be observed. Proactive pest  
719 control will allow the ACS to open without delay.

720

721 Planners will also need to consider infrastructure options for waste disposal and removal. Contracts with  
722 hazard remediation cleaners may need to be executed to deploy staff to clean a facility that has had  
723 limited upkeep over several years and prepare it for patient care. During the 3-7 days prior to opening the  
724 ACS, environmental staff will transition from a hazard remediation cleaning standard to an upkeep phase.  
725 It may be appropriate at this point to transition from cleaning contractors to other service vendors or staff  
726 familiar with general hospital sanitary operations.

727

728 For an ACS facility of 250-300 patients, the environmental engineering staff will likely include up to 30  
729 FTEs and 5 managers to cover all the shifts. These staff and managers should be familiar with U.S. Code  
730 pertaining to hospital cleanliness standards, OSHA regulations, Food and Drug Administration guidelines  
731 and regulations, EPA guidelines, and general best practices.

732

733 An environmental crew should be the first staff in the ACS, as soon as a department of public health has  
734 authorized its preparation for use. This disaster remediation team, noting the specific instructions based  
735 on the facility assessment, will be responsible for cleaning a facility that has not had a medical grade  
736 cleaning – and bringing it to sanitary standards appropriate for patients. Cleaners will maintain the ACS  
737 and keep general orderliness and cleanliness while many people enter and exit the ACS during the  
738 preparation period.

739

## ALTERNATE CARE SITES

740 Once patients are admitted and the ACS is operating, environmental services staff may take on a role  
741 identical to that at any traditional hospital. In an infectious agent or communicable disease epidemic  
742 scenario, their role will require additional germicidal and disinfectant tools. Basic tasks to be performed by  
743 environmental service staff include, but are not limited to:

- 744 • General cleaning of surfaces and walls within patient areas, including wet/dry methods, timing  
745 to repetition, appropriate materials, and detergents/disinfectants
- 746 • Mitigation of the use of mists, aerosols, and fumigants in patient areas and cleaning methods  
747 that disturb and distribute dust into patient areas
- 748 • Cleaning areas with immunocompromised patients
- 749 • Cleaning spills of bodily fluids
- 750 • Special care of carpeting and other cloth furnishing
- 751 • Special pathogen considerations

752  
753 As patients are gradually discharged and the surge facility is prepared for closure, cleaning staff can also  
754 be reduced. A core staff will remain to shut down the facility and return it to a safe closure state.  
755

## ALTERNATE CARE SITES

### 756 **Administrative Services**

757 *(See Administrative work group output document for medical record documentation, patient and valuables*  
758 *tracking, charge capture standards, registration and billing, and sample downtime procedures for*  
759 *registration, medical record number, and billing at an ACS.)*

760

761 *(See Personnel work group output document for streamlined credentialing and personnel verification*  
762 *during a healthcare surge.)*

763

764

### 765 **Staffing of Non-Clinical Personnel**

766 *(See Personnel work group output document for augmenting, organizing and maintaining a workforce at*  
767 *an ACS.)*

768

### 769 **Non-Clinical Supplies and Equipment**

770 *Communications and IT Capabilities.* Reliable communications and IT systems will be required among  
771 the ACS and nearby health institutions, EMS providers, unified command, law enforcement, suppliers,  
772 staff members and the public.<sup>4</sup> Redundant communication and IT capabilities for operations of an ACS is  
773 essential during a surge event. Communication and IT systems allow for ease of communication  
774 between ACS and hospitals, in addition to law enforcement, staff members and suppliers. Core  
775 communication and IT equipment could potentially be inaccessible due to damage, resulting in a lack of  
776 communication methods and IT capabilities during a surge. It is recommended that planners plan for the  
777 worst case scenario and consider the following means for internal and external ACS communications and  
778 IT support:

779

- Runners

780

- Portable/Hand Held radios

781

- Disaster radios

782

- Overhead announcers

783

- Telephone

784

- Cell phones

785

- PA system

786

- Fax System

787

- Televisions

788

- Hand held devices

789

- Lap tops

790

791 *(See Supplies, Pharmaceutical and Equipment work group document for additional information on the*  
792 *acquisition of non-clinical supplies and equipment.)*

793

## 794 **2.2.5 Clinical Operational Considerations**

795 An ACS can be described by its medical surge capability, which is descriptive of the types of services that  
796 can be offered/provided to patients during times when the health care system is experiencing a surge of  
797 patients.<sup>3</sup> Based on the patient types described in Section I of this document, the table below outlines the  
798 minimal treatment considerations for supportive, outpatient/inpatient and critical patients. The table can  
799 be used to determine the clinical operational considerations for setting up one of the three types of  
800 government contracted ACS(s): Medical Shelter, Outpatient/Inpatient Facility, or Mobile Field Hospital.

801

## ALTERNATE CARE SITES

Patient Type:	Supportive	Outpatient	Inpatient	Critical
<b>Treatment Considerations:</b>				
Laboratory / Blood Testing	Limited Lab Testing	Limited	Intermediate	Advanced
Pharmaceuticals	Basic	Limited (Basic / Routing Care)	Intermediate (IV Capabilities)	Advanced (IV Capabilities)
Imaging Capabilities	None	Limited (Portable X-Ray only)	Intermediate (Radiology including Portable X-Ray and Ultrasound)	Advanced
Medical Gases	Limited	Limited	Intermediate (Oxygen and Suction Only)	Advanced
OR	None	None	Procedural Sedation only	Yes
Dietary Needs	Special Dietary Needs	None	Reduced	Special Dietary Needs
ICU Support	Limited (Home ventilator only)	Limited	Respiratory Support Only	ICU with advanced respirator support
Morgue Plan	Yes	Yes	Yes	Morgue
Dialysis	Limited	None	None	Yes
Clinical Capabilities	On-going Chronic Medical Care	Peds	Med-Surg/Peds/OB/Psyc Capabilities	Med-Surg/Peds/OB/Psyc Capabilities
OP Clinic	None	Yes	Yes	Yes
Triage / ER	Medical Assessment Only	Triage only	Triage and ALS (+/-)	ER

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803

### 804 Laboratory Testing

805 In all probability, limited lab testing will be performed at an ACS, with the exception of a mobile field  
806 hospital. It will be easier to employ bedside point of care testing for common tests and courier service  
807 and contract with private laboratory testing companies or other hospitals for more advanced test than to  
808 try to establish a laboratory in an ACS.

809

### 810 Medical Record Documentation

811 *(See Administrative work group output document for medical record documentation.)*

812

### 813 Staffing of Clinical Personnel

814 *(See Personnel work group output document for scope of practice information and augmenting,*  
815 *organizing (staff ratio consideration for an ACS) and maintaining a clinical workforce at an ACS.)*

816

### 817 Clinical Supplies, Equipment and Pharmaceuticals

818 *(See Supplies, Pharmaceutical and Equipment work group document for additional information on the*  
819 *acquisition of clinical supplies, pharmaceuticals and equipment.)*

820

## 821 2.2.6 Incident Command Structure

822 Using a standardized organizational system that clarifies individual and team responsibilities, chain of  
823 command, and communication pathways will facilitate maximum staff efficiency in a difficult situation. As  
824 SEMS is recommend for the emergency response structure for the external authority of an ACS, it is  
825 recommended that the ACS planning and management team institute an ACS incident command  
826 structure adapted from the existing Hospital Incident Command System (HICS) for the internal operations.

827

## ALTERNATE CARE SITES

828 The adapted HICS structure will allow for<sup>10</sup>:

829

830

- Predictable chain of command

831

- Flexible organizational chart allows flexible response to specific emergencies

832

- Prioritized response checklists

833

- Accountability of position function

834

- Improved documentation for improved accountability and cost recovery

835

- Common language to promote communication and facilitate outside assistance

836

- Generic approach to command and control that is designed to function with positions instead of relying on key individuals

837

- Cost effective emergency planning within health-care organizations

838

839

840

The HICS model outlines a variety of key roles and responsibilities for incident command. It is scalable to the size of the event and the number of roles can be modified based upon the operational needs of an ACS during a surge event. At a minimum, it is suggested the following roles be considered for the operations of an ACS:

841

842

843

844

*Incident Commander.* The incident commander assumes overall leadership. He/she is assisted by several advisors/coordinators who deal with the news media, other agencies, security and safety, and physician assignment. The four major section chiefs are assigned by the incident commander. Each chief designates directors and unit leaders to sub-functions.

845

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*Logistics Section Chief.* The logistics section chief focuses on operations associated with the physical environment and ensuring adequate levels of food, shelter and supplies. He/she is responsible for power; utilities; sanitation; water; trash; communication systems (telephone, intercom, paging system); transportation of supplies, patients, and staff; and meals for patients and staff.

850

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854

*Planning Section Chief.* The planning section is responsible for compiling information about the current situation and developing long-range planning. He/she is to keep staff up to date regarding the current disaster situation inside the hospital and in the surrounding area, maintain an inventory of available staff and volunteers, organize and coordinate medical and nursing staff, track patient census by location and status, and anticipate needs.

855

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*Finance Section Chief.* The finance section is to monitor the utilization of financial assets. He/she is responsible for the accounting and documentation of all resource expenditures, providing cost analysis data, maintaining personnel time records, negotiating and/or issuing contracts to purchase or obtain resources and receiving and investigating all accident/incident claims resulting from an employee action on hospital property.

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866

*Operations Section Chief.* This is a large section covering the overall delivery of medical care, ancillary services, and staff support. This group is responsible for triage; patient admissions and discharges; planning for short- and long-term staffing and medical resource needs; morgue services; overseeing laboratory, radiology, and pharmacy services; and the social and psychological needs of the staff, patients, and families. This group would also be responsible for sheltering and feeding of staff and volunteer dependents.

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873

A communication and reporting plan should be developed to for internal and external briefings following the HICS model. Suggested forms for communication and reporting protocols include:

874

875

876

HICS Form 201: "Incident Briefing"

877

HICS Form 203: "Organization Assignment List"

878

HICS Form 205: "Incident Communications Log"

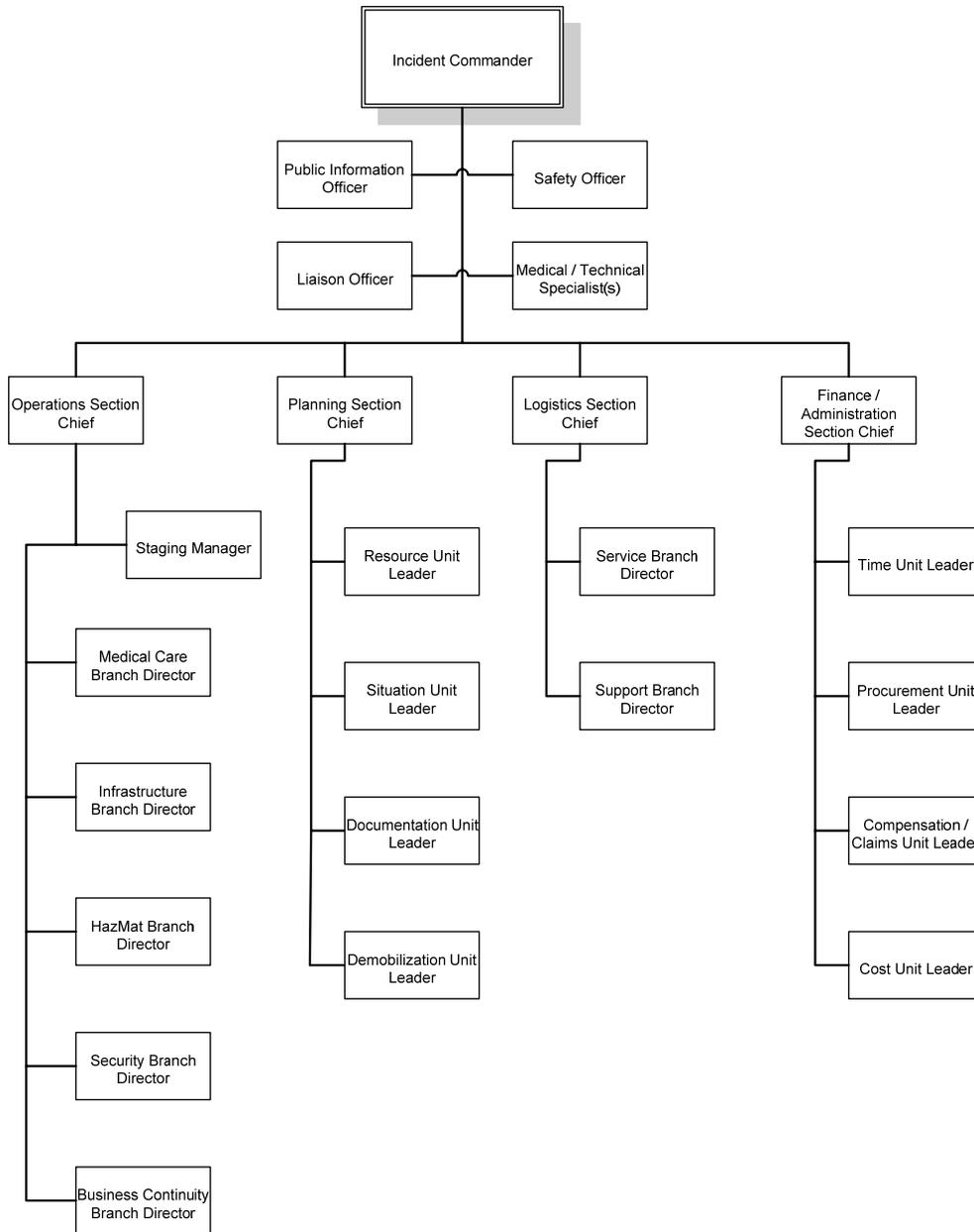
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<sup>10</sup> AHRQ. Publication No. 06-0029, "Reopening Shuttered Hospitals to Expand Surge Capacity." February 2006

## ALTERNATE CARE SITES

880 HICS Form 251: "Facility System Status Report"  
881 HICS Form 261: "Incident Action Plan Safety Analysis"  
882  
883



884

885

### 886 2.2.7 Training

887 Training for ACS operations requires both pre-event training and on-site/just-in-time training.  
888 Below is a list of training topics to be considered for pre-event training:

889

890

891

892

- SEMS
- ACS Incident Command System, adapted from HICS, to include job action sheets
- ACS setup training in the form of drills/table top exercises

## ALTERNATE CARE SITES

- 893 • Concepts of mass casualty care training for clinical staff including Public Health Principles -  
894 *Doing the greatest good for the greatest number of people*
- 895 • ACS Operational Training including inventory management, infection control and PPE, security  
896 and safety, equipment training,
- 897 • Orientation training including process flow for inside and outside the facility and communication  
898 protocols.
- 899 • Point of care testing
- 900 • Volunteer training

901  
902

### On-site / Just-in-time training

903 On-site, and/or just-in-time training may be required to provide orientation to ACS operations and  
904 procedures. It is assumed that medical and emergency medical training has been received by staff with  
905 medical licenses.

906  
907

- 908 • Patient tracking
- 909 • Report procedures, check in procedures, credentialing
- 910 • PPE, medical evaluation and testing, infection control, FIT testing
- 911 • Logistics and operational training
- 912 • Employee handbook of procedures

913

## 914 2.2.8 Legal Considerations

915 The California Emergency Services Act, the State of California and its political subdivisions have the  
916 responsibility and authority to take what ever actions necessary to mitigate the effects of an emergency.  
917 Specifically, "the state has long recognized its responsibility to mitigate the effects of natural, manmade,  
918 or war-caused emergencies which result in conditions of disaster or in extreme peril to life, property, and  
919 the resources of the state, and generally to protect the health and safety and preserve the lives and  
920 property of the people of the state." (California Government Code § 8550) Included within this authority  
921 is the ability of the state or local government to establish an Alternate Care Site (ACS) to enable the  
922 provisions of healthcare services necessary to treat those impacted by the disaster. As a response under  
923 a declared disaster, the ability to establish and operate an ACS is not subject to those state laws or  
924 regulations generally applicable to healthcare facilities as they existed pre-disaster.

925

### 926 Qualified Immunities

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

933

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

937

938 *Qualified Immunities for Facilities* - California Civil Code § 1714.5 defines the qualified immunities for  
939 facility liability claims at an ACS. Per § 1714.5, "no person who enters a designated building or premises  
940 for refuge, treatment, care or assistance during an emergency has a cause of action for personal injuries  
941 against one who owns or maintains any building or premises designated as a shelter or mass care center,  
942 first aid station, temporary hospital annexes or as other necessary facilities for mitigating the effects of an  
943 emergency. Designation obtained from any disaster council or any public office, body or officer of the  
944 state or US, unless willful act of such owner or occupant".

945

## ALTERNATE CARE SITES

946 California Civil Code § 1714.6 further defines that "no person shall be liable for negligence as a matter of  
947 law, or prosecuted for violation of any statute or ordinance, where the act or omission involved was  
948 required in order to comply with [omitted military order] any regulation, directive, or order of the Governor  
949 under the California Emergency Services Act. During a declaration of a disaster by the Governor, if an  
950 ACS is established to mitigate the effects of an emergency, no liability shall fall on the owners of the ACS  
951 facilities, unless an act of willful omission is committed".

952  
953 *Qualified Immunities for Volunteer Personnel* - The Volunteer Protection Act of 1997 states that "no  
954 volunteer of a nonprofit organization or governmental entity shall be liable for harm caused by an act or  
955 omission of the volunteer on behalf of the organization or entity if: (1) the volunteer was acting within the  
956 scope of the volunteer's responsibilities...etc. (2) if appropriate or required, the volunteer was properly  
957 licensed, certified, or authorized by the appropriate authorities...etc." This statute is very broad and may  
958 apply in broad circumstances, so long as summoned by a proper authority, and possesses the required  
959 first aid and emergency care training; immunity from liability appears to exist for providing any service that  
960 could fall within the definition of emergency services. For the purposes of this statute, emergency  
961 services includes but is not limited to first aid and medical services, rescue procedures, and  
962 transportation or other related activities necessary to insure the safety of the victim who is the object of a  
963 search or rescue operation.

964 California Civil Code § 1714.2 and .21 states that "if trained in basic CPR by the AHA or ARC and in good  
965 faith renders CPR at the scene of an emergency is not liable for any civil damages unless grossly  
966 negligent". Not applicable to those expecting compensation (e.g., staff/volunteers trained in CPR who  
967 render aid during duty hours). A person is not liable for any civil damages if rendered AED (defibrillator)  
968 at the scene of an emergency, if complied with applicable requirements of Health and Safety Code  
969 1797.196.

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

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

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

994 California Business & Professional Code § 2861.5 applies to licensed vocational nurses and states that "a  
995 person licensed under this chapter [licensed vocational nurse] who in good faith renders emergency care  
996 at the scene of an emergency which occurs outside both the place and the course of his employment

## ALTERNATE CARE SITES

997 shall not be liable for any civil damages as the result of acts or omissions in rendering the emergency  
998 care. This section shall not be construed to grant immunity from civil damage to any person whose  
999 conduct in rendering emergency care is grossly negligent".

1000 California Business & Professional Code § 3503.5 applies to physician's assistants and states that "a  
1001 person licensed under this chapter [physician's assistant] who in good faith renders emergency care at  
1002 the scene of an emergency that occurs outside both the place and course of that person's employment  
1003 shall not be liable for any civil damage as a result of any acts or omissions by that person in rendering the  
1004 emergency care. This section shall not be construed to grant immunity from civil damages to any person  
1005 whose conduct in rendering emergency care is grossly negligent. In addition to the immunity specified in  
1006 subdivision (a), the provisions of Article 17 (commencing with Section 2395) of Chapter 5 shall apply to a  
1007 person licensed under this chapter when acting pursuant to delegated authority from an approved  
1008 supervising physician".

1009  
1010

### **Clinical Laboratory Improvement Amendments**

1012 The CLIA statutes are very prescriptive, and prohibit any place from receiving or testing human  
1013 specimens unless it is CLIA certified (application, assurances of compliance, survey, etc). A CLIA waiver  
1014 still requires pre-approval based on an application, and limited scope of testing (42 USC 263a(d)(2).)  
1015 Since the effect of this necessitates pre-approval, it does not appear possible to secure a waiver prior to a  
1016 declared emergency. It is recommended to have a model request that included issuing a CLIA waiver to  
1017 ACS(s) under the authority of the government that are mobilized in the event of a declared local/state  
1018 emergency.

1019

### **Workers Compensation for Volunteers**

1021 The State of California Disaster Service Worker Volunteer Program (DSWVP) provides workers'  
1022 compensation insurance coverage in the event a Disaster Service Worker (DSW) volunteer is injured  
1023 while performing assigned disaster duties. Registered DSW volunteers may file a claim for injuries  
1024 sustained while engaged in the following activities:  
1025 "... Performing disaster service, including travel to and from the incident site, when called to duty during an  
1026 emergency or disaster, or while participating in a search and rescue operation...Participating in an  
1027 authorized and documented, planned disaster training activity or disaster exercise." Coverage for these  
1028 activities does not include travel to and from the training site.

1029

1030 Unregistered volunteers impressed into disaster service by a public official having the authority to do so,  
1031 may file a claim for injuries sustained while performing that service. Unregistered volunteer workers not  
1032 impressed into service may not file a claim if injured during a training activity or disaster exercise.

1033

### **HIPAA Compliance**

1035 *(Please see Administrative work group output document for HIPAA Compliance during a healthcare*  
1036 *surge.)*

1037

## 1038 2.2.9 Funding and Reimbursement Sources

1039

1040 Broad authority for establishing an ACS falls under the California Emergency Services Act which  
1041 recognizes the role of the state and its political subdivisions to mitigate the effects of an emergency.  
1042 Therefore the responsibility of identification of funding sources and reimbursement for an ACS is the  
1043 responsibility of the government.

1044

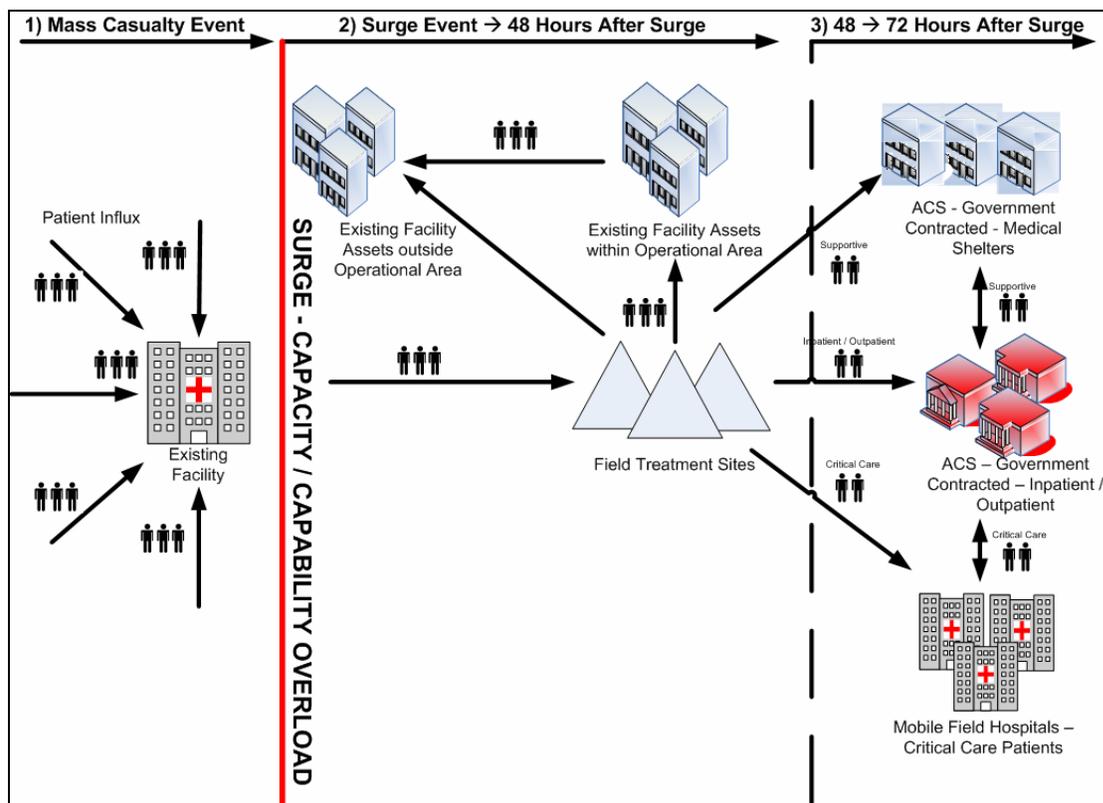
1045 *(See Funding and Reimbursement work group document output.)*

1046 **3 ACS Execution during Surge**

1047 **3.1 Surge Trigger**

1048 When a mass casualty event occurs, the population affected will seek medical care from the existing local  
 1049 hospitals and healthcare facilities. However, as the demand for healthcare services increase and existing  
 1050 healthcare facility assets become exhausted, the local or state government will have to step in and  
 1051 establish government contracted ACS(s) to absorb the patient load until the local healthcare system  
 1052 recovers from a surge.

1053  
 1054 At a minimum, 72 hours will be required to set up a government contracted ACS after a declared surge  
 1055 event. Existing resources, through the California Medical Services Authority, exist to assist communities  
 1056 within the first 48 hours of a declared surge event to offload less critical patients from existing facilities  
 1057 clearing beds for the more critical patients. The diagram below depicts the facility continuum for patient  
 1058 flow after a surge event is declared by the local health officer.  
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 1060



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**Phase 1: Mass Casualty Event Occurs, Surge is Declared**

When a mass casualty event occurs, those affected will move or be transported from their respective locations to the nearest existing facility. As time passes, existing facilities will experience a large influx of patients and eventually exceed capacity and capability. When this occurs, existing facilities will call upon the local health officer and the local health officer, using professional judgment, will determine whether or not to declare a surge.

**Phase 2: Excess Patients Transferred to Field Treatment Sites and Existing Facility Assets**

## ALTERNATE CARE SITES

1072 After the local health officer declares a surge, excess patients are transferred to Field Treatment Sites  
1073 (FTS). FTS(s) are medical response functions that can provide care and triage services for a period of up  
1074 to 48 hours.<sup>11</sup> Patients brought to the FTS may be again relocated to existing facility assets both within  
1075 and outside the affected operational area of a healthcare surge. (*For specific information regarding the*  
1076 *care provided to patients at existing facility assets, please refer to the Existing Facilities section of the*  
1077 *document.*)  
1078

### Phase 3: Excess Patients Transferred from FTSs to Government Contracted ACSs

1079 Between 48 and 72 hours, government contracted ACS(s) will be established and patients will be able to  
1080 be treated at these sites. Three types of government-contracted alternate care facilities can be deployed  
1081 by the Local Health Department:  
1082

- 1083 • Inpatient / Outpatient Alternate Care Site: this site will be equipped to treat patients who  
1084 present with general inpatient or outpatient care requirements and are not well enough to go  
1085 home.
- 1086 • Medical Shelters: Medical shelters will be equipped to treat patients with palliative care  
1087 requirements or existing conditions with maintenance care requirements (e.g. renal failure,  
1088 diabetes, etc.)
- 1089 • Mobile Field Hospitals: Mobile Field Hospitals will be equipped to treat patients with complex  
1090 critical care requirements, such as surgery or ICU needs.  
1091

## 1092 3.2 "Ramping Up" for a Healthcare Surge

1093 As soon as a healthcare surge is declared by the local health officer, ACS(s) will begin to be established  
1094 with the goal of being operational between 48 to 72 hours of the event. To ensure a successful ACS  
1095 opening, the following should be considered for "ramp up" activities:<sup>12</sup>  
1096

1097 During a declared healthcare surge, the individual and/or team identified by the ACS Planning and  
1098 Management team should:

- 1099 • Coordinate with each team member to ensure that the ACS can be fully operational two days  
1100 after a surge is declared
- 1101 • Ensure that at the time of opening, there is at LEAST: one armed guard, one physician and  
1102 one nurse
- 1103 • Contact ACS incident commander and operations chief
- 1104 • Assemble all applicable contracts for services and staff
- 1105 • Contact and mobilize staff for security, environmental, administrative, clinical and  
1106 pharmaceutical services
- 1107 • Contact vendors for supplies, pharmaceuticals and equipment to ensure smooth delivery
- 1108 • Act as liaison between vendors and entity alternate care site
- 1109 • Assist with troubleshooting or procuring additional assistance/resources as needed  
1110

### 1111 Facilities

1112 A thorough facility assessment should be conducted to ensure the structural integrity of the facility. It is  
1113 recommended that a facility vulnerability assessment report be completed at the initial stages of the ramp  
1114 up period (See Appendix C and D for sample facility assessment reports.) When ramping up for a  
1115 healthcare surge, the facility should be checked to ensure the following:

- 1116 • Functionality of utilities: electrical power; ventilation; heating; air conditioning; water and  
1117 plumbing systems
- 1118 • Functionality of HVAC system

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<sup>11</sup> Adapted from California Emergency Medical Services Authority

<sup>12</sup> Hassol A, Zane R. *Reopening Shuttered Hospitals to Expand Surge Capacity: Surge Tool Kit and Facility Checklist*. Prepared by Abt Associates Inc. under IDSRN Task Order No. 8. AHRQ Publication No. 06-0029. Rockville, MD: Agency for Healthcare Research and Quality. February, 2006.

## ALTERNATE CARE SITES

- 1119 • All areas that will not be used are partitioned off
- 1120 • Functionality of telephone and other communications systems
- 1121 • Functionality of back-up power, if available
- 1122 • Proper space needed for patient care: this may involve contacting an identified moving
- 1123 company to conduct move out of desks, etc.
- 1124 • Cleanliness of ACS. Efforts need to be made to make the ACS as sterile as possible.
- 1125 • Availability of fire extinguishers
- 1126 • Functionality of a supplemental morgue system if needed

1127

### 1128 **Non Clinical and Clinical Staffing**

1129 Potential staff required for the ACS depends on the type of patients each ACS will be admitting. Once  
1130 patient type is decided upon, notification to potential staff must go out and staff will begin to arrive. When  
1131 ramping up for the healthcare surge, the following actions must take place:

- 1132 • Finalize provisions of healthcare services to be provided and staff numbers needed
- 1133 • Notify Incident Command or Management Team Leader of staffing needs potentially provided
- 1134 by Federal, State and non-government sources.
- 1135 • Notify all applicable organizations regarding staffing needs. Such organizations include
- 1136 temporary staffing agencies, health professional schools and volunteer programs.
- 1137 • Perform streamlined credentialing for healthcare surge procedures
- 1138 • Provide orientation to specific units as workers arrive

1139

### 1140 **Security**

1141 Without proper safety and security measures at an ACS, the lives of patients and personnel will be in  
1142 jeopardy. It is recommended that a security assessment and vulnerability report be completed by security  
1143 personnel. (See Appendix E for sample standardized security/vulnerability assessment tool.) In addition, it  
1144 is recommended that an ACS be open to the public ONLY IF an armed guard is present at the time of  
1145 opening. Following security ramp up tasks should be performed:

- 1146 • Contact contracted security personnel
- 1147 • Keys must be obtained from current owner/operator for use by security staff
- 1148 • Test radios on-site, if applicable
- 1149 • Post security procedures and emergency call information in key locations
- 1150 • Set up access control parameters

## 1151 **3.3 Operations of ACS during Surge**

1152 *The majority of this section has been adapted from the existing facilities work group output document.*  
1153 *Because the patient needs of mass casualty events are simply unpredictable, the operations of an ACS*  
1154 *will be dependent on the availability of limited resources. As such, the operational considerations that*  
1155 *apply to an existing facility during a surge can serve as guidance and applied to ACS operations, as seen*  
1156 *fit by ACS management.*

1157

### 1158 **Standards of Care**

1159 The occurrence of a healthcare surge will require significant changes in the way in which health and  
1160 medical care is delivered. If the healthcare system is to optimize population outcomes, planning,  
1161 education, and training efforts should be focused on the development and implementation of appropriate  
1162 protocols for Standard of Care during a Healthcare Surge.

1163

1164 Standard of Care in California is defined by the scope of practice each provider is licensed to provide. It  
1165 provides a framework to identify the professional responsibilities of licensed personnel and permit  
1166 individual licensed personnel to be rationally evaluated, to ensure that it is safe, ethical and consistent  
1167 with the professional practice of the licensed profession in California<sup>13</sup>. Standard of Care is a legal

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<sup>13</sup> 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](http://www.mbc.ca.gov/MW_Standards.pdf)

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1168 concept that not only encompasses the diagnosis and treatment of patients but overall management of  
1169 patients as well. Per Jury Instructions Standard of Care is defined as:

1170  
1171 A practitioner must use "the degree of skill and diligence in the care and treatment of his patient that a  
1172 reasonably prudent doctor in the same field of practice for specialty in this State would have used under  
1173 the circumstances of this case."<sup>3n</sup>

1174  
1175 The law requires that licensed healthcare personnel, when caring for patients, adhere to the customary  
1176 skill and care that is consistent with good medical practice. Diligence implies compliance with laws and  
1177 regulations (for example, licensing requirements). Standard of Care covers all aspects of treatment - from  
1178 the administering of proper medications to performing open-heart surgery.

1179  
1180 Under normal conditions, current standards of care might be interpreted as employing appropriate health  
1181 and medical resources to improve the health status and/or save the life of each individual patient.  
1182 However, according to a report by, Health Systems Research Inc., Altered Standards of Care in Mass  
1183 Casualty Events; an AHRQ<sup>14</sup> Publication, April 2005) in the aftermath of a mass casualty event, the  
1184 demand for care provided in accordance with normal conditions (current standards) would exceed system  
1185 resources resulting in a healthcare surge. Therefore, it is critically important to identify, plan, and prepare  
1186 for making the necessary adjustments in current health and medical care standards to ensure that the  
1187 care provided in response to a healthcare surge results in as many lives being saved as possible.

1188  
1189 The report further states that currently no universally accepted definition of Standard of Care during a  
1190 mass casualty event exists. Joint Commission refers to such standards as "graceful degradation" under  
1191 which care and access to caregivers may become rationed. Per the report, Altered Standards of Care" is  
1192 referred to: "as a shift to providing care and allocating scarce equipment, supplies, and personnel in a  
1193 way that saves the largest number of lives in contrast to the traditional focus on saving individuals."

1194 According to the report, examples of shift in care include:

- 1195 • Triage efforts will need to focus on maximizing the number of lives saved. Instead of treating the  
1196 sickest or the most injured first, triage would focus on identifying and reserving immediate  
1197 treatment for individuals who have a critical need for treatment and are likely to survive. The goal  
1198 would be to allocate resources in order to maximize the number of lives saved. Complicating  
1199 conditions, such as underlying chronic disease, may have an impact on an individual's ability to  
1200 survive.
- 1201 • Triage decisions will affect the allocation of all available resources across the spectrum of care:  
1202 from the scene to hospitals to alternate care sites. For example, emergency department access  
1203 may be reserved for immediate-need patients; ambulatory patients may be diverted to outpatient  
1204 treatment centers or alternate care sites. Intensive or critical care units may become surgical  
1205 suites and regular medical care wards may become isolation or other specialized response units.
- 1206 • Needs of current patients, such as those recovering from surgery or in critical or intensive care  
1207 units; the resources they use will become part of overall resource allocation. Elective procedures  
1208 may have to be cancelled, and current inpatients may have to be discharged early or transferred  
1209 to another setting. In addition, certain lifesaving efforts may have to be discontinued.
- 1210 • Credentialing of providers may be granted on an emergency or temporary basis.
- 1211 • Equipment and supplies may be rationed and used in ways consistent with achieving the ultimate  
1212 goal of saving the most lives (e.g., disposable supplies may be reused).
- 1213 • Not enough trained staff. Staff will be scared to leave home and/or may find it difficult to travel to  
1214 work. Burnout from stress and long hours will occur, and replacement staff will be needed. Some  
1215 scarce and valuable equipment, such as ventilators, may not be used without staff available who  
1216 are trained to operate them.
- 1217 • Delays in hospital care due to backlogs of patients. Patients will be waiting for scarce resources,  
1218 such as operating rooms, radiological suites, and laboratories.

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<sup>14</sup> The Agency for Healthcare Research and Quality

## ALTERNATE CARE SITES

- 1219 • Providers may need to make treatment decisions based on clinical judgment. For example, if  
1220 laboratory resources for testing or radiology resources for x-rays are exhausted, treatment based  
1221 on physical exam, history, and clinical judgment will occur.
- 1222 • Current documentation standards will be impossible to maintain. Providers may not have time to  
1223 obtain informed consent or have access to the usual support systems to fully document the care  
1224 provided, especially if the health care setting is damaged by the event.
- 1225 • Backlog in processing fatalities. It may not be possible to accommodate cultural sensitivities and  
1226 attitudes toward death and handling bodies. Numbers of fatalities may make it difficult to find and  
1227 notify next of kin quickly. Burial and cremation services may be overwhelmed. Standards for  
1228 completeness and timeliness of death certificates may need to be lifted temporarily.

1230 While the examples suggest how clinical practices might shift, the definition of Altered Standards of Care  
1231 does not explore the liability and compliance issues that would arise out shift in care provided. To  
1232 address the lack of legal dimension in the definition of care provided during healthcare surge, the expert  
1233 panel chose to modify the Standard of Care definition (Jury instructions). As a first step, the expert panel  
1234 identified principles supporting the new definition, followed by development of a definition for care  
1235 provided during healthcare surge and finally, offered recommendations to support an effective response  
1236 to healthcare surge.

### Guiding Principles

- 1239 • The Adjusted or Altered Standard of Care during a healthcare surge will be "the" Standard of Care  
1240 available and should be termed "Standard of Care during a Healthcare Surge".
- 1241 • The Standard of Care definition, under normal conditions, adapted for large number of victims as  
1242 opposed to individual patients, would apply to healthcare surges.
- 1243 • The definition should broaden the scope of caregivers and afford protection to not just licensed  
1244 personnel but also volunteers and facilities.

1246 **Standard of Care during a Healthcare Surge:** "the degree of skill, diligence and reasonable exercise of  
1247 judgment in furtherance of optimizing population outcome during a healthcare surge event that a  
1248 reasonably prudent person or entity with comparable training experience or capacity would have used  
1249 under the circumstances"

- 1250 • The "under the circumstances" clause in the definition provides some protection to healthcare  
1251 providers (facilities, personnel and volunteers) during a healthcare surge as long as there is  
1252 evidence to support that there was no negligence, appropriate steps were taken (planning,  
1253 periodic training, relevant documentation, etc.) and that there was reasonableness demonstrated.

### Recommendations

- 1256 • Consideration should be given to protocol-based care rather than independent medical judgment.  
1257 Needs for consistent protocols are necessary because it offers defensibility against liability and  
1258 allows healthcare providers to focus on providing care to populations.
  - 1259 ■ Protocols enable determining how to deviate from the norm without the healthcare  
1260 provider experiencing repercussions. Protocols would also address triage and rationing  
1261 of supplies.
  - 1262 ■ Development of protocols at the State level would ensure that the protocols are equitable  
1263 to the populations.
- 1264 • The State should consider developing patient prioritization guidelines at the healthcare facility.  
1265 The guidelines would enable:
  - 1266 ■ Equitable, fair and ethical allocation of resources between various types of patients (for  
1267 example, existing vs. disaster patients, patients with co-morbidities, etc.)
  - 1268 ■ Appropriate use of resources by defining criteria for transfer of patient between levels of  
1269 care and/or discharge.
  - 1270 ■ Patient prioritization in accordance with Standard of Care during Healthcare Surge as  
1271 defined earlier.
  - 1272 ■ Coordination of field and facility triage. (Note: Training of responding medical personnel in  
1273 field triage protocols should be considered.)

## ALTERNATE CARE SITES

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- Risk communications and public education programs should be initiated before an incident and such programs should be incorporated in pre-event planning activities of the community. The information provided should set expectations for the Standard of Care that will be available during a healthcare surge and include appropriate guidance for all age groups and populations.

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Since the goal of Standard of Care during a Healthcare Surge is to optimize population outcomes, one key planning element to be considered is the training needs of responding medical personnel. Training should focus on behavioral adjustments - from delivering as much care as needed for each patient to applying predefined prioritization, delivery of care and discharge guidelines for populations.

### 1284 **Security**

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Controlling the movement of individuals into, throughout and out of the ACS during an emergency is essential to the safety of patients and staff, and to the security of critical supplies, equipment and utilities. The ACS security personnel in conjunction with the ACS Incident Commander may determine 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.

### 1291 **Lock Down vs. Restricted Visitation**

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Each incident will have its own security-related issues. ACS(s) cannot afford a passive approach to lock down or restricted visitation. "Gang violence," employee or patient-related violence, and terrorism are pressing reasons why ACS security must be taken seriously and comprehensive planning and training conducted.

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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.

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1316

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.

1317

1318 *(See Appendix F and G for lock down sample procedures and lock down checklist.)*

1319

### 1320 **Supplemental Security Staffing**

1321

1322

1323

1324

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).

### 1325 **Traffic Control**

1326

1327

1328

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

## ALTERNATE CARE SITES

1329 warrant inspecting all of these vehicles as they enter the campus; this will require additional personnel  
1330 and the equipment needed to do the inspection (Traffic Control Unit).

### 1331 **Patient and Valuable Tracking**

1332 Routine daily procedures for managing patient and valuable personal belongings may need to be  
1333 modified. The arrival of a large number of patients may present challenges in rapidly and accurately  
1334 cataloguing and securing belongings. (See *patient and valuable tracking section in the Administrative*  
1335 *work group output document.*)

### 1337 **Hazardous Waste Management**

1338 The term “emergency” is dependent upon several factors, including the hazards associated with the  
1339 substance, the exposure level, the potential for danger and the ability to contain the substance. OSHA  
1340 does not require that facilities receive accident victims, but if the victim were part of an emergency  
1341 involving hazardous substances and facility personnel needed to decontaminate, HAZWOPER would  
1342 apply (OSHA, 1992).

1343  
1344 The role of facility personnel in the safe decontamination of victims has been further clarified in the OSHA  
1345 publication “Best Practices for Hospital-Based First Receivers of Victims from Mass Casualty Incidents  
1346 Involving the Release of Hazardous Substances,” released in December 2004:

1347 [http://www.osha.gov/dts/osta/bestpractices/html/hospital\\_firstreceivers.html](http://www.osha.gov/dts/osta/bestpractices/html/hospital_firstreceivers.html). In this document OSHA  
1348 outlines the minimal level of personal protective equipment recommended for personnel decontaminating  
1349 victims presenting to a non-contaminated medical facility.

1350  
1351 The Environmental Protection Agency (EPA), as part of EPCRA, has stated that the agency will not  
1352 pursue enforcement actions for environmental consequences of necessary and appropriate actions, such  
1353 as decontamination, during the phase of an emergency response where an imminent threat to human  
1354 health and life is present. However, once this phase passes, every attempt should be made to contain  
1355 the runoff and dispose of it properly. ACS(s) implementing decontamination programs should include  
1356 procedures for runoff containment and management in the decontamination plan. EPA's website has  
1357 extensive guidelines for hazardous waste storage, disposal, transportation, and treatment. The guidance  
1358 can be accessed at: <http://www.epa.gov/epaoswer/osw/hazwaste.htm>

1359  
1360 Key aspects to consider in the development of the standard operating procedure for decontamination  
1361 include event recognition, activation, management, primary triage, patient registry and collection of  
1362 personal property, decontamination, secondary triage, logistics for treatment, public information and post-  
1363 incident actions. ACS decontamination training programs should follow NFPA Standard 473,  
1364 Professional Competence of EMS Personnel Responding to a Hazardous Materials Incident.

1365  
1366 Emergency first responders, at the site of the release, are covered under OSHA's Standard on Hazardous  
1367 Waste Operations and Emergency Response (HAZWOPER), or the parallel Cal/OSHA State Plan  
1368 standards (Title 8 CCR, Section 5192-E), and depending on their roles are also covered by the standard.

### 1370 **Infectious Waste Management**

1371 The Public Health and Hospital Preparedness - Public Health and Hospital Preparedness, State of  
1372 Wisconsin, *Wisconsin Hospital Emergency Preparedness Plan (WHEPP)*, Version 3, provides guidelines  
1373 for infectious waste management. According to the report, in a mass casualty event, the potential for  
1374 overloading the waste handling capacity is greatly increased. Because of this potential, each ACS should  
1375 develop waste management protocols that address the challenges associated with the increased volume  
1376 of infectious waste.

- 1377  
1378 1. Greater quantities of materials suitable for containing biological agents or infectious organisms  
1379 will be needed. These materials are to include but not limited to:
- 1380 a. Biohazard labeled bags
  - 1381 b. Sharps containers
  - 1382 c. Liquid handling containers
  - 1383 d. All other associated supplies materials

## ALTERNATE CARE SITES

- 1384 2. ACS(s) are to list the supplies with supporting information that shows:  
1385 a. The quantity normally on hand  
1386 b. An estimate of how long these supplies will last for an inpatient population level  
1387 determined by the facility.
- 1388 3. If the existing inventory of materials or usage rate compromises patient care or waste  
1389 containment needs, the facility is to obtain additional material:  
1390 a. If an Emergency Operation Center (EOC) is not activated, contact other participant  
1391 facilities and request the materials needed.  
1392 b. If the EOC is activated, contact the EOC and request the materials needed. The EOC  
1393 may obtain materials from:  
1394 i. Participant facilities  
1395 ii. Other known sources  
1396 iii. The State of California by submitting a request for materials from the Centers for  
1397 Disease Control (CDC), "Vendor Managed Inventory Program"

### Waste Storage:

- 1399 1. ACS(s) may consult with their medical waste disposal vendors for details of the vendor's ability to  
1400 provide continued waste disposal services during a mass casualty emergency.  
1401 2. ACS(s) may consult with their County/Tribal Emergency Management office for protocols for  
1402 storage of infectious waste during a mass casualty incident.  
1403 3. Infectious waste may need to be stored under refrigeration (<42°F) to limit nuisance conditions.  
1404 a. If the EOC is not activated, facilities are to contact the County/Tribal Emergency  
1405 Management office to obtain refrigerated storage.  
1406 b. If the EOC is activated, facilities are to contact the EOC to obtain refrigerated storage.  
1407 4. Separation of infectious waste from the solid waste stream is to be maintained.  
1408 5. Combined waste streams are to be handled as infectious waste.  
1409 6. Chemical and radiological wastes must be separated and segregated from infectious waste in  
1410 order to avoid dual contamination.  
1411 7. Waste stored on the premises of the ACS must be secure to prevent access by unauthorized  
1412 persons and to prevent accidental spread of contamination.  
1413 8. The designated storage area for infectious waste must display the appropriate 'bio-hazard'  
1414 symbols.  
1415 9. Refrigerated storage areas need to be located away from external air intakes or they need to be  
1416 maintained with negative airflow  
1417

1418 The regulations for medical waste management can be found in California's Medical Waste Management  
1419 Act (Division 194, Part 14 of the Health and Safety Code). During events when waste volumes increase  
1420 significantly, participating facilities are to comply with established institutional plans as required by the  
1421 California Department of Health Services' Medical Waste Management Act. Per Section 117960(i) of the  
1422 Medical Waste Management Act (MWMA) an emergency action plan is required. Indicate in the  
1423 emergency action plan the actions to be taken in the event of a disruption of service as a result of a  
1424 natural disaster or an equipment failure. Existing Federal and State waste disposal regulations and  
1425 statutes are to be followed as these events unfold. Facilities are also to contact Local governmental  
1426 agencies to determine Local regulations. Accurate record keeping is to be maintained as set forth in  
1427 various sections of MWMA.

### 1428 Mass Fatality Management

1429 When a mass casualty event occurs, normal public or hospital mortuary facilities may be overwhelmed to  
1430 deal with prolonged mortuary work, forensic examinations and other associated activities. For a mass  
1431 fatality fact sheet, refer to Appendix H. Per, Minnesota Department of Health, Disaster Mortuary  
1432 Emergency Response Team (D-MERT) Plan, a temporary morgue may need to be established if the  
1433 number of dead exceed the resources of the Local mortuaries. Potential temporary morgue sites could  
1434 be:

- 1435 • National Guard Armories
- 1436 • Schools with gymnasiums (without wooden floors)
- 1437 • Airport hangers

## ALTERNATE CARE SITES

- 1438 • V.F.W. and American Legion Halls
- 1439 • Warehouses
- 1440 • Reception halls
- 1441 • County fair grounds

1442

1443 Considerations for Temporary Morgue Site:

- 1444 • Proximity to disaster site
- 1445 • Electricity
- 1446 • Hot and cold running water
- 1447 • Restrooms
- 1448 • Adequate office space
- 1449 • Ventilation
- 1450 • Large open area of sufficient size to accommodate the number of dead to be cared for
- 1451 • Area for securing valuables
- 1452 • Parking
- 1453 • Secure from public

1454

1455 Minnesota Department of Health, Disaster Mortuary Emergency Response Team (D-MERT) Plan  
1456 (<http://www.health.state.mn.us/terrorism.html>) provides detailed guidance on setting up temporary  
1457 morgues.

1458

1459 Additional guidance can be found at Mass Fatality Response Plan, Office Of The Coroner Parish Of  
1460 East Baton Rouge: <http://ci.baton-rouge.la.us/Dept/OEP/plan/annexu/Appendix2.pdf>.

1461

1462 Note: Guidelines from other States do not necessarily comply with California laws, regulations and  
1463 standards. These references have been provided for informational purposes only.

## 1464 4 Post Surge - ACS Closure

1465 Shutdown of an Alternate Care Site will require removal of equipment and termination of ongoing  
1466 contracts or arrangements. Management team members will oversee shut-down activities in their area of  
1467 focus.

1468 Once all patients can be discharged or transported back to existing facilities for continued care and there  
1469 is no ongoing surge capacity need, the alternate care site can be closed. Shutdown should be expedited  
1470 so that the facility can be returned to the control of the existing owners quickly.

1471 Action checklist items for ACS closure should include but not be limited to the following:

- 1472 • Management team leader checks in periodically with each team member to ensure initiation  
1473 and completion of shutdown activities in that member's area of focus.
  
- 1474 • Management team leader assists with problem troubleshooting or procuring additional  
1475 assistance or resources as needed.
  
- 1476 • Management team leader or designate conducts a site walkthrough with the facility owner when  
1477 shutdown activities are completed to ensure that removal of equipment and supplies, cleaning,  
1478 and other surge closure activities have been completed to the owner's satisfaction.<sup>12</sup>
  
- 1479 • Perform medical record documentation storage procedures (*See Administrative work group*  
1480 *output document for procedures.*)

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**ALTERNATE CARE SITES**

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**Appendix A. Sample MOU Template**

The contractual requirements for securing premises and operating an ACS is imperative establishing an ACS under the authority if the Local Health Department. Below is a sample Memorandum of Understanding for consideration.

\*\*\*\*\*

**(County)**

**MEMORANDUM OF UNDERSTANDING (MOU) FOR USE OF FACILITIES  
IN THE EVENT OF A MASS MEDICAL EMERGENCY**

**(County), and (name of facility) agree that:**

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 soon as possible. Such an event may require a facility to support the activation of an Alternate Care Site (ACS). The ACS will serve as a site where supportive care can be provided to victims of a large-scale mass casualty or bio-event.

**(County) and (name of facility) enter into this partnership as follows:**

1. Facility Space: (County) accepts designation of (name of facility) located at (address of facility) as an Alternate Care Site (ACS), in the event the need arises.
2. Use of the Facility: Request to use facility as an ACS will occur as soon as possible through the local Emergency Operations Center. Designation and use of (name of facility) will be mutually agreed upon by all parties to this agreement.
3. Modification or Suspension of Normal Facility Business Activities: (name of facility) agrees to alter or suspend normal operations in support of the ACS as needed.
4. Use of Facility Resources: (name of facility) agrees to authorize the use of facility equipment such as forklifts, buildings, communications equipment, computers, Internet services, copying equipment, fax machines, etc. Facility resources and associated systems will only be used with facility management authorization and oversight to include appropriate orientation/training as needed.
5. Costs: All reasonable and eligible costs associated with the emergency and the operation of the ACS that include modifications or damages to the facility structure, equipment and associated systems directly related to their use in support of the ACS facility operations will be submitted for consideration and reimbursement through established disaster assistance programs.
6. Liability: [INSERT CA STATUTE - Emergency Services Act, Government Code, Disaster Service Workers] addresses immunity from liability for services rendered voluntarily and without compensation in support of emergency operations during an emergency or disaster declared by the Governor.
7. Contact Information: (name of facility) will provide (County) the appropriate facility 24 hour/7 day contact information, and update this information as necessary.

**ALTERNATE CARE SITES**

- 1539 8. Duration of Agreement: The minimum term of this MOU is two years from the date of the initial  
1540 agreement. Subsequent terms may be longer with the concurrence of all parties.  
1541
- 1542 9. Agreement Review: A review will be initiated by (County) and conducted following a disaster  
1543 event or within two years after the effective date of this agreement. At that time, this agreement  
1544 may be negotiated for renewal. Any changes at the facility that could impact the execution of  
1545 this agreement will be conveyed to the identified primary contacts or their designees of this  
1546 agreement as soon as possible. All significant communications between the Parties shall be  
1547 made through the primary contacts or their designees.  
1548
- 1549 10. Amendments: This agreement may be amended at any time by signature approval of the  
1550 parties' signatories or their respective designees.  
1551
- 1552 11. Termination of Agreement: Any Party may withdraw at any time from this MOU, except as  
1553 stipulated above, by transmitting a signed statement to that effect to the other Parties. This  
1554 MOU and the partnership created thereby will be considered terminated thirty (30) days from  
1555 the date the non-withdrawing Party receives the notice of withdrawal from the withdrawing  
1556 Party.  
1557
- 1558 12. Capacity to Enter into Agreement: The persons executing this MOU on behalf of their  
1559 respective entities hereby represent and warrant that they have the right, power, legal capacity,  
1560 and appropriate authority to enter into this MOU on behalf of the entity for which they sign.  
1561  
1562  
1563

1564 Facility Official	Date
1565 (County) Official	Date
1566 Public Health Department Official	Date
1567 Hospital Official	Date

**To authorize facility use, call:**

1573 \_\_\_\_\_  
1574 Name  
1575 \_\_\_\_\_  
1576 Daytime phone number  
1577 \_\_\_\_\_  
1578 After-hours/emergency phone number  
1579 \_\_\_\_\_  
1580 \_\_\_\_\_  
1581 \_\_\_\_\_

**To open facility, call:**

1582 \_\_\_\_\_  
1583 Name  
1584 \_\_\_\_\_  
1585 Daytime phone number  
1586 \_\_\_\_\_  
1587 After-hours/emergency phone number  
1588 \_\_\_\_\_  
1589 \_\_\_\_\_  
1590 \_\_\_\_\_

**Alternate contact to open facility, call:**

1591 \_\_\_\_\_  
1592 Name  
1593 \_\_\_\_\_  
1594 Daytime phone number  
1595 \_\_\_\_\_

**ALTERNATE CARE SITES**

1596 \_\_\_\_\_  
1597 After-hours/emergency phone number  
1598  
1599

1601  
1602  
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**Required Attachments Needed With This Assessment: Site Map and / or Floor plan drawing of facility structure**

<b>Site Name:</b>
<b>Address:</b>
<b>Thomas Brothers Map and Page grid #:</b>

1604

**Items to Be Completed Prior to Survey Visit**

Individual completing assessment:	
Date of assessment:	Phone:
Point of Contact for site access:	Phone:
After business hours point of contact:	Phone:
Point of Contact for facility maintenance (if applicable):	Phone:
Point of Contact for site security (if applicable):	Phone:
Total square feet:	Covered square feet: 40K required if requesting ACS with 250 bed unit capacity
# of buildings available:	(circle) One floor or Multilevel # of floors:

1605

**The following is a list of basic facility requirements to establish an ACS. Please determine if the requirement is present, not present or reasonably accommodated (potential to be present with refitting/renovation). P = Present; NP = Not Present; RA = Reasonably Accommodated**

<b>I. Infrastructure</b>	<b>P/NP/RA</b>	<b>Comments</b>
Door size adequate for gurneys		
Floors		
Loading Dock		
Parking for staff and visitors		
Roof		
Toilet facilities/showers (#: ___)		
Hand-washing facilities		
HVAC System for adequate ventilation		
Climate Control		
Walls		
Wheelchair access		
<b>II. Total Space Layout</b>	<b>P/NP/RA</b>	<b>Comments</b>
Auxiliary Spaces (Rx, Counselors)		
Equipment/supply storage area		
Family area		
Food and supply prep area		
Mortuary holding area		
Patient decontamination/isolation area		
Min 40 sq. feet per bed per person		
Staff support/rest break areas		
<b>III. Utilities</b>	<b>P/NP/RA</b>	<b>Comments</b>

Heating		
Lighting		
Water		
Fire protection safety and equipment		
Refrigeration for safe storage of medical supplies and food		
<b>IV. Communications</b>	<b>P/NP/RA</b>	<b>Comments</b>
Phone Capability (#: ____)		
Two-way radio capability		
Wired for IT and Internet Access		
<b>V. Clinical Requirements</b>	<b>P/NP/RA</b>	<b>Comments</b>
Triage/ER Patient Care		
Pharmacy		
Laboratory/Blood Testing		
Decontamination		
<b>VI. Other Services</b>	<b>P/NP/RA</b>	<b>Comments</b>
Ability to lock down facility		
Provide secure storage for controlled substance and medical materials		
Accessibility/proximity to public transportation		
Biohazard & other waste disposal		
Oxygen/medical gases delivery capability		

1606

<b>Please answer the following questions:</b>		
Has this site been identified for use in other emergencies?	Y	N
ADA access for persons with disabilities?	Y	N
Size of largest open room: _____ x feet		
Total covered area sq ft (estimate for 200 casualties +staff = 15,000-20,000):		
Are there any other indigenous communications resources (i.e. security radios, intercom, Internet etc)?		
Comments:		
Generator Capacity: _____ watts.		
Fuel on site : _____ gallons		Runtime with Hours
existing fuel?		
Nearest major thoroughfare:		
Road size and number of lanes for access to site:		
How does the general layout look?	Fair Congested	Good
Would materiel need to be relocated to use this facility/site?	Y	N
Estimate # of non-ambulatory casualties in all areas (@50 sq. ft. per patient)		

What would have to be brought in?

1607

**Overall Findings and Recommendations**

Please provide your overall assessment of the facility to provide care for patients with outpatient-like and inpatient-like requirements up to active status within 3 to 7 days of a declared surge event. There is no intention to set up surgical or ICU capabilities at the AC

Based on the walk-through, this facility would accommodate (circle one):

- |   |  |
|---|--|
| 1 | No potential for surge capacity use.   |
| 2 | Potential for an outpatient care during a surge event.   |
| 3 | Potential for outpatient and inpatient care during a surge event.                                    |
| 4 | Potential for critical care during a surge event. (Mobile Field Hospital can be set up at the site.) |
| 5 | Potential for supportive care during a surge event. (Medical Shelter can be set up at the site.)     |

**ALTERNATE CARE SITES**

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**Appendix C. ACS 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: _____
--

1610

#	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 ACS 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?	

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If "partial" or "no" answer to any question, ask provider to describe their plan and include that info in report to the incident commander. In addition, report a summary of findings to Disaster Preparedness Coordinator and/or Field Branch Chief.

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

**ALTERNATE CARE SITES**

1619 **Appendix D: ACS Facility On Site Damage/Operability Report**  
 1620 **(Comprehensive Assessment)**

1621 ACS Facility Name: \_\_\_\_\_ Date of Visit: \_\_\_\_\_  
 1622 Address: \_\_\_\_\_ Evaluator Names: \_\_\_\_\_  
 1623 City: \_\_\_\_\_

1624 Overall Damage Assessment:     
 1625  
 1626 (See OSHPD Placards\*) GREEN YELLOW RED

1627 AVAILABLE VACANT BEDS MALE  FEMALE

1628 PATIENT EVACUATION ORDERED BY: \_\_\_\_\_ TITLE \_\_\_\_\_

1629 TYPE OF EVACUATION: TOTAL  PARTIAL

BUILDING	YES	NO
PARTIAL COLLAPSE		
TOTAL COLLAPSE		
PHOTOS TAKEN		

COMMUNICATIONS	YES	NO
EXTERNAL		
INTERNAL		
ELEVATORS OPERATIONAL (IF APPLICABLE)		

1635

WATER AVAILABILITY	YES	NO
FROM UTILITY		
DRINKING WATER		
HOT WATER		

1636

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

1637

SUPPLIES	YES	NO
FOOD		
MEDICATIONS		
LINEN		
OTHER SUPPLIES		

STAFF AVAILABILITY	YES	NO
ADMINISTRATION		
NURSING		
DIETARY		
HOUSEKEEPING		

1638  
 1639  
 1640 EVALUATOR COMMENTS AND DIAGRAM (IF NECESSARY):  
 1641 \_\_\_\_\_  
 1642 \_\_\_\_\_  
 1643 \_\_\_\_\_  
 1644 \_\_\_\_\_  
 1645 \_\_\_\_\_

1646 Recommend Referral To: \_\_\_\_\_

1647  
 1648 Source: California Department of Health Services, Licensing and Certification, Emergency Preparedness & Response Plan

1649  
 1650  
 1651 \*Green: Habitable, minor or no damage,  
 1652 Yellow: Damage which represents some degree of threat to occupants  
 1653

**ALTERNATE CARE SITES**

1654 Red: Not habitable, significant threat to life safety

**ALTERNATE CARE SITES**

1655  
1656

**Appendix E: Standardized Security Assessment / Vulnerability Tool**

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

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Source: Adapted from California Primary Care Association, *The Community Clinic & Health Center Emergency Operations Plan Template*, 2004.

## ALTERNATE CARE SITES

### Appendix F: Lockdown Policy and Procedure Sample

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#### I. PURPOSE

To provide procedures and guidance when the need to lockdown an ACS 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 ACS 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 ACS 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 ACS Incident Command System.

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

##### B. MASS CONTAMINATION

1. Contaminated individuals/equipment entering the ACS 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

## ALTERNATE CARE SITES

- 1714 b. Appropriate Administrative Directors  
1715 c. Safety Officer or designee  
1716 d. Emergency Management Chairperson  
1717 e. Operations Supervisor during off hours and weekends

1718  
1719 2. Announcement/Notification

1720  
1721 a. Upon specific guidance from the Administrator or designee, the operator will announce the civil  
1722 disturbance three times via the public address system. The proper announcement is:

1723  
1724 **<<Code Name for Lockdown>> “Nature and Location of Disturbance”**

1725  
1726 Repeat the statement every 15 minutes for the first hour, or as often as the Incident  
1727 Commander directs.

1728  
1729 b. When directed by the Incident Commander, the operator will contact the appropriate law  
1730 enforcement office and request immediate assistance.

1731  
1732 c. The operator will contact Public Relations at the phone numbers provided for that purpose.

1733  
1734 d. When so directed by the Incident Commander or the senior administrative individual  
1735 in the facility, the All Clear will be announced of the public address system as follows:

1736  
1737 **“<<Code Name for Lockdown>>, Location, ALL CLEAR” (three times)**

1738  
1739 3. Upon announcement of lockdown, the Incident Command Center and other designated  
1740 portions of the Incident Command System organization will be activated. This will normally  
1741 include as a minimum, a portion of the Planning Section and the Public Information Officer.

## 1742 1743 D. SECURITY OPERATIONS

1744  
1745 1. In the case of a civil disturbance, the senior Security representative present will immediately  
1746 assess the situation and provide that information to the Administrator or Incident Commander if  
1747 has already been initiated.

1748  
1749 2. In the case of a mass contamination situation, the Infection Control Coordinator, or designated  
1750 clinical staff member will assess the situation and recommend appropriate action.

1751  
1752 3. If required security augmentation will be initiated either through recall of off duty security,  
1753 appointing other available staff to perform security duties, or by obtaining augmentation from  
1754 security companies.

1755  
1756 4. Security will immediately commence locking all exterior doors and will advise staff to close  
1757 ground floor window coverings if possible.

1758  
1759 5. A Single Entry Point will be established. Staff guarding other exterior doors will be instructed to  
1760 not allow anyone in or out of those doors. A security representative or other designated individual  
1761 will allow individuals with legitimate reason into and out of the Single Entry Point based on the  
1762 situation. In the case of mass contamination, only those individuals KNOWN to be free of  
1763 contamination will be allowed in the building.

1764  
1765 6. A security officer will be stationed in the primary treatment area (Emergency Department or  
1766 Urgent Care).

1767  
1768 7. If anyone exits the building, a staff or security member must ensure the door is firmly closed  
1769 and locked after the individual.

## ALTERNATE CARE SITES

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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. ACS OPERATIONS

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

### G. POST CRISIS MANAGEMENT

After cancellation of the 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.

## ALTERNATE CARE SITES

### 1819 Appendix G: Lockdown Checksheet

1820

1821 Mission: The primary goal in a lockdown situation is to isolate and control the situation while caring for the  
1822 safety of the patients, visitors, staff, and property.

1823

1824 \_\_\_\_ Personnel discovering the lockdown situation will promptly notify their supervisor who will pass the  
1825 information to the Administrator or designee.

1826

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

1827

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

1828

1829

\_\_\_\_ Do not allow any entry or exit from other than through the Single Entry Point, which will be  
controlled by Security

1830

1831

\_\_\_\_ Only individual KNOWN to be free of contamination will be allowed to enter the building in a mass  
contamination event.

1832

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

1833

\_\_\_\_ Allow law enforcement to quell the civil disturbance.

1834

1835

1836

Source: This policy and procedure sample was adapted from CODE CD - Lockdown for Scripps Mercy  
Hospital.

## ALTERNATE CARE SITES

### Appendix H: Mass Fatality Fact Sheet

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#### Health Impacts

- The health risk to the general public from large numbers of dead bodies is negligible
- Drinking water must be treated to avoid possible diarrhoeal diseases
- Body handlers should follow universal precautions for blood and body fluids, wear gloves, and wash their hands

#### Body Storage

- Refrigerated containers provide the best storage, if available
- Temporary burial in trench graves can be used if refrigeration is not available

#### Body Identification

- Visual recognition or photographs of fresh bodies are the simplest forms of non-forensic identification and should be attempted after all natural disasters
- If resources and comparative data are available, simpler methods can be supplemented by forensic techniques (dental, fingerprint, and DNA analysis)

#### Body Disposal

- Communal graves may be necessary following large disasters
- Bodies should be buried in one layer to facilitate future exhumation
- Graves should be clearly marked

#### Coordination

- A named person/organization should have an agreed mandate to coordinate the management of dead bodies

#### Preparedness

- Mass fatality plans should be included in national and Local disaster preparedness activities
- Systematic documentation about how the dead are managed in future disasters is needed to learn from them

#### Communications

- Close working with the media is needed to avoid misinformation and to promote the rights of the survivors to see their dead treated with dignity and respect

Source: *Mass Fatality Management following the South Asian Tsunami Disaster: Case Studies in Thailand, Indonesia, and Sri Lanka*, Oliver W. Morgan, Pongruk Sribanditmongkol, Clifford Perera, Yeddi Sulasmi, Dana Van Alphen, Egbert Sondorp, 2006