



Development of Standards and Guidelines for Healthcare Surge during Emergencies

Alternate Care Sites

ALTERNATE CARE SITES

NOTE: This document is the first draft output from the Alternate Care Sites work team. It is the culmination of input received from multiple sources which includes ideas generated by stakeholders, reference material gathered through research, documents submitted by stakeholders, and analysis of current regulations and statutes. It is a work in progress and will continue to be refined over the next few weeks. We would like to solicit your feedback on the content of this document. Should you have reference material or ideas, please contribute them via email to hcsurge@us.pwc.com. The quality and effectiveness of this deliverable is ultimately decided by you, the stakeholder.

Introduction

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

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

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

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

Alternate Care Sites

Alternate Care Sites can assist in providing care for patients when the existing structure of the healthcare delivery system is no longer functioning under normal operating conditions. They can be defined as alternate operating locations used for healthcare services when existing healthcare facilities are inaccessible due to a disaster or when the volumes of patients exceed the capabilities of those facilities.

The objective of this document is to provide a basic understanding of the core requirements for establishing and operating an ACS. As such, the document is divided into seven sections. The first section provides a description of an ACS. For this project, ACS(s) are defined as facilities that are not currently providing healthcare services and will be converted to provide healthcare services on a temporary basis. They are not part of the assets of an existing facility (i.e. extensions of a general acute care hospital), but rather are assets under the authority of the government or private parties.

The second section identifies the governmental authority for establishing an ACS. Under the California Department of Health Services Pandemic Influenza Response Plan, the responsibility for identifying and planning for ACS(s) resides with the local health department. In addition, broad

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authority for establishing an ACS falls under the California Emergency Services Act which recognizes the role of the state and its political subdivisions to mitigate the effects of an emergency.

Sections three of the document focuses on the planning requirements for the establishment an ACS. During the planning stages, it is important to define the contractual requirements for securing premises and operating an ACS on behalf of Local Health Departments. In addition, it is important for planners to identify potential venues that can provide the minimum physical requirements for operations of an ACS (e.g., minimum building equipment, physical structure).

Section four focuses on the operational requirements of the ACS. There will be a minimum set of administrative operational requirements for all ACS facility types (i.e. safety and security, IT requirements, etc.) However, the clinical operational requirements will be driven by the patient types that will be treated at each ACS facility. For this work team, three patient types will be treated: Basic Patients, Critical Patients, and Complex Critical Patients. The authority for the internal operations of an ACS will be established under the Hospital Incident Command Structure (HICS).

Section five focuses on the qualified immunities for claims liability at an ACS. Qualified immunities refer to the immunity from civil liability that is afforded within a certain range of circumstances, as by a requirement of good faith or due care. At an ACS, qualified immunities would be applicable to the facility, volunteer personnel, contracted personnel and paid personnel.

Section six describes the funding and reimbursement responsibilities for the operations of an ACS. As this work team will concentrate only on the government and private asset ACS(s), the funding and reimbursement responsibility lie with governmental and private agencies.

The final section will outline the basic training requirements for an ACS. It will include operational training as well as a clinical training component that will teach healthcare professionals basic procedures/techniques to consider when operating outside their normal scope of practice (e.g. a general practitioner delivering a child at an ACS).

Description of ACS

For this project, ACS(s) are defined as facilities that are not currently providing healthcare services and will be converted to provide healthcare services on a temporary basis. They are not part of the assets of an existing facility (i.e. extensions of a general acute care hospital), but rather are assets under the authority of the government or private parties.

Alternate care sites can be described by the facility type. ACS facility types can be public buildings, private property, tribal entities and federal entities and for the scope of this work team include the following:

- Arenas
- Football fields
- Churches
- Gyms
- Community Centers
- Parking Lots
- Mobile Field Hospitals

Each ACS facility type can serve a multitude of purposes depending on the facility's ability to provide the minimal clinical operations for treating patients. The description of an ACS can be further defined by the types of patients that will be receiving care at an ACS. Three patient types have been defined for purposes of understanding the role an ACS will serve:

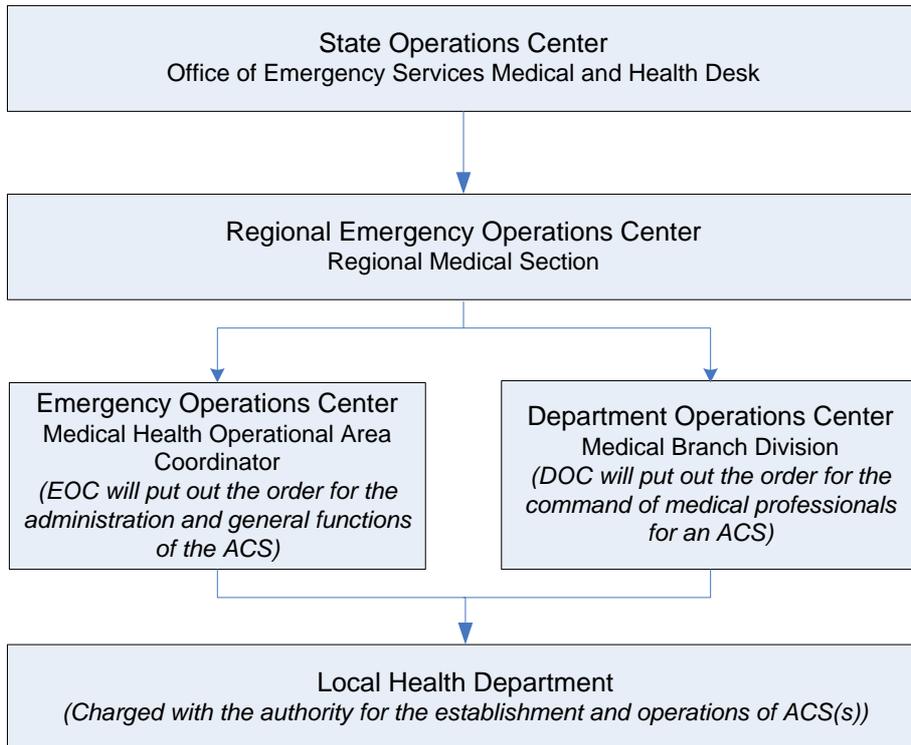
Patient Type	Type of Care	Facility Type
Basic	Patient presents with general outpatient care requirements	Gym, Churches, Community Center
Complex	Patient presents with outpatient care and/or general inpatient care requirements	Parking lot, football fields

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Critical Complex	Patient presents with outpatient care, general inpatient care and/or complex critical care requirements	Mobile Field Hospitals
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Authority for the Establishment of an ACS

There are no known existing laws prescribing minimum criteria to establish an ACS. However, under the CDHS Pandemic Influenza Response Plan, responsibility for identifying and planning for alternate care sites resides with the local health department (LHD). LHDs must address issues such as the identification of the individual(s) with the authority to decide whether, when, and where an ACS should be opened, and the authority to operate the site. Broad authority for establishing an ACS also falls under the California Emergency Services Act which recognizes the role of the state and its political subdivisions to mitigate the effects of an emergency. A possible authority structure for the establishment an ACS using the existing emergency response structure is depicted below, with the State Operations Center having the highest authority.



Planning for the Establishment of an ACS

During the planning stages, it is important to define the contractual requirements for securing premises and operating an ACS on behalf of Local Health Departments. In addition, it is important for planners to identify potential venues that can provide the minimum physical requirements for operations of an ACS (e.g., minimum building equipment, physical structure).

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. With guidance from legal experts, work team members are currently modifying the MOU.

(County)

MEMORANDUM OF UNDERSTANDING (MOU) FOR USE OF FACILITIES

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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) ACSepts 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.
8. Duration of Agreement: The minimum term of this MOU is two years from the date of the initial agreement. Subsequent terms may be longer with the concurrence of all parties.
9. Agreement Review: A review will be initiated by (County) and conducted following a disaster event or within two years after the effective date of this agreement. At that time, this agreement may be negotiated for renewal. Any changes at the facility that could impact the execution of this agreement will be conveyed to the identified primary contacts or their designees of this agreement as soon as possible. All significant communications between the Parties shall be made through the primary contacts or their designees.
10. Amendments: This agreement may be amended at any time by signature approval of the parties' signatories or their respective designees.
11. Termination of Agreement: Any Party may withdraw at any time from this MOU, except as stipulated above, by transmitting a signed statement to that effect to the other Parties. This MOU and the partnership created thereby will be considered terminated thirty (30) days

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from the date the non-withdrawing Party receives the notice of withdrawal from the withdrawing Party.

- 12. Capacity to Enter into Agreement: The persons executing this MOU on behalf of their respective entities hereby represent and warrant that they have the right, power, legal capacity, and appropriate authority to enter into this MOU on behalf of the entity for which they sign.

Facility Official Date

(County) Official Date

Public Health Department Official Date

Hospital Official Date

To authorize facility use, call:

Name

Daytime phone number

After-hours/emergency phone number

To open facility, call:

Name

Daytime phone number

After-hours/emergency phone number

Alternate contact to open facility, call:

Name

Daytime phone number

After-hours/emergency phone number

In addition to establishing the contractual requirements, the selection of the ACS venue is critical for the successful operations of the ACS. The work team will be developing an ACS site selection tool

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that will assist planners in identifying potential venues that can serve as an ACS and the minimum physical requirements for operations of an ACS. The tool will assist in determining the criteria/requirements/standards for a particular ACS venue as it relates to:

- Venue considerations for an ACS: schools, churches, gyms, community centers, arenas, parks, non-operating hospitals and football fields.
- Infrastructure: Is there sufficient square footage to provide space for patient cots or mats and space for work area for healthcare providers, ancillary workers and support staff? Is there space to store supplies? Can access to the building be safely controlled? Is the building environmentally safe for patients and workers?
- Total space and layout: Is there an area where patients can easily be transferred from ambulances into the building? Is there ample parking for workers and patient families? Is there adequate space to safely store contaminated waste until pick up?
- Utilities: Does the building have a system of back up power? Electrical outlets? Sanitary facilities? Running water?
- Communication: Can multiple phone lines and internet connections quickly be activated at the site? Who do they need to serve? Is the wiring sufficient to support phone lines and internet connections?
- Other services: Is there an area where food can be prepared safely or received from a catering service?

The ACS work team will also be developing an ACS Configuration Assessment tool to assist planners in determining standard requirements for the physical configuration and set-up of an ACS (e.g., minimum building equipment, physical structure, departments such as ER, ICU, OP Surgical Center, Special Needs, In-Patient, etc).

It is important to consider the population density and geographic distribution of population affected by an event when selecting an ACS. For example, in major metropolitan areas, ACS(s) may be extremely large and designed to treat more than 1000 patients at a time. However, in rural areas, population density and the geographic distribution of the population may direct the appropriate size and location of ACS(s). Despite these differences between the sites and the number of patients served, there will still be common areas apart from patient care that should be considered when selecting an ACS. These areas include, but are not limited to:

- Medical Command Center
- Admissions/Registration
- Communications Area
- Behavioral Health Support Center
- Family Support/ Community Outreach
- Pharmacy
- Food Service Area
- Loading and Receiving area
- Supply management areas, and
- Temporary Morgue
- Security

Administrative and Clinical Operational Requirements of an ACS

There will be a minimum set of administrative operational requirements for all ACS facility types (i.e. IT requirements, safety and security, etc.) However, the clinical operational requirements will be driven by the patient types that will be treated at each ACS facility. For this project, three patient types will be treated: Basic Patients, Critical Patients, and Complex Critical Patients. The authority for

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the internal operations of an ACS will be established under the Hospital Incident Command Structure (HICS).

Administrative Operational Requirements - Information technology and communication requirements are essential during a surge. Communication systems allow for ease of communication between ACS and hospitals, in addition to law enforcement, staff members and suppliers. Contingency plans during surge should be addressed due to its importance for patient tracking and resource tracking. As such, the ACS work team will be developing guidelines for the minimum IT and communication requirements for all types of ACS facilities.

Safety and security is the most essential operational requirement of an ACS. Without proper safety and security measures at an ACS, the lives of patients and personnel will be in jeopardy. It is the suggestion of the ACS work team, to open an ACS ONLY IF proper security enforcement are present at the time of opening. The following is a list of safety and security measures for consideration during a surge:

- Increased security personnel
- Increased monitoring of ACS premises and surroundings
- A lockdown plan that can be rapidly implemented (including campus buildings that may be used in nontraditional capacities as part of the facility response plan)
- Designated entrances
- Visitor limits
- Security screenings
- Augmented law enforcement presence (an MOA might be needed)
- ACS(s) that are equipped with trained security personnel, with the ability to use less-than-lethal methods of behavioral control (e.g., batons, pepper spray)
- Security personnel should report to the person in charge of the ACS operations
- Strict guidelines on hours of operations

Clinical Operational Requirements - Patient types will drive the clinical operational requirements for an ACS. Below is a table that lists the minimal clinical operations required to treat patient types, as defined for this project: Basic, Complex, Critical Complex.

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	Patient Type: Basic	Patient Type: Critical	Patient Type: Critical Complex
Clinical Operational Requirements	Type of Care: OP	Type of Care: OP/IP	Type of Care: OP/IP/CC
Laboratory / Blood Testing	Limited	Intermediate	Advanced
Pharmaceuticals	Limited (Basic / Routing Care)	Intermediate (IV Capabilities)	Advanced (IV Capabilities)
Imaging Capabilities	Limited (Portable X-Ray only)	Intermediate (Radiology including Portable X-Ray and Ultrasound)	Advanced
Medical Gases	Limited	Intermediate (Oxygen and Suction Only)	Advanced
OR	None	Procedural Sedation only	Yes
Dietary Needs	None	Reduced	Special Dietary Needs
ICU Support	Limited	Respiratory Support Only	ICU with advanced respirator support
Morgue Plan	Yes	Morgue Plan	Morgue
Dialysis	None	None	Yes
Clinical Capabilities	Peds	Med-Surg/Peds/OB/Psyc Capabilities	Med-Surg/Peds/OB/Psyc Capabilities
OP Clinic	Yes	Yes	Yes
Triage / ER	Triage only	Triage and ALS (+/-)	ER

The command structure of an ACS may be one of the most important issues to address. It is the suggestion of the work team to establish authority within an ACS using the Hospital Incident Command System (HICS). Proper and thorough training will need to be developed to ensure all ACS personnel understand the existing HICS structure.

Qualified Immunities for Liability claims at an ACS

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

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

California Civil Code § 1714.6 further defines that no person shall be liable for negligence as a matter of law, or prosecuted for violation of any statute or ordinance, where the act or omission involved was required in order to comply with [omitted military order] any regulation, directive, or order of the Governor under the California Emergency Services Act. During a declaration of a disaster by the

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Governor, if an ACS is established to mitigate the effects of an emergency, no liability shall fall on the owners of the ACS facilities, unless an act of willful omission is committed.

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

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

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

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

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

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

California Business & Professional Code § 3503.5 applies to physician's assistants and states that a person licensed under this chapter [physician's assistant] who in good faith renders emergency care at the scene of an emergency that occurs outside both the place and course of that person's employment shall not be liable for any civil damage as a result of any acts or omissions by that

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person in rendering the emergency care. This section shall not be construed to grant immunity from civil damages to any person whose conduct in rendering emergency care is grossly negligent. In addition to the immunity specified in subdivision (a), the provisions of Article 17 (commencing with Section 2395) of Chapter 5 shall apply to a person licensed under this chapter when acting pursuant to delegated authority from an approved supervising physician.

Qualified Immunities for Paid Personnel - Liability immunities for paid personnel do not exist. Paid personnel are subject to the terms and conditions of the employment agreement between an employer and the employee.

Funding and Reimbursement of an ACS

As this work team will concentrate only on the government and private asset ACS(s), the funding and reimbursement responsibility lie with governmental agencies.

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

Training Requirements for an ACS

Training will include operational training as well as a clinical training component that will teach healthcare professionals basic procedures/techniques to consider when operating outside their normal scope of practice (e.g. a general practitioner delivering a child at an ACS).

Below is a list of training topics as suggested by the ACS work team:

- HICS
- Equipment training
- Setup training
- Just in Case and Just in Time
- Operational Training
- Clinical Training
- Orientation training including process flow for inside and outside the facility, and communication protocols.
- Security and safety
- Point of care testing
- Infection control and PPE
- Disaster triage
- CDLS training
- Inventory management