



# Development of Standards and Guidelines for Healthcare Surge during Emergencies

## Existing Facilities

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**NOTE:** This document is the first draft output from the Existing Facilities 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 several 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](mailto:hcsurge@us.pwc.com).

### 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.

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While hospitals are a crucial element in health care surge, a comprehensive healthcare surge system is established only if all the healthcare entities within a community work in tandem. These healthcare entities include:

- Hospitals
- Out-of-hospital health care centers (e.g., clinics, home health, hospice, nursing homes, physician offices)
- Health and medical service centers (e.g., laboratory, occupational health, pharmacy, radiology)
- Healthcare organizational assets (e.g. administrative office buildings, parking lots, warehouses)

An existing facility for the purposes of this project includes hospitals, clinics, ambulatory surgery centers, nursing homes, skilled nursing facilities, veterinarian hospitals, home health, hospice care, rural health clinics, etc. that currently provide medical care inclusive of other organizational assets such as an administrative building, medical office buildings, etc. under the organization’s direct control where expanded capacity can be utilized.

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This document has been divided into five sections: 1) Standards of Care, 2) Surge Capacity, 3) Facility Operations, 4) Patient Management, and 5) Continuity of Business Operations

Section I defines Standard of Care during normal and healthcare surge situations. The section also provides guidance regarding licensing and standards requirements for Standards of Care during healthcare surge including non-traditional treatment means and out-of-scope services.

Section II defines surge capacity and provides guidance for flexing patient care capacity during a healthcare surge. The guidance includes identifying licensure and standards requirements when using non-clinical areas of facility for medical care, the degree to which facilities' capacity can be flexed, available waivers, criteria for flexing existing patient care areas and criteria for using non-clinical areas for patient care.

Section III provides guidance regarding licensure, standards and liability requirements and available waivers when operating a facility during a healthcare surge. The section also provides planning considerations for waste management, infection control, mass fatality management and security planning.

Section IV provides guidance for management of patients during a healthcare surge. This includes ethical and legal considerations for allocation of scarce resources, and liability considerations for treating patients with no medical history, patient abandonment, patient restraints and patient transfers.

Section V provides guidance for continuity and recovery of business operations during a healthcare surge. This includes identifying standards for essential services and hospital emergency preparedness, planning requirements for maintaining on-going operations of core non-clinical departments, external communication protocols, and business continuity.

Reimbursement was discussed with respect to Existing Facilities however will be covered more comprehensively by the Reimbursement and Funding Sources Work Team.

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### Section I: Standards of Care

Standard of Care is a legal concept that encompasses the diagnosis and overall management of patients, not just treatment. Per Jury Instructions, Civil Instruction No, 35.000, Standard of Care is defined as:

- A practitioner must use "the degree of skill and diligence in the care and treatment of his patient that a reasonably prudent doctor in the same field of practice for specialty in this State would have used under the circumstances of this case"

The Standard of Care covers all levels of treatment - from the administering of proper medications based on Food and Drug Administration and Physicians Desk Reference recommendations to performing open-heart surgery.

During a mass casualty event, resulting in public health or medical emergency involving thousands, or even tens of thousands, of victims, the ability of local or regional health systems to deliver services consistent with established standards of care could be compromised. Therefore, it is critically important to identify, plan, and prepare for making the necessary adjustments in current health and medical care standards to ensure that the care provided in response to a mass casualty event results in as many lives being saved as possible.

Currently, no universally accepted definition of "Altered Standards of Care" exists. Joint Commission refers to Altered Standards of Care as "graceful degradation" under which care and access to caregivers may become rationed. Agency for Healthcare Research and Quality (AHRQ) refers to Altered Standards of Care as a shift to providing care and allocating scarce equipment, supplies, and personnel in a way that saves the largest number of lives in contrast to the traditional focus on saving individuals. Specifically:

- Triage efforts will need to focus on maximizing the number of lives saved. Instead of treating the sickest or the most injured first, triage would focus on identifying and reserving immediate treatment for individuals who have a critical need for treatment and are likely to survive. The goal would be to allocate resources in order to maximize the number of lives saved. Complicating conditions, such as underlying chronic disease, may have an impact on an individual's ability to survive.
- Triage decisions will affect the allocation of all available resources across the spectrum of care: from the scene to hospitals to alternate care sites. For example, emergency department access may be reserved for immediate-need patients; ambulatory patients may be diverted to alternate care sites (including non-medical space, such as cafeterias within hospitals, or other non-medical facilities) where "lower level" hospital ward care or quarantine can be provided. Intensive or critical care units may become surgical suites and regular medical care wards may become isolation or other specialized response units.
- Needs of current patients, such as those recovering from surgery or in critical or intensive care units; the resources they use will become part of overall resource allocation. Elective procedures may have to be cancelled, and current inpatients may have to be discharged early or transferred to another setting. In addition, certain lifesaving efforts may have to be discontinued.
- Usual scope of practice standards will not apply. Nurses may function as physicians, and physicians may function outside their specialties. Credentialing of providers may be granted on an emergency or temporary basis.
- Equipment and supplies will be rationed and used in ways consistent with achieving the ultimate goal of saving the most lives (e.g., disposable supplies may be reused).
- Not enough trained staff. Staff will be scared to leave home and/or may find it difficult to travel to work. Burnout from stress and long hours will occur, and replacement staff will be needed. Some scarce and valuable equipment, such as ventilators, may not be used without staff available who are trained to operate them.
- Delays in hospital care due to backlogs of patients. Patients will be waiting for scarce resources, such as operating rooms, radiological suites, and laboratories.
- Providers may need to make treatment decisions based on clinical judgment. For example, if laboratory resources for testing or radiology resources for x-rays are exhausted, treatment based on physical exam, history, and clinical judgment will occur.

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- Current documentation standards will be impossible to maintain. Providers may not have time to obtain informed consent or have access to the usual support systems to fully document the care provided, especially if the health care setting is damaged by the event.
- Backlog in processing fatalities. It may not be possible to accommodate cultural sensitivities and attitudes toward death and handling bodies. Numbers of fatalities may make it difficult to find and notify next of kin quickly. Burial and cremation services may be overwhelmed. Standards for completeness and timeliness of death certificates may need to be lifted temporarily.

### Key Recommendations:

The work team made the following recommendations:

- The Altered Standard of Care during a healthcare surge will be "the" Standard of Care available.
- The current Standard of Care definition adapted for large number of victims, as opposed to individual patients, would apply to healthcare surges. This population-based Standard of Care is to be termed as "Standard of Care for a Healthcare Surge".
- Standard of Care for a Healthcare Surge: "the degree of skill, diligence and reasonable exercise of judgment in furtherance of saving most number of lives during a mass casualty event that a reasonably prudent doctor in this State would have used under the circumstances"
- The "under the circumstances" clause in Standard of Care definition provides some protection to healthcare providers (facilities and personnel) during healthcare surge as long as there is evidence to support that the facility was not negligent, took appropriate steps (planning, periodic training, HICS, etc.) and that there was reasonableness demonstrated.

### Current Statutory and Regulatory Requirements: Providing Out-of-Scope Services

There are several statutory requirements that outline the types of services that facilities are to provide, at a minimum.

On a Federal level, Medicare Conditions of Participation, Sections 482.21 through 482.45 list the basic hospital functions that must be met in order to participate in the Medicare program. These functions include provision of: a quality assessment and performance improvement program, medical staff, nursing services, medical record services, pharmaceutical services, radiologic services, laboratory services, food and dietetic services, utilization review, physical environment, infection control, discharge planning, and organ, tissue, and eye procurement. Sections 482.51 through 482.57 further lists the services that hospitals have the option, but are not mandated, to provide including: surgical services, anesthesia services, nuclear medicine services, outpatient services, emergency services, rehabilitation services and respiratory care services.

On a State level, CCR 22 §70011 defines a general acute care hospital's basic services as: medical, nursing, surgical, anesthesia, laboratory, radiology, pharmacy and dietary services. For skilled nursing facilities (CCR 22 §72301), basic services include: physician, skilled nursing, dietary, pharmaceutical and an activity program. Intermediate care facilities (per CCR 22 §73301) are to provide physician, intermittent nursing, dietary, pharmaceutical and an activity program. Primary care clinics (per CCR 22 §75026) are to provide only those services for which it is organized, staffed and equipped. Intermediate care facilities for the developmentally disabled (per CCR 22 §76301) are to provide patients with a developmental program, health support, food and nutrition, and pharmaceutical services. For intermediate care facilities for the developmentally disabled – habilitative (CCR 22 §76853), basic services include active treatment, health support, food and nutrition, recreational and pharmaceutical services. And correctional treatment centers (per CCR 22 §79597) are to provide patients with physician, psychiatrist, psychologist, nursing, pharmaceutical, dentist, and dietary services.

### Current Statutory and Regulatory Requirements: Treatment Using Non-Traditional Means

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Patients have an overarching right to receive information regarding their treatment. When Standard of Care for a Healthcare Surge are implemented at facilities, it is a possibility that the treatment patients receive would be considered “non-traditional”. In this instance, facilities’ responsibility to notify patients of their treatment remains in effect, perhaps even more so. Therefore, early preparation and notification ahead of a disaster would be prudent.

Under CCR 22 §70707(b)(5) hospitals are required to adopt and post a written policy on patients’ rights which includes the right to receive as much information about any proposed treatment or procedure as the patient may need in order to give informed consent or to refuse this course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in this treatment, alternate courses of treatment or non-treatment and the risks involved in each and to know the name of the person who will carry out the procedure or treatment.

Additional language on patients’ rights to be informed of their treatment may be found in each hospital’s Terms of Conditions of Admission.

Requirements for other facilities posted patients’ rights notice have not been found to date.

### Existing Waivers

In the event of a surge, facilities will be faced with extenuating circumstances during which they will have to provide patient care services for which they may not be licensed – going beyond the “basic” services, or to treat patients using “non-traditional” treatment means. As such, facilities need to be aware of the existing waivers and liability protections to which they are afforded.

Per the Public Health Security and Bioterrorism Preparedness and Response Act of 2002 (HR 3448), the Secretary of Health and Human Services or the Assistant Secretary of Preparedness and Response (ASPR) has the authority to flex the Conditions of Participation upon request by the Governor during a state of emergency.

With respect to the State regulations governing facilities’ provision of basic services, Health and Safety Code §1276(b) and CCR 22 §70129 provide hospitals with a program flexibility provision and allow DHS the authority to flex existing requirements such as those discussed above. This provision allows the use of alternate concepts, methods, procedures, techniques, equipment, personnel qualifications, bulk purchasing of pharmaceuticals, or conducting of pilot projects as long as statutory requirements are met and the use has the prior written approval of the department or the office, as applicable. The approval of the department or office shall provide for the terms and conditions under which the exception is granted. A written request plus supporting evidence shall be submitted by the applicant or licensee to the department or office regarding the exception, as applicable.

To the extent that invoking program flexibility provisions for each facility type (CCR §70129 for general acute care hospitals, 72213 for skilled nursing facilities, 73227 for intermediate care facilities, and 71127 for acute psychiatric hospitals) would not adequately allow facilities to provide services for which they are not licensed or to provide non-traditional treatment means, the Governor – under Government Code §8571 – has the authority during a state of war emergency or a state of emergency to suspend any regulatory statute, or statute prescribing the procedure for conduct of state business, or the orders, rules, or regulations of any state agency, including subdivision (d) of Section 1253 of the Unemployment Insurance Code, where the Governor determines and declares that strict compliance with any statute, order, rule, or regulation would in any way prevent, hinder, or delay the mitigation of the effects of the emergency.

### Liability Protection

Current legislation already provides facilities with liability protection, including:

*Government Code §8659* which states that any physician or surgeon (whether licensed in this state or any other state), hospital, pharmacist, nurse, or dentist who renders services during any state of war emergency, a state of emergency, or a local emergency at the express or implied request of

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any responsible state or local official or agency shall have no liability for any injury sustained by any person by reason of such services, regardless of how or under what circumstances or by what cause such injuries are sustained; provided, however, that the immunity herein granted shall not apply in the event of a willful act or omission;

*Civil Code §1714.5* which deems that there shall be no liability on the part of one, including the State of California, county, city and county, city or any other political subdivision of the State of California, who owns or maintains any building or premises which have been designated as a shelter from destructive operations or attacks by enemies of the United States by any disaster council or any public office, body, or officer of this state or of the United States, or which have been designated or are used as mass care centers, first aid stations, temporary hospital annexes, or as other necessary facilities for mitigating the effects of a natural, manmade, or war-caused emergency, for any injuries arising out of the use thereof for such purposes sustained by any person while in or upon said building or premises as a result of the condition of said building or premises or as a result of any act or omission, or in any way arising from the designation of such premises as a shelter, or the designation or use thereof as a mass care center, first aid station, temporary hospital annex, or other necessary facility for emergency purposes, except a willful act, of such owner or occupant or his servants, agents or employees when such person has entered or gone upon or into said building or premises for the purpose of seeking refuge, treatment, care, or assistance therein during destructive operations or attacks by enemies of the United States or during tests ordered by lawful authority or during a natural or manmade emergency. No disaster service worker who is performing disaster services ordered by lawful authority during a state of war emergency, a state of emergency, or a local emergency, as such emergencies are defined in Section 8558 of the Government Code, shall be liable for civil damages on account of personal injury to or death of any person or damage to property resulting from any act or omission in the line of duty, except one that is willful; and

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

However, these protections only provide relief at the State level and for state-run programs and thus, the recommendation should be made that similar protection should be implemented at a Federal level.

### Indicators for Implementing Standards of Care for a Healthcare Surge

A local or state emergency declaration through the involvement of MHOAC will trigger the formal implementation of Standards of Care for a Healthcare Surge. Note, the shift from Standard of Care under normal conditions to Standards of Care for a Healthcare Surge occurs gradually over time as demand for healthcare services outstrip capacity and capability. The declaration is a means to activate facility as well as county disaster plans.

<< Analysis in progress to consolidate documents received from work team members and other research material >>

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### Section II: Surge Capacity

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 as declared for a mass casualty event.

#### Current Licensure Requirements: Expanding a Facility's Licensed Capacity

Current regulations (CCR 22 §70809) state that no hospital shall have more patients or beds set up for overnight use than the approved licensed capacity except in the case of justified emergency when temporary permission may be granted by the Director or his designee. Beds not used for overnight stay such as labor room beds, recovery beds, beds used for admission screening or beds used for diagnostic purposes in X-ray or laboratory departments are not included in the approved licensed bed capacity.

Temporary permission may be granted by the Department of Health Services Licensing & Certification Office (DHS L&C) upon the facility's submittal, and DHS L&C district office approval, of an application (All Facilities Letter AFL 06-33 Attachment A – DHS L&C Temporary Permission for Increased Patient Accommodations Request Review and Approval Sheet).

Patient accommodation regulations for skilled nursing facilities, intermediate care facilities, and acute psychiatric hospitals may be found at CCR 22 §72607, 73609, and 71609 respectively. However, similar guidance (i.e., and All Facilities Letter) for other facilities to increase patient accommodations and their capacity in response to a surge, should be developed.

#### Current Licensure Requirements: Using Non-Clinical Areas for Clinical Purposes

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

Per CCR 22 §70805, spaces approved for specific uses at the time of licensure shall not be converted to other uses without the written approval of the Department. Although this regulation pertains specifically to general acute care hospitals, space conversion regulations for skilled nursing facilities, intermediate care facilities and acute psychiatric hospitals may be found at CCR 22 §72603, 73605 and 71605 respectively.

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

#### Existing Waivers

Health and Safety Code §1276(b) and CCR 22 §70129 provide hospitals with a program flexibility provision and allow DHS the authority to flex existing requirements such as those discussed above. This provision allows the use of alternate concepts, methods, procedures, techniques, equipment, personnel qualifications, bulk purchasing of pharmaceuticals, or conducting of pilot projects as long as statutory requirements are met and the use has the prior written approval of the department or the office, as applicable. The approval of the department or office shall provide for the terms and conditions under which the exception is granted. A written request plus supporting evidence shall be submitted by the applicant or licensee to the department or office regarding the exception, as applicable.

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To the extent that invoking program flexibility provisions for each facility type (CCR §70129 for general acute care hospitals, 72213 for skilled nursing facilities, 73227 for intermediate care facilities, and 71127 for acute psychiatric hospitals) would not adequately allow facilities to expand their licensed capacity, or to use non-clinical areas for medical care during a surge, the Governor – under Government Code §8571 – has the authority during a state of war emergency or a state of emergency to suspend any regulatory statute, or statute prescribing the procedure for conduct of state business, or the orders, rules, or regulations of any state agency, including subdivision (d) of Section 1253 of the Unemployment Insurance Code, where the Governor determines and declares that strict compliance with any statute, order, rule, or regulation would in any way prevent, hinder, or delay the mitigation of the effects of the emergency.

At this time, there is no known authority to waive or suspend NFPA standards.

### Liability Protection

Current legislation already provides facilities with liability protection, including:

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

*Civil Code §1714.5* which deems that there shall be no liability on the part of one, including the State of California, county, city and county, city or any other political subdivision of the State of California, who owns or maintains any building or premises which have been designated as a shelter from destructive operations or attacks by enemies of the United States by any disaster council or any public office, body, or officer of this state or of the United States, or which have been designated or are used as mass care centers, first aid stations, temporary hospital annexes, or as other necessary facilities for mitigating the effects of a natural, manmade, or war-caused emergency, for any injuries arising out of the use thereof for such purposes sustained by any person while in or upon said building or premises as a result of the condition of said building or premises or as a result of any act or omission, or in any way arising from the designation of such premises as a shelter, or the designation or use thereof as a mass care center, first aid station, temporary hospital annex, or other necessary facility for emergency purposes, except a willful act, of such owner or occupant or his servants, agents or employees when such person has entered or gone upon or into said building or premises for the purpose of seeking refuge, treatment, care, or assistance therein during destructive operations or attacks by enemies of the United States or during tests ordered by lawful authority or during a natural or manmade emergency. No disaster service worker who is performing disaster services ordered by lawful authority during a state of war emergency, a state of emergency, or a local emergency, as such emergencies are defined in Section 8558 of the Government Code, shall be liable for civil damages on account of personal injury to or death of any person or damage to property resulting from any act or omission in the line of duty, except one that is willful; and

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

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However, these protections only provide relief at the State level and for state-run programs and thus, the recommendation should be made that similar protections should be requested at a Federal level.

### Key Recommendations:

- It is critical for communities to ensure that all its assets are deployed during a surge. A broader network of healthcare providers should call upon the community to pool resources when an incident occurs. A community coalition of healthcare assets will create a better response plan. For example, Alameda county has developed a memorandum of understanding (MOU) with skilled nursing facilities to actively participate during a surge response. Similarly, San Diego county has developed an MOU with the local VA hospital to treat civilians during a surge.
- While a local office can declare a local emergency, Government Code 8571 would not apply under such circumstances. Thus facilities must be provided permission ahead of time to flex patient care areas and move patients from licensed units to non-licensed part of organizational asset. Require an analog to Civil Code 1714.5 that would provide protection for flexing patient care areas
- Total waiver - State & Federal; retroactive to experience of surge; waiver should include waiver of regulation as well as enforcement. Governor makes recommendation for waiver of federal requirements
- From a pre-planning perspective there is an opportunity to get licensed "surge beds"

### Planning Considerations for Flexing Capacity

<< Analysis in progress to consolidate documents received from work team members and other research material >>

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### Section III: Facility Operations

#### Current Statutory and Regulatory Requirements Related to Facility Operations

Several statutory guidelines are currently in effect as it relates to the requirements for structural safety of healthcare facilities.

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

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

Specific to the determination of seismic safety of healthcare facilities, Health and Safety Code 129680 (a) It is the intent of the Legislature that hospital buildings that house patients who have less than the capacity of normally healthy persons to protect themselves, and that must be reasonably capable of providing services to the public after a disaster, shall be designed and constructed to resist, insofar as practical, the forces generated by earthquakes, gravity, and winds. In order to accomplish this purpose, the office shall propose proper building standards for earthquake resistance based upon current knowledge, and provide an independent review of the design and construction of hospital buildings.

In terms of regulatory requirements that govern medical waste management, the Environmental Protection Agency (EPA) has regulations governing emissions from Hospital/Medical/Infectious Waste Incinerators. 40 CFR Part 62, Sections 14410 through 14413 discuss the emission limits, sections 14430-14432 discuss the requirements for reporting and recordkeeping, and sections 14460 through 14465 outline the requirements for a facility to develop a waste management plan. A broader set of regulations for medical waste management may also be found in California's Medical Waste Management Act (Division 194, Part 14 of the Health and Safety Code).

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

#### Existing Waivers and Liability Protection

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

The argument could be made that among the statutes to be suspended in the event of a surge be the strict observance of structural safety standards. However, preserving a structurally sound

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facility in which to provide patient care can only support the guiding principle that the objective during a surge is to save the most lives as possible. As such, a more effective approach may be to examine the feasibility of recommending that the enforcement of these standards be waived during a mass casualty disaster.

Additionally to the extent that Government Code §8659 and Civil Codes §1714.5 and 1714.6 do not sufficiently protect facilities from liability, the recommendation should be made that liability protections be developed, or current protections be expanded, to ensure that facilities are not held liable so long as they can show reasonable efforts to preserve safety for both its patients and staff.

### Key Recommendations:

The following should be considered in the development, and maintenance of, a facility operations plan in response to a surge:

- Hospitals should create their own plan to decide when to leave a degraded environment. It is about managing liability, not solving it. Disaster plans should address all issues relating to working in a degraded environment. These facilities need to have criteria for making decisions to stay or go from such an environment.
- An appropriate tool, to determine if facility is safe for operations, would be a modified ATC-20 (Applied Technology Council) Rapid Evaluation. In addition to structural issues, the facility would likely also need to assess issues of operation possibly affected by earthquake such as: hazardous materials release, operability of fire protection and emergency evacuation systems, availability of electrical power, availability of fuel sources, availability/functionality of med gas and vacuum systems, functionality of internal and external communications, availability of water, functionality of diagnostic equipment, operation of mechanical equipment in sensitive environments (e.g. operating rooms, isolation rooms, intensive care units, nurseries), operation of elevators, functionality of sterilizing equipment, etc. << Materials received from OSHPD are being consolidated and will be incorporated >>
- For the State: incentives and resources need to be given to the local community to build coalition with MOUs where doctors can provide the care needed. Pre-planning and cooperation is necessary. See Appendix 1 for a sample Mutual Aid Agreement. A detailed "Model Hospital Mutual Aid Memorandum of Understanding", can be found at California Hospital Association's website:  
<http://www.calhealth.org/public/press/Article%5C103%5CAHA%20Hospital%20MOU%20MODEL.pdf>
- Identify an organization person to designate performing an immediate assessment. This involves creating a checklist where this individual determines what is assessed and who does the assessing. Currently, JCAHO standards are in place that can be tailored to solve this particular issue.
- Need to develop a grid of who to call regarding the stability of building structure from the hospital/SNF, freestanding clinic and state facility perspective. Ensure that all types of buildings are listed.
- Develop waivers necessary for moving from an existing facility to another healthcare asset that doesn't meet the required standards. Ask for qualified immunity.
- To address gap for training, it is important to bring in other healthcare assets within the community and coordinate efforts within this initiative.
- Community plans (i.e., consult LHO and Pandemic Flu coordinators) need to address the issue of liability related to a facility's inability to perform post-mortem activities. Members of the community should get together to discuss issues. DHS should develop a mechanism that targets individual communities instead of counties.
- Due to regulations, hospitals with internal surge plans will not be able to set up HRSA funded tents in advance if they predict that a surge will occur. The local district office will have to provide permission and regulatory agencies have to agree to autonomy.
- Ensure that surge plans do not wait until a surge to activate ICS. Must be able to plan for the potential of surge and activate prior to the surge.
- Surge can be enacted through a proclamation or an emergency order. Empowering the Local Health Officer (LHO) seems to be the best way to do this, since it can directly tie into the Civil

## EXISTING FACILITIES

Code for immunity. If the LHO cannot do this, then the Regional Disaster Medical Health Coordinator (RDMHC) can.

- Security Planning
  - “Borrow” from existing lock down plans from law enforcement (police, corrections) and hospitals Labor and Delivery departments and tailor them towards a surge facility.
  - Address education and risk communication to public relating to change in procedures during a surge scenario.
  - Develop clear policies surrounding crowd control.
  - Develop communication strategies through the use of media.
  - Expand definition of patient security to include vigilante, influx of patients and perimeter lock down.
  - Develop a “list” of communication strategies and education of what to expect during a surge and how it will be different from a security perspective.

### Planning Considerations for Facility Operations

<< Analysis in progress to consolidate documents received from work team members and other research material >>

## EXISTING FACILITIES

### Section IV: Patient Management

#### Current Statutory and Regulatory Requirements: Prioritizing Patients

Perhaps the most applicable statutory requirement with respect to the prioritization of patients is the Examination and Treatment for Emergency Medical Conditions and Women in Labor Act, or EMTALA (42 U.S.C. 1395dd), which states that hospitals must provide individuals who come to the emergency department with an appropriate medical screening examination to determine whether or not an emergency medical condition exists.

Upon verifying that the patient does have an emergency medical condition, the hospital must then provide either within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition, or for transfer of the individual to another medical facility. If an individual at a hospital has an emergency medical condition which has not been stabilized, the hospital may not transfer the individual unless the individual – after being informed of the hospital's obligations and of the risk of transfer – in writing requests transfer to another medical facility; or a physician has signed a certification that based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual and, in the case of labor, to the unborn child from effecting the transfer; or if a physician is not physically present in the emergency department at the time an individual is transferred, a qualified medical person (as defined by the Secretary in regulations) has signed a certification; and the transfer is an appropriate transfer. A certification shall include a summary of the risks and benefits upon which the certification is based.

#### Existing Waivers and Liability Protection

Although 42 USCA §1320b-5 grants the Secretary of Health and Human Services the authority to temporarily waive or modify application of Federal program requirements, with respect to EMTALA, the only portion that has been waived (as it was during Hurricane Katrina in 2005) have been the sanctions for a transfer of an individual who has not been stabilized if the transfer arises out of the circumstances of the emergency.

To date, no waivers for the program requirement itself have been developed nor has there been a general immunity protection developed for violation of a Federal regulation during a disaster.

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

<< Material related to regulatory requirements and liability protection for patient management is being created and will be added in the next iteration of this document >>

#### Guidelines for Prioritization of Patients in a Facility

The Council on Ethical and Judicial Affairs (CEJA) develops ethics policy for the AMA. CEJA maintains and updates the AMA's Code of Medical Ethics. CEJA's Report K – A-93; "Ethical Considerations in the Allocation of Organs and Other Scarce Medical Resources Among Patients" provides guidelines on prioritizing scarce resources. The report was eventually adapted under Section E-2.00 Opinions on Social Policy Issues, E-2.03 Allocation of Limited Medical Resources

Per the report, decisions regarding the allocation of limited medical resources among patients should consider only ethically appropriate criteria relating to medical need. These criteria include: likelihood of benefit, urgency of need, change in quality of life, duration of benefit, and, in some cases, the amount of resources required for successful treatment. In general, only very substantial differences among patients are ethically relevant; the greater the disparities, the more justified the

## EXISTING FACILITIES

use of these criteria becomes. In making quality of life judgments, patients should first be prioritized so that death or extremely poor outcomes are avoided; then, patients should be prioritized according to change in quality of life, but only when there are very substantial differences among patients. Non-medical criteria, such as ability to pay, age, social worth, perceived obstacles to treatment, patient contribution to illness, or past use of resources should not be considered. The full text of the article can be found at:

[http://www.ama-assn.org/ama1/pub/upload/mm/369/ceja\\_ka93.pdf](http://www.ama-assn.org/ama1/pub/upload/mm/369/ceja_ka93.pdf)

### Key Recommendations:

- The principles outlined in the AMA report are better suited for re-triaging patients once they are in a hospital
- Field triage principles are better suited to triage that happens outside the hospital. << Analysis in progress to consolidate documents received from work team members and other research material >>
- Patient prioritization and management will be carried out, all under consideration of standard of care as defined earlier. Patient prioritization and management plans need to be holistic and not just discuss a patient exiting a facility but also where s/he goes and is taken care of in other parts of the healthcare delivery system.
- Need a consistent approach with the state for transfer of patients. We cannot have facilities contacting facilities. An overarching location needs to be identified that provides this information and directs mutual aid and transportation of patients.
- Recommendations that will be addressed in other work teams:
  - Administrative: Patient tracking as the biggest cause of lawsuits after Katrina. Plans need to be holistic and not just discuss a patient exiting a facility but also where s/he goes and is taken care of in other parts of the healthcare delivery system.
  - Administrative: Plans need to address patient tracking system / medical record system
  - Population Rights: Patients' Rights document should include the patient's responsibilities during a disaster

## EXISTING FACILITIES

### Section V: Continuity of Business Operations

#### Key Recommendations:

- Requirements for continuity of business operations has primarily focused on hospitals and ambulatory centers but has not expanded to other healthcare organization like SNFs, etc.
- Understand and explain the roles of MHOACs
- Describe NDMS and interconnectivity of HICS to all healthcare organizations that can provide capacity
- Tool that provides a comparison of what a continuity of business plan looks like under normal operations and what a continuity of business plan looks like for surge. (Look at sample MOUs with vendors. Might be able to generate ideas for these)
  - Developing a method to allow payment in advance will help the contractual relationships between these entities
  - Developing a co-coverage agreement would also aid in the contractual relationships between these entities.
- Checklist of items that should be on a continuity of business plan
- Develop a command chart of horizontal responsibilities for continuity of business plans and how they relate to the state. Chart provides simplistic way of educating and communicating to business the roles and resources available
- Identify insurer requirements for continuity of business operations (CBO) plan. CBO plans are not currently required for hospitals however if they need insurance coverage, than it is needed. Joint Commission has a simple form that can be used to build upon.
- Recommendation for Administrative work team: Develop a mini-medical record card that can capture information during a disaster. What pertinent information would be important to capture? (insurance, name, level of care, etc)

#### Current Statutory and Regulatory Requirements Related to Facility Operations

<<Material under development>>

#### Existing Waivers and Liability Protection

<<Material under development>>

## **EXISTING FACILITIES**

### **Reimbursement and Funding**

Reimbursement was discussed with respect to Existing Facilities however will be covered more comprehensively by the Funding Sources Work Team. Considerations for how existing facilities may “preserve revenue stream” within the first 72 hours after a surge were discussed.

## EXISTING FACILITIES

### Appendix 1: MUTUAL AID AGREEMENT

In consideration of the mutual commitments given herein, each of the Signatories to this Mutual Aid Agreement agrees to render aid to any of the other Signatories as follows:

1. Request for aid. The Requesting Signatory agrees to make its request in writing to the Aiding Signatory within a reasonable time after aid is needed and with reasonable specificity. The Requesting Signatory agrees to compensate the Aiding Signatory as specified in this Agreement and in other agreements that may be in effect between the Requesting and Aiding Signatories.
2. Discretionary rendering of aid. Rendering of aid is entirely at the discretion of the Aiding Signatory. The agreement to render aid is expressly not contingent upon a declaration of a major disaster or emergency by the federal government or upon receiving federal funds.
3. Invoice to the Requesting Signatory. Within 90 days of the return to the home work station of all labor and equipment of the Aiding Signatory, the Aiding Signatory shall submit to the Requesting Signatory an invoice of all charges related to the aid provided pursuant to this Agreement. The invoice shall contain only charges related to the aid provided pursuant to this Agreement.
4. Charges to the Requesting Signatory. Charges to the Requesting Signatory from the Aiding Signatory shall be as follows:
  - a.) Labor force. Charges for labor force shall be in accordance with the Aiding Signatory's standard practices.
  - b.) Equipment. Charges for equipment, such as bucket trucks, digger derricks, and other special equipment used by the Aiding Signatory, shall be at the reasonable and customary rates for such equipment in the Aiding Signatory's location.
  - c.) Transportation. The Aiding Signatory shall transport needed personnel and equipment by reasonable and customary means and shall charge reasonable and customary rates for such transportation.
  - d.) Meals, lodging and other related expenses. Charges for meals, lodging and other expenses related to the provision of aid pursuant to this Agreement shall be the reasonable and actual costs incurred by the Aiding Signatory.
5. Counterparts. The Signatories may execute this Mutual Aid Agreement in one or more counterparts, with each counterpart being deemed an original Agreement, but with all counterparts being considered one Agreement.
6. Execution. Each party hereto has read, agreed to and executed this Mutual Aid Agreement on the date indicated.

Date \_\_\_\_\_ Entity \_\_\_\_\_

By \_\_\_\_\_

Title \_\_\_\_\_

Source: Minnesota Municipal Utilities Association