

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

Community Care Clinics Training Guide

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What is the goal of the Community Care Clinics Training?

Community Care Clinics Training Overview

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This training course is intended to serve as an overview of the content in the *Community Care Clinics Volume of the Standards and Guidelines for Healthcare Surge during Emergencies* project.

- The presentation is designed to be used as a tool for community care clinics when developing training programs on their healthcare surge plans.
- Community care clinics should use this training course as a starting point and customize it to include organization-specific surge planning objectives.
- Community care clinics are encouraged to incorporate interactive elements and tailor the presentation contents to their audience.

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What are the learning objectives for the Community Care Clinics Volume of the Standards and Guidelines Manual?

Community Care Clinics Training Overview and Learning Objectives

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Upon completion of this course, you will be able to:

- Understand the potential roles of community care clinics in a healthcare surge
- Understand the responsibilities of community care clinics, which impact patients, staff, and communities
- Articulate the ethical and behavioral principles and practice guidelines required during surge planning and a healthcare surge event
- Be familiar with existing waivers and provisions to regulations as they pertain to a health emergency situation, and be able to locate those provisions
- Locate and utilize regulatory information and other resources for planning and implementing a response to a healthcare surge

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Introduction

California's Healthcare System Response to a Healthcare Surge

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It is critical that healthcare systems and community care clinics not only be prepared to provide services on an individual basis but also be prepared to participate in an overall emergency community response. Key Considerations:

- An attack using biological, chemical, or radiologic agents, the emergence of diseases such as severe acute respiratory syndrome or pandemic influenza; or the occurrence of a natural disaster are threats capable of imposing significant demands on California's healthcare resources and state-wide healthcare delivery system.
- The overwhelming increase in demands for medical care arising out of such an event is called a healthcare surge. The magnitude of a healthcare surge will require a focused planning approach.
- In *Emergency Management Principles and Practices for Healthcare Systems*¹, the Institute for Crisis, Disaster, and Risk Management has found that healthcare system response during emergencies demonstrates the following recurrent findings:

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| <ul style="list-style-type: none">• Local response is primary• Medical response is complex• Coordinated response is essential• Bridging the "public-private divide"• Public health as an essential partner | <ul style="list-style-type: none">• The need for robust information processing• The need for effective overall management• Medical system resiliency |
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- An effective response to healthcare surge will promote healthcare system resiliency as well as providing the most efficient care for victims of the event.

¹ *Emergency Management Principles and Practices for Healthcare Systems*. The Institute for Crisis, Disaster, and Risk Management (ICDRM) at the George Washington University, for the Veteran's Health Administration, United States Department of Veteran's Affairs. Washington, D.C., June 2006. Available at <http://www1.va.gov/emshg/>

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Additional Notes



Local response is primary: The initial response to any medical event will be almost entirely based upon locally available health and medical organizations.

Medical response is complex: The response to a large-scale emergency impacts an entire community and involves numerous, diverse medical and public health entities, including healthcare systems and facilities, public health departments, emergency medical services, medical laboratories, licensed healthcare professionals, and medical support services.

Coordinated response is essential: An effective healthcare system response to major events usually requires support from public safety agencies and other community response entities that are not normally partnered with the community healthcare systems during everyday operations.

Bridging the "public-private divide": Healthcare organizations have traditionally planned and responded to emergencies as individual entities. This has occurred, in part, because of the "public-private divide": the legal, financial, and logistical issues in planning and coordination between public agencies and primarily private healthcare entities. Healthcare organizations must view themselves as integrated components of a larger response system.

Public health as an essential partner: Public health departments are not traditionally integrated with other community emergency response operations, including the acute care medical and mental health communities. Public health departments are an essential partner in any successful response to a healthcare surge.

The need for robust information processing: Medical issues that arise from large scale incidents may not be immediately apparent. Complex information must be collected from disparate sources, processed, and analyzed rapidly in order to determine the most appropriate course of action. This requires a robust information management process that can differ markedly from routinely used information collection systems.

The need for effective overall management: Medical response to a healthcare surge situation can be very complex, requiring many diverse tasks. Responsibility for each of these activities can vary significantly across organizations in different communities. Even within a single

Community Care Clinics

healthcare system, many actions require coordination between operating units that may not normally work together. Despite these challenges, all necessary functions must be adequately addressed for a successful mass casualty or mass effect response.

Medical system resiliency: A major hazard impact that creates the need for healthcare surge capacity will likely impact the normal functions of the everyday healthcare systems. Medical system resiliency is necessary for the system to maintain its effectiveness and, at the same time, provide a functioning platform upon which medical surge may occur. Medical system resiliency is achieved by a combination of mitigation measures and adequate emergency preparedness, assuring the continuity of healthcare system operations despite emergency.

Reference



Emergency Management Principles and Practices for Healthcare Systems. The Institute for Crisis, Disaster, and Risk Management (ICDRM) at the George Washington University; for the Veteran's Health Administration, United States Department of Veteran's Affairs. Washington, D.C., June 2006. Available at <http://www1.va.gov/emshg/>.

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What are the key healthcare surge planning concepts?

Key Healthcare Surge Planning Concepts for California

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The following concepts serve as the foundation for understanding the context and perspective for the information presented in the *Standards and Guidelines for Healthcare Surge Manuals*:

- During a catastrophic emergency, healthcare providers will focus on saving the maximum number of lives possible.
- The movement from individual-based care to population outcomes challenges the professional, regulatory, and ethical paradigms of the healthcare delivery system. There is a great deal of flexibility in current California state statutes and regulations to enable a move to a population-based healthcare response.
- The coordination of activities during a healthcare surge entails significant responsibilities for local government as well as community healthcare professionals.
- The proclamation of a healthcare surge may be accompanied by proclamations of emergency which activate legal immunities or allow the suspension of practice requirements that may impede the healthcare surge response.

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What are the key healthcare surge planning concepts?

Key Healthcare Surge Planning Concepts for California (continued)

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The intent of the *Standards and Guidelines Manual* is not to solve the challenges of the current healthcare delivery system but to operate within it. While the current healthcare delivery system is complex, much can be done in the event of a surge response to simplify it.

- Preserving overall financial liquidity in the healthcare delivery system during a catastrophe is an issue that is larger than any single stakeholder.
- Effective surge response requires all stakeholders to accept new responsibilities, behave differently than they may have been trained, and cooperate with each other in unprecedented ways.

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What does "healthcare surge" mean for community care clinics?

Overview of Community Care Clinics Volume

C

Given the unpredictable nature of a disaster and its potential to significantly impact the healthcare delivery system, sufficient planning and coordination between providers, community care clinics, and payers will be essential to maintaining business continuity and sustaining operations at facilities providing medical care.

"Healthcare surge" has varying meanings to participants in the healthcare system. In planning a response to a catastrophic emergency in California, "healthcare surge" is defined as follows: A healthcare surge is proclaimed in a local health jurisdiction when an authorized local official, such as a local health officer or other appropriate designee, using professional judgment, determines, subsequent to a significant emergency or circumstances, that the healthcare delivery system has been impacted, resulting in an excess in demand over capacity in hospitals, long-term care facilities, community care clinics, public health departments, other primary and secondary care providers, resources, and/or emergency medical services.

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Additional Notes



During a healthcare surge, the delivery of care may be different, and the goal of care may change based on available resources. The scope of a provider's practice may change based on need, the sites of care may look different due to access issues, and the traditional methods of claims identification and submission may be forced to undergo adjustments that require practical solutions. Additionally, during a catastrophic emergency, the primary focus of the healthcare community will be on responding to the emergency and caring for the ill and injured. These changes will require clinics and other providers to work with health plan partners to meet the needs of the healthcare surge environment and ensure adequate provisions of care and cash flow.

How can community care clinics plan for a healthcare surge?

Overview of Community Care Clinics Volume *(continued)*

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As a core participant in any healthcare delivery response, community care clinics should use this volume and corresponding tools as a resource to build a comprehensive and coordinated approach to surge planning. Considerations should include:

- A general community response to a healthcare surge may include many different entities, including community care clinics and public health entities, each playing several distinct roles and serving many different needs. These entities may take on roles other than those supported during normal conditions and any healthcare surge planning activities should take this potential for role expansion into consideration.
- The actions of the federal and California state governments, as well as potential funding available during surge conditions, must be considered in any surge planning efforts.
- Understanding the opportunities available to community care clinics when developing an approach to surge planning will enable community care clinics to develop a surge facility plan which addresses many aspects of the operation, including increasing access to care, expanding the clinic workforce, and augmenting clinical staff.
- A proactive approach when working with health plan partners is an important component of the planning process and may include developing revised agreements between providers and health plans which focuses on the simplification of administrative requirements and reimbursement obligations.

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How will a transition to population-based care impact resource allocation?

Transitioning From Individual Care to Population-Based Care Community Care Clinics Volume, Section 2.1

C

Healthcare surge capacity planning must consider a departure from individual patient-based outcomes in favor of an approach that saves the most lives (population-based care). It is anticipated that certain legal requirements may be waived or suspended by state and/or federal government authorities during a healthcare surge in order to support a shift to population-based care. To the fullest extent possible, this shift to population-based care should adhere to longstanding principles of ethical practice.

- The following guidelines provide ethical guidance on appropriate and inappropriate criteria for resource-allocation decisions during a healthcare surge:¹

Appropriate Criteria for Resource Allocation	Inappropriate Criteria for Resource Allocation
<ul style="list-style-type: none"> • Likelihood of survival • Change in quality of life • Duration of benefit • Urgency of need • Amount of resources required 	<ul style="list-style-type: none"> • Ability to pay • Provider's perception of social worth • Patient contribution to disease • Past use of resources

¹Ethical Considerations in the Allocation of Organs and Other Scarce Medical Resources Among Patients. (*Arch Intern Med.* 1995; 155: 29-40). © 1993 American Medical Association.

Guidance



For more information on healthcare surge ethical principles, allocation of scarce resources, and guidelines designed to alleviate, to the extent possible, concern over the liability associated with making such difficult decisions see *Foundational Knowledge* Section 9, "Transitioning from Individual Care to Population-based Care."

Reference



- "Ethical Considerations in the Allocation of Organs and Other Scarce Medical Resources Among Patients." (*Arch Intern Med.* 1995; 155: 29-40). © 1993 American Medical Association.
- Health Systems Research Inc., "Altered Standards of Care in Mass Casualty Events," (an Agency for Healthcare Research and Quality (AHRQ) Publication, April 2005).

How is "Standard of Care" defined?

Standard of Care Defined Community Care Clinics Volume, Section 2.2

C

Standard of care is a legal concept that requires licensed healthcare personnel, when caring for patients, to adhere to the customary skill and care that is consistent with good medical (or other healthcare) practice.

- The "standard of care" in California is based on what a reasonably prudent person with similar knowledge and experience would do under similar circumstances.

- For the purposes of this document:

The standard of care during a healthcare surge is defined as the utilization of skills, diligence and reasonable exercise of judgment in furtherance of optimizing population outcomes that a reasonably prudent person or entity with comparable training, experience or capacity would have used under the circumstances.

- The "standard of care" provides a framework to identify and objectively evaluate the professional responsibilities of licensed healthcare professionals to ensure that care is safe, ethical, and consistent with the professional practice of the licensed profession in California.
- Standards of care apply to all aspects of care and treatment, from initial assessment, to administering of proper medications and performing open-heart surgery.

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What is the National Incident Management System (NIMS), and how do NIMS implementation activities apply to community care clinics?

National Incident Management System Implementation Activities focused on Community Care Clinics Community Care Clinics Volume, Section 3.1

C

The federal government requires a standardized approach to emergency response management. This federal system is called the National Incident Management System (NIMS).

- Homeland Security Presidential Directive/HSPD-5 Management of Domestic Incidents called for the establishment of a single, comprehensive National Incident Management System (NIMS). NIMS is a system that improves response operations through the use of Incident Command Systems and other standard procedures and preparedness measures.
- All clinics and healthcare systems receiving federal emergency preparedness and response grants, contracts or cooperative agreements (e.g., Hospital Preparedness Program funds, Department of Homeland Security grants) must work to implement NIMS.
- Major categories for implementation activities for community care clinics and healthcare systems include¹:

<ul style="list-style-type: none">• Organizational Adoption• Command and Management• Preparedness Planning	<ul style="list-style-type: none">• Preparedness Training• Preparedness Exercises• Resource Management• Communications and Information Management
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¹Federal Emergency Management Administration, Fact Sheet, NIMS Implementation for clinics and Healthcare Systems, September 12, 2006. http://www.fema.gov/pdf/emergency/nims/imp_hos_fs.pdf

Reference



Federal Emergency Management Administration, Fact Sheet, "NIMS Implementation for Hospitals and Healthcare Systems," September 12, 2006. This document is available at http://www.fema.gov/pdf/emergency/nims/imp_hos_fs.pdf.

What is the Standardized Emergency Management System (SEMS)?

Standardized Emergency Management System (SEMS) Community Care Clinics Volume, Section 3.2

C

The Standardized Emergency Management System (SEMS) is a system for managing the response to multi-agency and multi-jurisdictional emergencies in California.¹ The system integrates NIMS, the Incident Command System, and the support and coordination system developed under SEMS.

- Every local agency, in order to be eligible for any funding of response-related (i.e., personnel) costs under disaster assistance programs, must also use SEMS to coordinate multiple jurisdiction or multiple agency emergency and disaster operations.²
- Unified Command is a management concept under the Incident Command System that occurs when there is more than one agency with jurisdictional responsibility (e.g., public health, law enforcement, and fire) for the emergency or when emergency incidents expand across multiple political boundaries.
- An Operational Area is used by the county and the political subdivisions comprising the Operational Area for the coordination of emergency activities and to serve as a link in the communications system during a state of emergency or a local emergency.³ The Operational Area, defined in the Emergency Services Act, is a required concept of SEMS.⁴

¹In a letter dated September 28, 2006, the director of OES certified to the federal Department of Homeland Security the compliance of SEMS/NIMS with the National Incident Management System (NIMS) for fiscal year 2006.

²Government Code Section 8607(e).

³Government Code Section 8605.

⁴Government Code Section 8559(b), 8605, and 8607(a)(4)

Additional Notes



SEMS is based on the concept of the Incident Command System. The Incident Command System provides a standardized management structure with accompanying processes that can be used by any organization to respond to emergencies and requires the following five management functions be performed.

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

Guidance



For additional information on SEMS/NIMS, see *Foundational Knowledge* Section 3.9, "Standardized Emergency Management System."

Reference



- In a letter dated September 28, 2006, the director of OES certified to the federal Department of Homeland Security the compliance of SEMS/NIMS with the National Incident Management System (NIMS) for fiscal year 2006.
- Government Code Section 8607(e)
- Government Code Section 8559(b), 8605, and 8607(a)(4)
- Government Code Section 8605

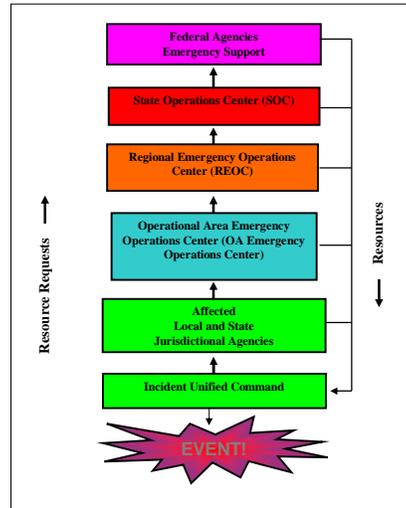
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What is the Standardized Emergency Management System (SEMS)?

Standardized Emergency Management System (continued) Community Care Clinics Volume, Section 3.2

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- SEMS is designed to foster the coordination of public and private sector resources at all levels of its structure.
- Requests for resources flow upward from the local level to the federal level and assistance to meet these requests flows downward from the federal level to the local level.
- To facilitate the request and assistance for resources, it is imperative that each coordination level above the requesting level be contacted in order to effectively supply and account for available resources.



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Additional Notes



The Standardized Emergency Management System (SEMS) is a system for managing the response to multi-agency and multi-jurisdictional emergencies in California. This system integrates the National Incident Management System (NIMS), the Incident Command System, and the support and coordination system developed under SEMS. All state agencies are required to use SEMS to coordinate multiple jurisdiction or multiple agency emergency operations. Every local agency, in order to be eligible for any funding of response-related (i.e., personnel) costs under disaster assistance programs, must also use SEMS to coordinate multiple jurisdiction or multiple agency emergency operations. This means that local emergency plans must also incorporate SEMS, assuming the local government wants to be reimbursed for emergency personnel costs.

How do community care clinics connect to the emergency response system?

How Community Care Clinics Connect to the Emergency Response Structure **Community Care Clinics Volume, Section 3.3**

C

The first step in planning the successful implementation the Incident Command System of should include determining which roles a community care clinic will staff.

- It is recommended that at a minimum the following four roles be staffed at every community care clinic:
 - **Operations Section Chief**
 - **Planning Section Chief**
 - **Logistics Section Chief**
 - **Finance / Administration Chief**
- In determining who should serve these roles, community care clinics may want to keep in mind that during a healthcare surge, executive managers will need to continue to fulfill their responsibilities and may not be the best choices for managing the Incident Command System.

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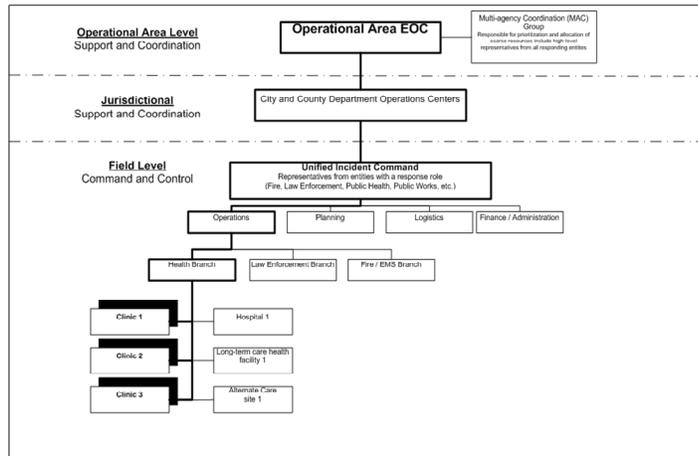
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How do community care clinics connect to the emergency response system?

How Clinics Connect to the Emergency Response Structure Community Care Clinics Volume, Section 3.3

C

All healthcare providers must be integrated into this Unified Command. An authorized local official, or designee, will notify healthcare facilities that the Unified Command has been established and provide a contact for coordination of patient movement and requests for resources, services and supplies.



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Additional Notes



The Unified Command coordinates the movement of patients, establishes priorities, and allocates scarce resources, services, and supplies among all healthcare providers.

Hospital-based clinics may be converted to the Hospital Incident Command system (HICS). HICS is a system management tool that has been created by adapting the Incident Command System for the hospital environment.

Tools



The **Emergency Response Team Position Assignments** chart can also be found in the *Community Care Clinics Operational Tools Manual*. The Emergency Response Team Position Assignments chart will be used to evaluate existing staff's skill set to determine the most appropriate role for clinic staff within the emergency response team.

How does the Hospital Incident Command System (HICS) apply to community care clinics?

The Hospital Incident Command System and Hospital-Based Clinics Community Care Clinics Volume, Section 3.4

C

The Hospital Incident Command System (HICS) is a system management tool that has been created by adapting the Incident Command System for the hospital environment.

- Hospital-based clinics may be converted to HICS. HICS can be used by all community care clinics as a guide to assist in all hazards emergency planning and response. However, it is not a template or an operational plan.
- The August 2006 update to the Clinic Incident Command Guidebook¹ is a valuable resource for community care clinics as well. It provides specific guidance for incorporating an incident management system including:
 - The function of the Emergency Operations Plan
 - Procedures for event recognition and activation of the incident command system
 - Position descriptions including surge roles and job action sheets
 - Scenario-specific Incident Planning Guides
 - Incident management forms for documentation needs associated with clinic response to an incident

¹The Hospital Incident Command System Guidebook (August 2006) can be found at www.emsa.ca.gov/hics

Reference



- The Hospital Incident Command System Guidebook (August 2006) can be found at <http://www.emsa.ca.gov/HICS/default.asp>.
- Additional HICS resources and training materials can be found at www.hicscenter.org.

What is the relationship between ICS and SEMS?

Relationship Between the Incident Command System and the Standardized Emergency Management System Community Care Clinics Volume, Section 3.5

C

The SEMS concept recommends that community care clinics adopt the Incident Command System for emergency organization structure and management.

- Each Operational Area's system is somewhat unique in its approach to receiving requests, providing resources, interacting with community care clinics, and coordinating Medical response to emergencies.
- Clinics should work with their consortia and local government agencies to obtain guidance, assistance, or referral to sources of information on emergency preparedness.

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What community organizations and external response partners should a community care clinic include in its emergency operations plan?

Community Surge Planning Community Care Clinics Volume, Section 3.6

C

In order to mitigate risks and sustain an effective response, a community care clinic must not only prepare its staff for healthcare surge but also collaborate with the community, suppliers, and external response partners. Key considerations include:

- Clinics should monitor applicable accreditation standards such as the Joint Commission and the Accreditation Association for Ambulatory Health Care (AAAHC) standards. Community care clinics do not necessarily need to be accredited to use these standards as guides in developing surge plans.
- Contact information for the following organizations should be maintained in the clinic's emergency operations plan:
 - **The public health department and Local Health Officer**
 - **The Medical Health Operations Area Coordinator, or other appropriate designee** (see Foundational Knowledge, Section 3.10.6: "Medical Health Operational Area Coordinator" for more information)
 - **The Local Emergency Medical Services Agency Administrator and Medical Director**
 - **The Operational Area emergency operations center staff**

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Additional Notes



According to the Joint Commission's report, *Health Care at the Crossroads: Strategies for Creating and Sustaining Community-wide Emergency Preparedness Systems* (2003), "managing a mass casualty or bioterrorism situation is no job for a single provider organization. This is, in fact, the responsibility of 'the community' – an as yet ill-defined composite that, at a minimum, includes emergency medical services, fire, police, the public health system, local municipalities and government authorities, and local clinics and other healthcare organizations."

Reference



- The Joint Commission, "Health Care at the Crossroads: Strategies for Creating and Sustaining Community-wide Emergency Preparedness Systems" (2003).
- The CNA Corporation, "Medical Surge Capacity and Capability: A Management System for Integrating Medical and Health Resources during Large-Scale Emergencies" (August, 2004).

Community Care Clinics

What role do Government-Authorized Alternate Care Sites play in a community care clinic's surge plan?

Clinic Expansion vs. Government-Authorized Alternate Care Sites

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Community Care Clinics Volume, Section 3.7

Two ways to address the increased demand for healthcare surge include:

- Expanding existing healthcare facilities to increase capacity for patient care
- Establishing temporary healthcare facilities to provide care in non-healthcare locations.
- A government-authorized alternate care site is defined as:
 - **A location that is not currently providing healthcare services and will be converted to an alternate care site to enable the provision of healthcare services to support, at a minimum, outpatient and/or inpatient care required after a declared catastrophic emergency. These specific sites are not part of the expansion of an existing healthcare facility (i.e., extensions of clinics or hospitals), but rather are designated under the authority of the local and/or State government.**
- The objective for establishing government-authorized Alternate Care Sites is to absorb the excess patient load until the local healthcare system (e.g., hospitals, community care clinics, and long-term care facilities) can manage the demands for patient care.

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Additional Notes



Setting up government-authorized alternate care sites may require 72 hours or more once a decision has been made that they are needed. In some rural and frontier areas, the clinic site may be the only location for a government-authorized care site.

A government-authorized alternate care site will be established only when it is anticipated that all other healthcare resources are exhausted. The services provided at a government-authorized Alternate Care Site will vary based on resource availability and event-specific patient needs. Since a government-authorized alternate care site, except for a mobile field clinic, will operate in a non-healthcare facility, it cannot fully replicate a clinic setting. For additional explanation regarding government-authorized alternate care sites and the role clinics and their staff may play in a response effort, see *Volume II: Government-Authorized Alternate Care Sites Standard and Guidelines*.

Guidance



Additional explanation regarding government-authorized alternate care sites and the role clinics and their staff may play in a response effort may be located in the *Volume II: Government-Authorized Alternate Care Sites Standard and Guidelines*.

What is a Hazard Vulnerability Analysis?

Developing a Hazard Vulnerability Analysis Community Care Clinics Volume, Section 3.8

C

The Hazard Vulnerability Analysis is the needs assessment for a clinic's emergency preparedness program, and can help community care clinics to determine their particular areas of vulnerability.

- In *Emergency Management Principles and Practices for Healthcare Systems*¹, the following points are described to illustrate how the nature of clinics contribute to their vulnerability:
 - Clinics can be complex buildings combining the functions of an office, laboratory, warehouse, and pharmacy. Their planning is complicated because of the presence of many small rooms. After an incident occurs, patients and visitors can be very confused, lights may be out, and hallways and room exits may be blocked.
 - The clinic's supplies (e.g., pharmaceuticals, splints, and bandages) are essential for patient treatment and survival. Patient records are vital for accurate patient treatment, particularly in the event of patient evacuation to other facilities. Damage to storage and records areas may render these items unavailable at the time they are most needed.
 - Clinics are dependent upon utilities such as power, water supply, waste disposal, and communication. Imaging, monitoring, sterilization, and other equipment must be powered.
 - Some items in a clinic are hazardous if overturned or damaged (e.g., drugs, hazardous gases, chemicals, heavy equipment, and radiation devices).
 - In addition to internal problems caused by damage to the facility itself, community impact may result in an influx of injured people, as well as friends and relatives seeking information about injured patients. Clinic staff are likely to be injured or killed by the catastrophic event as well, potentially resulting in a shortage of trained staff at the clinic.

¹Emergency Management Principles and Practices for Healthcare Systems. The Institute for Crisis, Disaster, and Risk Management (ICDRM) at the George Washington University (GWU); for the Veterans Health Administration (VHA)/US Department of Veterans Affairs (VA), Washington, D.C., June 2006. Available at <http://www1.va.gov/emshg/>.
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Reference



Emergency Management Principles and Practices for Healthcare Systems. The Institute for Crisis, Disaster, and Risk Management (ICDRM) at the George Washington University; for the Veteran's Health Administration, United States Department of Veteran's Affairs. Washington, D.C., June 2006. Available at <http://www1.va.gov/emshg/>.

Tool



The **Hazard Vulnerability Analysis** can also be found in the *Community Care Clinics Operational Tools Manual*. Conducting a Hazard Vulnerability Analysis involves identifying all hazards that may affect a clinic and its surrounding community, assessing the probability of hazard occurrence and the consequence for the organization associated with each hazard, and analyzing the findings to create a prioritized comparison of hazard vulnerabilities.

Community Care Clinics

What is an emergency management program?

Clinic Emergency Management Community Care Clinics Volume, Section 4

C

An emergency management program is defined as a program that implements the organization's mission, vision, management framework, and strategic goals and objectives related to emergencies and disasters. It uses a comprehensive approach to emergency management as a conceptual framework, combining mitigation, preparedness, response and recovery into a fully integrated set of activities."¹ Several authorities provide guidance on emergency management programs, including:

- The **Joint Commission's Environment of Care** standard provides guidance and criteria for community-based surge capacity.
- **National Fire Protection Association Standard 99** establishes minimum criteria for clinic emergency management in the development of a program for effective disaster preparedness, response, mitigation and recovery.
- **California Code of Regulations Title 22, Division 5: Licensing and Certification of Health Facilities** requires licensed facilities, as a condition of licensure, to develop and maintain a written disaster and mass casualty program in consultation with county or regional and local planning offices.

¹Adapted from National Fire Protection Association 1600, 2004, and the Veterans Health Administration Guidebook, 2004.

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Additional Notes



The Joint Commission provides the following standards for community-based surge capacity. Because not all community care clinics are accredited by the Joint Commission, American Association for Ambulatory Health Care (AAAHC) guidelines that closely parallel Joint Commission standards are provided as an additional reference.

- **Joint Commission - Environment of Care 4.11:** The organization plans for managing the consequences of emergencies.
- **AAAHC - Chapter 4, Quality of Care Provided:** As appropriate, the organization participates in community health emergency preparedness.
- **Joint Commission - Environment of Care 4.12:** The organization develops and maintains an emergency operations plan.
- **AAAHC - Chapter 8, Facilities and Environment:** The organization has a comprehensive emergency plan to address internal and external emergencies.
- **Joint Commission - Environment of Care 4.14:** The organization establishes strategies for managing resources and assets during emergencies.
- **AAAHC - Chapter 4, Quality of Care Provided:** A credible organization provides healthcare services in accordance with the principles of professional practice and ethical conduct.

Reference



Adapted from National Fire Protection Association Standard 1600, 2004, and the *Veterans Health Administration Guidebook*, 2004.

What steps can community care clinics take to increase surge capacity?

Increasing Surge Capacity in Community Care Clinics **Community Care Clinics Volume, Section 5.1**

C

During a healthcare surge, community care clinics will face facility and operational challenges as they try to meet the demands of the healthcare surge.

- This will mean that community care clinics may be unable to comply with certain regulatory requirements and standards.
- During the planning process clinics should identify area and spaces that could be opened and/or converted for use as patient/inpatient treatment areas.
- Community care clinics should identify which areas will be used first as patient/inpatient healthcare surge capacity treatment areas. Procedures for accomplishing this expansion should be included in the clinic's emergency operations plan.

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Reference



Health Systems Research Inc., *Altered Standards of Care in Mass Casualty Events*, an Agency for Healthcare Research and Quality publication, April 2005.

Community Care Clinics

What are some points community care clinics should consider with respect to patient management during surge?

Patient Management Community Care Clinics Volume, Section 5.2

C

Patient Transfer from Clinics to Hospitals and from Hospitals to Clinics

- A community care clinic may need to transfer patients to, or receive patients from, other facilities to meet the demand for patient care.
- Clinic emergency operations plans should consider patient transfer and the point at which patient transfers are coordinated through the Unified Command structure to ensure coordination of response efforts.
- Following the request and after the patient registers at the receiving healthcare facility, the patient becomes the receiving healthcare facility's patient and is placed under care of the receiving healthcare facility's admitting physician until discharged, transferred, or reassigned.
- Transfer plans may need to include alternative resources to emergency vehicles, which may not be available.

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Additional Notes



The patient-transferring healthcare facility (clinic, hospital, or long-term healthcare facility) is responsible for coordinating transportation of patients to the receiving healthcare facility through the local emergency Medical services agency or appropriate emergency response authority. Following the request and after the patient registers at the receiving healthcare facility, the patient becomes the receiving healthcare facility's patient and is placed under care of the receiving healthcare facility's admitting physician until discharged, transferred, or reassigned. Transfer plans may need to include alternative resources to emergency vehicles, which may not be available.

What structural safety issues do community care clinics need to consider during healthcare surge?

Structural Safety Community Care Clinics Volume, Section 5.4

C

Before considering facility expansion to meet the demand for patient care after an emergency, clinics must determine if the healthcare facility is structurally sound. Community care clinics should work closely with local experts to develop facility policies and procedures on structural safety and post-disaster assessments.

- A Facility Post-Disaster Status Assessment will be important to evaluating structural safety during an emergency.
 - It is recommended that community care clinics develop plans to guide decision-making around operating or abandoning a degraded environment.
 - Plans should include the identification of an organizational person to perform an immediate assessment and include a list of "fatal deficiencies/flaws" that would trigger immediate evacuation.
 - A variety of operational tools to assist community care clinics in conducting this assessment are provided in the *Community Care Clinics Volume* and the *Community Care Clinics Operational Tools Manual*.
- The Office of Statewide Health Planning and Development (OSHPD) has authority over healthcare facilities, including community care clinics. During a healthcare surge, OSHPD will close healthcare facilities only if a threat to life safety exists.

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Additional Notes



Because healthcare facilities will be in demand following a disaster, OSHPD will close these facilities only as a last resort and only if a threat to life and safety exists. OSHPD will not participate in emergency repair decisions made by healthcare facilities, and unobserved repair of healthcare facilities will be allowed for a specified time period following an earthquake. The time period will be determined by the severity of the earthquake and dictated by the length of the emergency period. OSHPD response teams will not interfere with local efforts to keep a healthcare facility open and providing service to the community as long as there is no threat to life safety at the site. It is OSHPD's intent to allow healthcare facilities to provide services to the public as best they can under emergency conditions without interference.

Reference



Office of Statewide Health Planning and Development, "Emergency Response Plan Memo," available at <http://www.oshpd.state.ca.us/FDD/Regulations/EmergencyPlan.pdf>.

Tools



The **Facility Damage Report (Limited Assessment)** can be found in the *Community Care Clinics Operational Tools Manual*. The facility damage report is a high-level assessment of the structural integrity of a facility during a mass medical emergency.

The **Facility On-Site Damage/Operability Report (Comprehensive Assessment)** can be found in the *Community Care Clinics Operational Tools Manual*. The Facility On-Site Damage/Operability Report (Comprehensive Assessment) is an assessment tool that will aid in the decision whether to keep the facility open or evacuate patients and staff.

The **Facility System Status Report** can be found in the *Community Care Clinics Operational Tools Manual*. The Facility System Status Report can be used to thoroughly assess facility status for the operational period of the incident.

What infection control issues do community care clinics need to consider during healthcare surge?

Infection Control Community Care Clinics Volume, Section 5.5

C

During and following a catastrophic event the risk of infection may be exacerbated due to operational changes in patient care in order to accommodate disaster relief efforts. Community care clinics should use existing standards to guide the development of infection control policies and procedures of use during a healthcare surge.

- The Centers for Disease Control Healthcare Infection Control Practices Advisory Committee provides the following guidelines for infection control:
 - Use Healthcare Infection Control Practices Advisory Committee standards to address healthcare acquired Infections, such as those associated with catheters, blood stream infections associated with central venous lines, pneumonia associated with the use of ventilators, and surgical site infections.
 - Prepare written reports on existing resources and evaluation measures (once every three years and updated annually).
 - Develop a pandemic influenza component in the clinic's disaster plan.
- Cal/OSHA provides guidance on infection control requirements for the protection of workers against occupational exposure to blood or other potentially infectious materials. These requirements include hygiene provisions and the supply of personal protective equipment.

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Additional Notes



As a positive practice, community care clinics should develop and maintain written infectious disease control programs and address prevention of healthcare-acquired infections. In developing these plans, clinics can leverage the Joint Commission's infection control standards in the "Surveillance, Prevention, and Control of Infection" chapter of the *Comprehensive Accreditation Manual for Hospitals*. Even community care clinics not accredited by the Joint Commission can benefit from this guidance. Some recommendations include the following:

- Incorporate an infection control program as a major component of safety and performance improvement programs.
- Perform ongoing assessments to identify risks for the acquisition and transmission of infectious agents.
- Use an epidemiological approach consisting of surveillance, data collection, and trend identification.
- Effectively implement infection prevention and control processes.
- Educate and collaborate with clinic leaders to effectively participate in the design and implementation of the infection control program.
- Integrate efforts with healthcare and community leaders to the extent practicable, recognizing that infection prevention and control is a community-wide effort.
- Remain a viable community resource in properly planning for an increase in infection rate.

Reference

8 CCR 5193 provides guidelines for handling occupational exposure to blood or other potentially infectious materials and outlines specific requirements employers must follow to ensure compliance.

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In a proposed addition to 8 CCR 5199, clinics would be required to establish and implement a written Aerosol Transmissible Disease Exposure Control Plan specific to the work place. Additional information on these requirements can be found at the Department of Industrial Relations website: <http://www.dir.ca.gov/dosh/doshreg/airborneinfectious%2Dmeetings.html>.

For information on influenza infection control, see CDPH's *Pandemic Influenza Preparedness and Response Plan*, Chapter Five, "Infection Control in the Healthcare Setting," available online at:

<http://www.cdph.ca.gov/programs/immunize/Documents/CDHSPandemicInfluenzaPlanFinal.pdf>.

DRAFT

What decontamination issues do community care clinics need to consider during healthcare surge?

Decontamination Community Care Clinics Volume, Section 5.6

C

Similar to infection control, community care clinics should have a plan or program for radioactive, biological, and chemical isolation and decontamination not only for normal operations, but also as a component of their emergency management plan.

- Community care clinics are encouraged to establish relationships and notification procedures with appropriate local agencies.
- The primary role of a clinic in a hazardous materials catastrophic emergency is to triage, treat, decontaminate, and medically screen patients as necessary.
- Additional planning considerations may include establishing a "fast track" decontamination line for patients, establishing a separate decontamination area for patients that require secondary and/or technical decontamination, or establishing a separate "lane" for patients arriving by Emergency Medical Services transport.

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Reference



Clinics may reference the Emergency Medical Services Authority "Patient Decontamination Recommendations", in which specific algorithms for different contamination situations are included for integration into a plan. This document is available at <http://www.emsa.ca.gov/pubs/pdf/emsa233.pdf>.

Community Care Clinics

What hazardous and medical waste management issues do community care clinics need to consider during healthcare surge?

Hazardous Waste Management and Medical Waste Management Community Care Clinics Volume, Sections 5.7 and 5.8

C

Just as a plan or program for decontamination would be critical after a catastrophic emergency such as a nuclear attack, plans for hazardous waste management and medical waste management are necessary as well.

- Hazardous Waste Management
 - Emergency first responders, at the site of the release, are covered under California Occupational Safety and Health Administration State Plan Standards 8 CCR 5192(e).
 - Federal Occupational Safety and Health Administration 1910.120 – Hazardous Waste Operations and Emergency Response Requirements apply to hospital-based clinics in at least three situations:
 - When clinics have an internal release of a hazardous substance which requires an emergency response.
 - When clinics respond as an integral unit in a community-wide emergency response to a release of hazardous substance.
 - When a clinic serves as a Resource Conservation and Recovery Act-permitted Treatment, Storage and Disposal facility.
- Medical Waste Management
 - During a catastrophic emergency, the potential for overloading the waste handling capacity of clinics is greatly increased, a situation which could cause a secondary disaster if the medical waste is not properly managed.
 - Because of this potential, each clinic should develop protocols that go beyond existing waste management plans to address the challenges associated with increased volume of medical waste during an emergency.

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Additional Notes



Issues to consider in developing waste management protocols include:

- Purchasing greater quantities of materials suitable for containing biological agents or infectious organisms. These materials include, but are not limited to:
 - Labeled Biohazard bags
 - Sharps containers
 - Liquid handling containers
 - Rigid, closeable, leak-proof containers
 - All other associated supplies materials
- Developing a system to document the quantity of the materials above and an estimate of how long these supplies will last for an outpatient population level determined by the clinic
- Developing procedures for obtaining additional material, in the event the clinic has exhausted its supplied resources

Reference



- In addition to California Occupational Safety and Health Administration and federal Occupational Safety and Health Administration regulations, the Veterans Health Administration Center for Engineering and Occupational Safety and Health, in its *Emergency Management Program Guidebook*, 2008, provides extensive guidance around hazardous waste management (<http://www1.va.gov/emshg/page.cfm?pg=114>) and discusses key Occupational and Safety and Health Administration hazardous materials regulations related to hazardous waste management.
- The Hospital and Healthcare System Disaster Interest Group and Emergency Medical Services Authority, *Patient Decontamination Recommendations for Hospitals*, July 2005.
- The regulations for medical waste under normal operations can be found in California's Medical Waste Management Act (Health and Safety Code, Division 194, Part 14).

What mass fatality management issues do community care clinics need to consider during healthcare surge?

Fatality Management Community Care Clinics Volume, Section 5.9

C

Although discussing mass fatalities may be challenging for clinics and their staff, it remains important to plan for mass fatality scenarios during a healthcare surge

- Clinic Fatality Management
 - Clinics should plan for the appropriate bagging and storage of the dead, and consider the evidentiary needs (bodies stored with some space/distance between bodies, appropriate identification/labeling of the body). If the body is contaminated (e.g., by infectious disease or radiation), special bagging, handling and labeling procedures must be ensured.
 - The clinic plan must also include a procedure for providing information about viewing the dead by family members. Careful identification and tracking of the dead must be documented by the clinic and provided to authorities when requested.
 - Clinics should be in contact with the Operational Area Emergency Operations Center to learn where temporary morgue sites have been established in their community.
- State and County Fatality Response
 - The Office of Emergency Services has established the California State Mass Fatality Management Planning Committee.
 - This committee has drafted a **Mass Fatality Management Planning Concept of Operations** as a first step in developing a broader plan to address all the topics for management of mass fatalities during catastrophic events.
 - Local government may establish temporary morgue sites in the community in response to mass fatalities and a representative from the Unified Command will communicate the location and transfer procedures to the clinic. Until assistance can be obtained from local government resources to manage fatalities, clinics must implement internal plans to manage the deceased.

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Additional Notes



Each California county has a Sheriff-Coroner, Coroner, or Medical Examiner to manage fatalities. These local government officials rely on the State's mutual aid system to meet their resource needs in events that overwhelm their response capacity. The mutual aid system for these officials is defined in the statewide Coroners Mutual Aid Plan.

If needed, the State of California may request a federal Disaster Mortuary Operational Response Team to assist with the management of mass fatalities. Until assistance can be obtained from local government resources to manage fatalities, clinics must implement internal plans to manage the deceased.

What security planning issues do community care clinics need to consider during healthcare surge?

Security Planning **Community Care Clinics Volume, Section 5.10**

C

Heightened security during a healthcare surge may be needed to protect clinic staff, patients, and visitors as well as the facility and its assets. If clinics cannot maintain a secure environment during a healthcare surge, then evacuation may become necessary. To facilitate security planning, the following steps should be considered:

- Supplemental Security Staffing
 - Planning should consider when law enforcement will be able to assist and how they will be integrated into clinic operations and the clinic's Incident Command System.
 - Consideration should be given to having a contingency contract(s) with local or national private security firms to provide trained personnel during an emergency.
 - In developing plans for security staffing during a healthcare surge, clinics should collaborate with public health departments, local emergency medical services agencies, law enforcement, and local emergency management planners. Many of these groups may already maintain plans for prioritizing and allocating scarce security coverage during an emergency and clinics should work within their community's plan.
- Lock-Down vs. Restricted Access/Visitation
 - Implementing a lock-down prohibits entrance into or exit from the facility.
 - Restricting access by controlling and directing the flow of people into and out of the facility through points of access may be more feasible than a lock-down.
 - Each clinic should outline the triggers for deciding to lock-down or restrict access in its Emergency Operations Plan with supporting incident-specific clinic plans, policies and procedures.

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What security planning issues do community care clinics need to consider during healthcare surge?

Security Planning (continued) Community Care Clinics Volume, Section 5.10

C

Additional considerations should include:

- Chain-of-Custody
 - "Chain of custody" refers to the document or paper trail showing the seizure, custody, control, transfer, analysis, and disposition of physical and electronic evidence. Because evidence can be used in court to convict persons of crimes, it must be handled in a scrupulously careful manner to avoid later allegations of tampering or misconduct.
 - Outline a fundamental strategy for evidence handling in the emergency operations plan.
 - These procedures should address everything from handling a patient's personal effects to packaging and transferring of laboratory specimens.
 - Local law enforcement should be consulted when developing these procedures to ensure the outlined steps are consistent with accepted local practice.

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Tools



The **Standardized Security Assessment/Vulnerability Tool** can be found in the *Community Care Clinics Operational Tools Manual*. Clinics can use the Standardized Security Assessment/Vulnerability Tool to identify potential gaps in security and vulnerabilities at their facility, thereby ensuring the well-being and safety of patients and personnel during a mass medical emergency.

A sample **Facility Security Plan Process Flow** can be found in the *Community Care Clinics Operational Tools Manual*. The sample Facility Security Plan Process Flow can help clinics identify and secure sensitive areas within clinics that may require restricted access during a healthcare surge.

A **Sample Lock-Down Policy and Procedure** can be found in the *Community Care Clinics Operational Tools Manual*. The Sample Lock-Down Policy and Procedure provides procedures and guidance for when the need to lock-down a facility exists for any reason.

What traffic control issues do community care clinics need to consider during healthcare surge?

Traffic Control **Community Care Clinics Volume, Section 5.11**

C

Traffic patterns may need to be revised to optimize emergency medical services and other emergency vehicle arrivals.

- All available parking areas should be opened and consideration given to suspending gate-entry systems and fee payments.
- Policies should be developed to address situations such as abandoned vehicles, including those with possible chemical contamination, and how they should be removed from areas near the facility entrance and other critical locations.
- It should also be anticipated that law enforcement may request vehicle information (tag number, make and model of the car and location) for the patients being seen.

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What business continuity planning issues do community care clinics need to consider during healthcare surge?

Business Continuity Planning **Community Care Clinics Volume, Section 5.12**

C

Business continuity planning involves formulating an action plan that enables an organization to perform its routine day-to-day operations in the event of an unforeseen incident.

- The overall purpose of business continuity planning is to:
 - Identify the essential functions required to be prepared at all times.
 - Resume vital operations within a specified time after the incident occurs.
 - Return to normal operations as soon as practical and possible.
 - Train personnel and familiarize them with emergency operations.
- The business continuity planning process should cover these main areas:
 - **Business Planning** – Determines which aspects of the clinic's operations are most essential to its ability to provide care.
 - **Technical Support** – Determines the feasibility of the plan from a technical standpoint and ensures that the different departments have the equipment and technical support to provide care.
 - **Implementation** – Ensures that clinic personnel are able and willing to implement the plan.
- **Standard operating procedures** for key activities of equipment, plant, and utilities should be developed as part of a clinic's business continuity planning.

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Tools



The **Sample Business Continuity Plan Checklist** can be found in the *Community Care Clinics Operational Tools Manual*. The Sample Business Continuity Plan Checklist summarizes areas to consider when developing a business continuity plan.

The **Sample Business Continuity Plan Template** can be found in the *Community Care Clinics Operational Tools Manual*. The Sample Business Continuity Plan Template contains key elements that will enable an organization to perform its routine day-to-day operations in the event of an unforeseen incident.

What planning activities should community care clinics consider with respect to facility operations recovery?

Facility Operations Recovery Community Care Clinics Volume, Section 5.12.2

C

The recovery phase of an emergency management program for clinics focuses upon returning the clinic to baseline levels of functioning.

- Aspects of the **Recovery Phase** include:
 - Identifying a starting point for recovery
 - Determining the endpoint to recovery
 - Return to readiness
 - Recovery as part of a larger effort
- Activities that recovery planning should address include:
 - Personnel recovery
 - Physical structure recovery
 - Equipment and Supply Cache recovery
 - Financial recovery
 - Business systems recovery
 - Coordination with external systems
 - Organizational learning/systems improvement
 - After Action Reports/Corrective Action Plans
 - Community recovery activities

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Reference



Adapted from: *Emergency Management Principles and Practices for Healthcare Systems*. The Institute for Crisis, Disaster, and Risk Management (ICDRM) at the George Washington University; for the Veteran's Health Administration, United States Department of Veteran's Affairs. Washington, D.C., June 2006. Available at <http://www1.va.gov/emshq/>.

What does a community care clinic need to consider with respect to expanding its workforce during a surge?

Expanding the Workforce **Community Care Clinics Volume, Section 6**

C

Increasing staff during a disaster will be one of the greatest challenges that a clinic must address. Planning considerations include:

- During a healthcare surge, a clinic's first option to address staffing demands is to depend on existing staff (e.g., increasing the number of hours per work shift, calling back staff that have been on medical leave).
- When clinics have maximized the productivity of their existing staff the next option would be to call upon external sources for temporary staff, as they normally would when there is a staff shortage.
- Clinics may opt to collaborate with neighboring clinics to acquire staff through the development of Memoranda of Understanding or Memoranda of Agreement.
- Once these sources are exhausted, additional staffing resources will be requested through the SEMS/NIMS structure.
- In developing their emergency plans, it is recommended that clinics consider the following:
 - Staffing plans should encompass both clinical roles such as registered nurses and how they may be assigned to different duties based on designated patient care levels, and non-clinical staff.
 - Matrices should be developed to assist staffing supervisors in identifying staff who possess specific skills or could rapidly acquire them.

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Community Care Clinics

What does a community care clinic need to consider with respect to expanding its workforce during a surge?

Expanding the Workforce (continued) Community Care Clinics Volume, Section 6

C

- Although the acquisition process for varying types of personnel may differ depending on the volunteer organization used, the **acceptance and deployment process** would be consistent.
- At any point in the healthcare surge when a Unified Command structure is activated, resources will be prioritized and allocated through that structure rather than through any pre-established Memoranda of Agreement.
- Staffing resources that can be accessed through **SEMS/NIMS** include regional, state, and federal assets such as Medical Reserve Corps, Community Emergency Response Teams, Disaster Medical Assistance Teams/ California Medical Assistance Teams, Ambulance Strike Teams, and Mission Support Teams.
- Once a staff member has been assigned a role during a healthcare surge, a process must be established to track that person providing services in the clinics.

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Reference



Emergency Management Principles and Practices for Healthcare Systems. The Institute for Crisis, Disaster, and Risk Management (ICDRM) at the George Washington University (GWU); for the Veterans Health Administration (VHA)/US Department of Veterans Affairs (VA). Washington, D.C., June 2006. Available at <http://www1.va.gov/emshq/>.

Tools



The **Acceptance and Assignment of Augmented Staff During Healthcare Surge Flow Chart** can be found in the *Community Care Clinics Operational Tools Manual*. The Acceptance and Assignment of Augmented Staff during Healthcare Surge Flow Chart is designed to assist planners and staffing coordinators at existing facilities in understanding the process by which augmented staff are accepted and deployed.

The **Staffing Component Considerations for Development of Mutual Aid/Mutual Assistance Memoranda of Understanding** can be found in the *Community Care Clinics Operational Tools Manual*. The Staffing Component Considerations for Development of Mutual Aid/Mutual Assistance Memoranda of Understanding specifies areas to consider when drafting the staffing or personnel components of Memoranda of Understanding.

The **List of Potential Staffing Sources during Healthcare** can be found in the *Community Care Clinics Operational Tools Manual*. The List of Potential Staffing Sources during Healthcare Surge provides healthcare surge planners and other appropriate facility representatives with a list of organizations that could be considered as potential sources for augmented staff.

What guidance exists around scope of practice and liability protections during health care surge?

Scope of Practice and Liability Protections Community Care Clinics Volume, Sections 7.1

C

During a healthcare surge, when the demand for patient care is greater than the supply of providers needed to deliver healthcare, it may become necessary to allow healthcare professionals to practice outside of their licensed scope of practice in order to fulfill the overarching mission of ensuring the best population outcome or “the greatest good for the greatest number” of people.

- The following **California Healing Boards** have provided guidance on current statutory flexibility in scope of practices and liability protections:

<ul style="list-style-type: none"> • Licensed Vocational Nurses • Pharmacy • Physician Assistant • Dentists 	<ul style="list-style-type: none"> • Podiatric Medicine • Respiratory Care • Nursing Practitioners • Medical Assistance
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- The **Emergency Services Act** authorizes the Governor to make, amend, and rescind orders and regulations necessary to carry out the provisions of the Emergency Services Act.
- **Standby orders** are directions issued by the Governor that make, amend, or rescind certain state laws that prescribe the conduct of state business that may in any way prevent, hinder, or delay the mitigation of the effects of the emergency. Standby orders can address the likely need for increasing the number of paid healthcare professionals during a state of emergency.

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Reference



- California Business Professions Code Section 2860.5 outlines the normal scope of practice for licensed vocational nurses.
- California Business Professions Code Sections 4052.1 – 4052.5 outlines the normal scope of practice for pharmacists.
- California Business Professions Code Section 3502 outlines the normal scope of practice for physician assistants.
- California Business Professions Code Section 2472 outlines the normal scope of practice for doctors of podiatric medicine.
- California Business Professions Codes Sections 3702 and 3702.7 outline the normal scope of practice for a professionals licensed by the Respiratory Care Board of California.
- California Business Professions Codes Sections 2725, 2836.1, 2836.2, and 2837 outlines the normal scope of practice for a Nurse Practitioners licensed by the Board of Registered Nursing.
- California Business Professions Codes Sections 1625, 1646, and 1647 outline the normal scope of practice for Dentists, including use of general anesthesia and conscious sedation.
- As per the California Medical Board, Medical Assistants are not licensed, certified, or registered by the State of California. California Business Professions Codes Sections 2069 and 2070 outline the normal scope of practice for a medical assistant.

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Tools



The **Skills and Abilities Assessment Tool** can be Found in the *Community Care Clinics Operational Tools Manual*. The Skills and Abilities Assessment Tool is designed to assist staffing coordinators at clinics with planning and allocating personnel resources during a healthcare surge.

DRAFT

Community Care Clinics

What special staffing considerations exist for pharmacists during a healthcare surge?

Special Considerations for Pharmacists: The California State Board of Pharmacy Waiver of Pharmacy Practices Community Care Clinics Volume, Section 7.2

C

In the event of a declared disaster or emergency, the California State Board of Pharmacy expects to use its authority to encourage and permit emergency provision of care to affected patients and areas, including waiver of requirements that may be implausible to meet during surge events.¹

- In the event the pharmacy waiver is activated, the **California State Board of Pharmacy** will communicate this information to the Office of Emergency Services to be widely distributed.
- The Board expects licensed pharmacists to use their judgment and training when providing medication to patients in the best interest of the patients, with circumstances at the time dictating the extent to which regulatory requirements can be met in affected areas.

¹California Emergency Services Act [California Government Code Section 8550-8668] and the California Disaster Assistance Act.

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Reference



- California Emergency Services Act [California Government Code Section 8550-8668] and the California Disaster Assistance Act
- California Business and Professions Code, Section 4062, subdivision (a)

What special staffing considerations exist for pharmacists during a healthcare surge?

Special Considerations for Pharmacists *(continued)* Community Care Clinics Volume, Section 7.2

C

- A **licensed pharmacist** may authorize non-licensed pharmacists/healthcare providers to fill a prescription when:
 - The licensed pharmacist has access to prescription, patient profile, or other relevant medical information for purposes of patient and clinical consultation and advice.
 - Access to the information is secure from unauthorized access and use.
- The California State Board of Pharmacy encourages persons outside of California to assist California residents during declared states of emergency.
- **Furnishing medications without a prescription:** Business and Professions Code Section 4062(a) states that a pharmacist may, in good faith, furnish a dangerous drug or dangerous device in reasonable quantities without a prescription during a federal, state or local emergency to further the health and safety of the public.¹

¹California Business and Professions Code, Section 4062, subdivision (a).

What does a community care clinic need to consider with respect to credential verification during a surge?

Credential Verification Community Care Clinics Volume, Section 7.4

C

In an emergency the Governor has the authority to waive certain requirements that would allow clinics to call upon otherwise unavailable health professionals (e.g., physicians with inactive or retired licenses).

- During a healthcare surge, clinics are required to verify credentials and competency and maintain oversight of healthcare professionals and the care they deliver. If primary source verification cannot be obtained within 72 hours from the health professional presenting to the clinic for service, the clinic must keep records of the reasons for not completing the required verification check.
- The process for increasing the pool of potential staff may be accelerated using the following techniques:
 - Implementing a streamlined credentialing/privileging process.
 - Collecting the minimum amount of information necessary.

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Additional Notes



The Joint Commission Comprehensive Accreditation Manual for Hospitals (2007) defines “credentialing” as the process of obtaining, verifying and assessing the qualifications of a healthcare professional in order to provide patient care services in or for a healthcare organization. “Privileging” is defined as the process whereby a specific scope and content of patient care services (that is, clinical privileges) are authorized for a healthcare professional by a healthcare organization, based on evaluation of the individual’s credentials and performance.

Reference



- State and federal credential requirements can be found in Business and Professions Code Sections 2282, 2283; 22 CCR 70703; and 42 CFR 482.12 and 482.22
- The Joint Commission. Comprehensive Accreditation Manual for Hospitals. Oakbrook Terrace: Joint Commission Resources. 2007

Tools



The **Volunteer Application for Clinical Staff** can be found in the *Community Care Clinics Operational Tools Manual*. The Volunteer Application for Clinical Staff serves as a tool to verify identification of volunteers, capture needed emergency information, and identify skills of volunteer staff.

The **Credentialing Log for Licensed Healthcare Professionals** can be found in the *Community Care Clinics Operational Tools Manual*. The Credentialing Log for Licensed Healthcare Professionals provides clinics with a template to document that health professionals who have been granted temporary disaster privileges have provided the appropriate and required documentation.

Community Care Clinics

What does a community care clinic need to consider with respect to augmenting non-clinical staff during surge?

Augmenting Non-Clinical Staff **Community Care Clinics Volume, Section 8**

C

In addition to clinical staff, the operation of a clinic requires non-clinical staff to carry out functions such as administration, food service, child care, laundry, traffic control, security, engineering, pastoral care, housekeeping, transport services and maintenance.

- In developing its emergency operations plan, clinics should identify which functions can be performed by community-based organizations, volunteer staff, and/or private contractors.
- The clinic may choose to maintain Memoranda of Understanding with local staffing agencies to provide this support. If so, the Memoranda should include a process for verifying the employee's background.
- The *Community Care Clinics Volume* and the *Community Care Clinics Operational Tools Manual* include operational tools to assist clinics in planning for and augmenting non-clinical staff during a healthcare surge

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Reference



State of Wisconsin. "Guidelines for Managing Inpatient and Outpatient Surge Capacity, Recommendations of the State Expert Panel on Inpatient and Outpatient Surge Capacity." November 2005.

Tools



The **Volunteer Application for Non-Clinical Staff** can be found in the *Community Care Clinics Operational Tool Manual*. The Volunteer Application for Non-Clinical Staff serves as a tool to verify identification of volunteers, capture needed emergency information, and identify skills of volunteer staff.

The **Non-Clinical Support Matrix** can be found in the *Community Care Clinics Operational Tool Manual*. The Non-Clinical Support Matrix provides clinics with a template and guidelines for inpatient non-clinical staffing needs for a facility operating in healthcare surge.

What should a community care clinic consider with respect to maintaining the workforce during surge?

**Maintaining the Workforce
Community Care Clinics Volume, Section 9**

C

During a healthcare surge or other emergency, clinics must ensure the health and safety of their workforce. The development of staff support provisions are recommended to maintain the workforce and avoid the need to augment staff. Surge planners should be aware of the following:

Workforce Health and Safety and Workers' Rights

- Occupational safety and health requirements are set forth in federal and California state statutes and regulations, including the federal Occupational Safety and Health Administration regulations and the California Labor Code and Cal/OSHA regulations.
- One of the methods by which a clinic can protect the health and safety of their workforce is in the provision of **personal protective equipment**.
- Another workforce health and safety issue that may arise is the requirement that vaccinations be provided to all employees and volunteers. Clinics will be responsible for providing vaccinations to staff unless such requirements are waived by appropriate authority during a state of disaster.
- Employers not only have an obligation to safeguard the health and safety of their workforce, they also have responsibility to honor employees' rights.
- Occupational Safety and Health Planning
 - Clinics should have a health and safety plan that addresses the following:

<ul style="list-style-type: none"> • Infection control • Life safety • Emergency action plan • Control of hazardous substances 	<ul style="list-style-type: none"> • Fatigue • Heat stress • Provision of sanitary facilities • Personal protective equipment
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Additional Notes



Under Labor Code Section 6401, “every employer shall furnish and use safety devices and safeguards and shall adopt and use practices, means, methods, operations, and processes which are reasonably adequate to render such employment and place of employment safe and healthful.” Additional specific guidance for the provision of personal protective equipment is outlined in 8 CCR 3380.

In some cases, employers may need employees on disability leave to return to work during an emergency, or employees may wish to return to work early to help. 8 CCR 9776.1 addresses the general requirement that a return-to-work release with limitations and/or accommodations should be completed prior to an employee returning to work.

Tools



The **Considerations for Staff Support Provisions** can be found in the *Community Care Clinics Operational Tools Manual*. The Considerations for Staff Support Provisions tool is intended to lay out issues that a clinic should consider for its staffing plans and strategies, and it is designed to serve as a starting point for healthcare surge planners when outlining necessary policies and provisions to support staff during a healthcare surge.

The **Policy for Workforce Resilience during an Emergency** can be found in the *Community Care Clinics Operational Tools Manual*. The Policy for Workforce Resilience during an Emergency offers guidelines for dealing with needs and training to optimize workforce resilience in the event of a disaster. It provides minimum standards for facilities to incorporate into current workforce resiliency policies.

The **Sample Policy for Dependent Care** can be found in the *Community Care Clinics Operational Tools Manual*. The Sample Policy for Dependent Care provides guidance to clinics on the policies and procedures that should be in place in the event it becomes necessary to house staff member’s children and elderly or disabled family members during a

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healthcare surge.

The **Sample Tracking Form for Dependent Care** can be found in the *Community Care Clinics Operational Tools Manual*. The Sample Tracking Form for Dependent Care allows clinics to track the individuals for whom they provide dependent care during a healthcare surge and to monitor the healthcare services provided to individuals while they are under dependent care.

The following additional disaster plan templates can be found in the *Community Care Clinics Operational Tools Manual*: the **Sample Family Emergency Plan**, the **Sample Family Emergency Supply List**, the **Pandemic Flu Planning Checklist for Individuals and Families**, and the **Family Emergency Health Information Sheet**.

Reference



- Labor Code Section 6401
- 8 CCR 3380
- 8 CCR 9776.1
- California Industrial Welfare Commission Order Number 4-2001, 3(B) (9)-(10)

What should a community care clinic consider with respect to maintaining the workforce during surge?

Maintaining the Workforce (continued) Community Care Clinics Volume, Section 9

C

- Support Provisions for Staff
 - it is unlikely that clinic staff will report for duty or remain at work during an emergency if they are concerned about the safety and welfare of their family.
 - Providing staff support and dependent care (i.e., childcare, elder care, and care for family members with disabilities) may enable clinics to maintain the workforce and alleviate the need to augment staff with volunteers and temporary staff.
- Clinic Staff Family Disaster Plan
 - Healthcare facilities should encourage staff to plan with their families for what could happen in a disaster. Planning should include:
 - Discussing the types of disasters and emergencies that are most likely to happen and what to do in each case.
 - Establishing an out-of-town emergency contact.
 - Arranging pet care if necessary.
 - Assembling an emergency supply kit.

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Community Care Clinics

How can community care clinics maximize sustainability during a surge?

Maximizing Sustainability **Community Care Clinics Volume, Section 10.1**

C

Effective planning for facility sustainability will help to mitigate the effects of limited resource availability during a healthcare surge.

- The first step in preparing for a healthcare surge is ensuring the clinic can function independently at surge levels for 72-96 hours.
- Connecting to the Unified Command will be critical as during a healthcare surge the emergency response structure may manage resource allocation so that scarce resources and supplies can be prioritized among all healthcare providers.
- Clinics will then go through this command structure to obtain additional supplies to provide services during a healthcare surge.
- In order to **maximize sustainability**:
 - Clinics should have enough pharmaceuticals, supplies, and equipment at their facility to be self-sufficient to operate at or near full capacity for a minimum of 72 hours, with a goal of 96 hours.
 - Clinics may need to rely on the available market supply (e.g., Memoranda of Understanding, retailers or wholesalers) and state and federal stockpiles for specific resources.
 - Clinics should base their surge plans on specific likely risks (e.g., floods if the clinic is in a flood plain, earthquakes, forest fires) identified in the facility's Hazard Vulnerability Analysis.

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Additional Notes



Once the impact of an emergency is sufficient to involve multiple emergency response disciplines (law enforcement, fire, public health), these responding entities form a Unified Command. An authorized local official or designee will notify community care clinics that the Unified Command has been established and provide contact information. During a healthcare surge, this emergency response structure manages resource allocation so that scarce resources and supplies can be prioritized among all healthcare providers. Connecting to the Unified Command will be critical; clinics can go through this command structure to obtain additional supplies to support the provisions of services during surge conditions.

Reference



Kaiser Daily Health Policy Report, Prescription Drugs: Pandemic Flu Could Cause Breakdown of Drug-Supply Chain (Jan 12, 2006), available at http://www.kaisernetwork.org/Daily_reports/rep_index.cfm?DR_ID=34753.

How can community care clinics acquire pharmaceuticals during a surge?

Acquiring Pharmaceuticals Community Care Clinics Volume, Section 10.2

C

One of the most challenging aspects of acquiring pharmaceuticals is determining which pharmaceuticals are needed and in what quantity.

- The decision as to which pharmaceuticals are needed and the quantity required is dependent on the existing complexity of services offered, volume expectations during a healthcare surge, and the needs of the community.
- The decision to increase existing pharmaceutical inventories to accommodate a healthcare surge should be made in conjunction with clinic leadership with consideration given to the specific risks that the clinic has identified in its Hazard Vulnerability Assessment.
- Strong consideration should be given to involving key members of the clinic staff and suppliers in planning for determining which pharmaceuticals to have available for a healthcare surge.

Off-Label Drug Use

- There is no known statutory or regulatory prohibition against **off-label use of a drug** by a physician. Consequently, pharmacists may dispense pharmaceuticals for off-label purposes without being out of compliance.
- A proclamation of an emergency could include a provision making the standard of care the prevention of the greatest loss of life, which could allow some off-label uses even if not generally accepted by the medical community, but consistent with the goal of saving a life.

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Reference



The Federal Food, Drug and Cosmetic Act, Chapter V, Subchapter E, Section 564, 21 USC Section 360bbb 3, - Authorization for Medical Products for Use in Emergencies.

Tools



The **Inventory-Based Pharmaceuticals by General Classifications List** can be found in the *Community Care Clinics Operational Tools Manual*. The Inventory-Based Pharmaceuticals by General Classifications List, in conjunction with a Hazard Vulnerability Assessment, can assist clinics in determining the specific types and quantities of pharmaceuticals that a clinic should have on hand during a healthcare surge.

Community Care Clinics

What should a community care clinic consider with respect to supplies and equipment during surge?

Supplies and Equipment Community Care Clinics Volume, Section 10.3

C

Supplies and medical equipment will be critical to a clinic's ability to function during an emergency and should be a focus of surge planning.

- Decisions regarding what supplies and equipment to maintain at the clinic are dependent upon the complexity of services offered and volume of patients expected during a healthcare surge.
- Clinics should consider resources used every day that may be needed in larger supplies during a healthcare surge in addition to supplies specifically needed for an all-hazard catastrophic emergency.
- Planning should consider the potential volume of patients that may require hydration for a 72-hour period.
- If requested by the Governor or CDPH, the United States Secretary of Health and Human Services may authorize the introduction of a drug, device, or biological product intended for use in an actual or potential emergency. This authorization allows for an emergency use of a product that is:
 - Not approved, licensed, or cleared for commercial distribution (i.e., an unapproved product) or
 - Is approved, licensed, or cleared under such provision, but the use is not an approved, licensed, or cleared use of the product (i.e., an unapproved use of an approved product).

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Additional Notes



When building a supply and equipment inventory during the planning process, community care clinics should evaluate the supplies and equipment that will be necessary based on the types of responses that might be required and the projected volume of patients. Since it is anticipated that clinics may be required to perform an increased number of procedures or services in response to surge conditions, clinics should consider resources used every day that may be needed in larger supply.

These supplies might include:

- Sutures
- Dressing materials
- Orthopedic splints
- Crutches
- Wheelchairs

During the planning process, clinics should consider supplies necessary for treatment or procedures not performed during normal clinic operations, but which may be essential to a surge response.

Reference



- The 1995 Occupational Safety and Health Administration manual "Best Practices for Hospital Based First Receivers", http://www.osha.gov/dts/osta/bestpractices/html/hospital_firstreceivers.html.
- The 2006 Institute of Medicine report, "Reusability of Facemasks During an Influenza Pandemic: Facing the Flu," http://www.nap.edu/catalog.php?record_id=11637.
- The CDC has developed a model to predict personal protective equipment needs; this model can be found at <http://www.cdc.gov/flu/tools/flusurge/> with supplemental guidance at http://www.cdc.gov/flu/pdf/FluSurge2.0_Manual_060705.pdf.

Community Care Clinics

Tools



The **Detailed Supplies and Equipment List** can be found in the *Community Care Clinics Operational Tools Manual*. The Detailed Supplies and Equipment List provides planners with a guide for ordering specific supplies and equipment. This list should not be considered comprehensive but should be used as a guide when considering the types of supplies and equipment that are needed during a catastrophic emergency.

DRAFT

Community Care Clinics

What should a community care clinic consider with respect to personal protective equipment during surge?

Personal Protective Equipment Community Care Clinics Volume, Section 10.4

C

Employers are required by Cal/OSHA to use personal protective equipment to limit employee exposure to hazards.

- Guidance on Selecting and Acquiring Personal Protective Equipment
 - Clinics should, at a minimum, be prepared for OSHA Level D, but equipment selection should be clinic-specific.
 - Clinics should use a Hazard Vulnerability Analysis to contemplate hazards that may impact a facility and the specific potential hazard to employees (e.g., skin, ingestion, inhalation, mucous membrane contact through the eyes, nose, or mouth).
 - Clinics should consider using equipment similar to that used by local emergency responders in order to standardize personal protective equipment within a community/region for interoperability.
 - Some circumstances may require greater levels of protection. Natural disaster/biological situations are infection control/epidemiological issues, which require universal precautions. Respiratory precautions may also be required depending on the situation.

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Additional Notes



During a healthcare surge community care clinics will primarily operate at OSHA Level D, and the acquisition of personal protective equipment and training should reflect this level. Some clinics may wish to consider planning to operate at OSHA Level C. Levels A through D and associated types of personal protective equipment are described below.

- **Level A:** Greatest level of protection required for skin, eye, and respiratory protection
- **Level B:** Greatest level of respiratory protection but a lesser level of skin protection
- **Level C:** Required when criteria for using air purifying respirators has been met; emphasis on respiratory protection
- **Level D:** A work uniform that provides minimal protection to safeguard against contamination

The 2006 Institute of Medicine report, *Reusability of Facemasks during an Influenza Pandemic: Facing the Flu*, provides recommendations for healthcare workers who must reuse facemasks during an influenza pandemic. The complete guide can be found at http://www.nap.edu/catalog.php?record_id=11637. Key recommendations from this report include:

- N-95/N-100 respirators should be protected from external surface contamination when there is a high risk of exposure to influenza (e.g., by placing a medical mask or cleanable faceshield over the respirator so as to prevent surface contamination but not compromise the device's fit).
- Appropriate hand hygiene should be practiced before and after the removal of the respirator. Appropriately disinfect the object used to shield the respirator whenever possible.
- N-95/N-100 respirators should be used and stored in such a way that the physical integrity and efficacy of the respirator will not be compromised.

What should a community care clinic consider with respect to storage and inventory management during surge?

Storage and Inventory Management of Supplies and Equipment Community Care Clinics Volume, Section 10.5

C

After selecting which supplies and equipment to stockpile, clinics must plan for the storage and inventory management of those supplies and equipment. Planning considerations should include:

- A process to monitor expiration dates, storage dates and for rotating stock from a cache into the general inventory to minimize pharmaceuticals that may expire.
- Ongoing maintenance of stockpiled supplies and equipment to ensure items (e.g., portable monitoring equipment, ventilators, ventilator seals, other items that use batteries) are operable and available during a healthcare surge or other emergency.
- Prioritizing on-site storage space. Storage options include storing supplies and equipment at other facilities within the healthcare system or arranging for warehouse space.

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Tools



The **Pharmaceutical Storage Checklist** can be found in the *Community Care Clinics Operational Tool Manual*. The Pharmaceutical Storage Checklist addresses the issues and processes that clinics are encouraged to consider in storing pharmaceuticals.

The **Supplies and Equipment Storage Checklist** can be found in the *Community Care Clinics Operational Tool Manual*. The Supplies and Equipment Storage Checklist lists considerations for supplies and equipment storage.

Community Care Clinics

What factors should a community care clinic consider when selecting a storage and maintenance vendor?

Use of Vendors and Suppliers for Supply, Pharmaceutical, and Equipment Procurement **Community Care Clinics Volume, Section 10.6**

C

Clinics should work with their vendors to ensure adequate supplies in the event of a healthcare surge. Below is a list of factors a clinic should consider when selecting a vendor to ensure proper storage and maintenance of supplies and equipment:

- “Disaster clauses” within the contract with the vendor to understand what they are responsible for during a healthcare surge situation.
- Process for the rotation of stock and inventory (control management).
- Vendor lead time for critical supplies, pharmaceuticals and equipment.
- Process for material delivery during a healthcare surge.
- Memoranda of Understanding
 - A Memorandum of Understanding with vendors and suppliers may be an effective method of sustaining operations in a clinic if resources are scarce.
 - The benefits of planning for and developing Memoranda of Understanding include an increased level of awareness and understanding of a community’s needs and capabilities, and an environment of trust and collaboration.
- Donations of Supplies and Equipment
 - Potential sources of donations may include corporations and faith-based organizations that may have stockpiles of supplies and equipment.
 - It is recommended that the donations be coordinated at the Operational Area Emergency Operations Center.

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Additional Notes



A Memorandum of Understanding with vendors and suppliers can be an effective method to sustain clinic operations if resources are scarce. Important aspects of a Memorandum of Understanding include:

- The parties involved in the agreement
- Description of shared supplies and equipment
- Scope and applicability of services
- Liability (professional, tort, expenses)
- Definition of terms
- Date the Memorandum of Understanding is effective
- Date the Memorandum of Understanding will be terminated
- Points of contact
- Cost of services, equipment, and staff involved
- If the agreement is subject to any governing body
- Safeguards in case the understanding/agreement collapses

Community Care Clinics

What additional State and federal resources exist for community care clinics?

Acquiring Additional Supplies, Equipment, and Pharmaceuticals through SEMS Community Care Clinics Volume, Section 10.7

C

Even with extensive planning, clinics may require supplies, equipment and pharmaceuticals beyond local availability. Additional resources can be requested through the SEMS/NIMS process.

- The **State has the following resources** that can be distributed during a healthcare surge based on event specific priorities through SEMS/NIMS:
 - **N-95 respirators:** CDPH purchased 50.9 million N-95 respirators for use by and protection of healthcare workers at healthcare facilities and government-authorized Alternate Care Sites.
 - **Ventilators:** CDPH has 2400 ventilators maintained for deployment.
- Through **state and federal partnerships**, the following resources can also be made available during a healthcare surge:
 - **Antivirals:** Through a federal cost-sharing program, CDPH maintains a total of 3.7 million courses of antivirals, comprised on 90% Tamiflu and 10% Relenza. The federal government maintains an additional 5.3 million courses for California. The federal cache is comprised of 80% Tamiflu and 20% Relenza. Together these courses provide 9 million courses for treatment of approximately 25% of California's population.
 - **Strategic National Stockpile:** The federal Strategic National Stockpile contains large quantities of pharmaceuticals and medical supplies to protect the American public if there is a public health emergency severe enough to cause local supplies to run out. These caches are available to CDPH upon request and would be delivered by the state to sites pre-identified by local health departments.

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Guidance



See *Foundational Knowledge* Section 3.9, "Standardized Emergency Management System" for additional information on SEMS/NIMS.



Community Care Clinics

What staging considerations should community care clinics consider when planning for surge?

Staging Considerations Community Care Clinics Volume, Section 10.8

C

Many community care clinics have limited storage capacity, so emergency supplies are often stored in the least convenient available space, including offsite storage facilities. During a healthcare surge, this storage plan could result in delays in care as clinics try to retrieve their supplies from various storage locations. Staging considerations should include the following:

- Clinics may wish to consider identifying a small storage area near their designated disaster triage and treatment site. This area can be used for the “first push” of the supplies likely needed in the first moments of a crisis.
- If space allows, the “first push” supplies may be packaged in a cart or trailer to make deployment more rapid. Consideration should be given to the path of travel between the storage site and the destination so that the chosen cart or trailer will successfully clear all obstacles
- A detailed inventory should accompany the first push of supplies, indicating “what” and “how many” of each item is immediately available, and where additional supplies are located so that they can be acquired by staff who may not be knowledgeable of how the supplies are organized and stored.¹
- As the catastrophic emergency evolves, and additional supplies are needed, the more remote storage areas can be tapped to replenish or supplement the first push of supplies. Plans to retrieve the additional supplies should be activated as their first set is deployed.

¹James Lenthall, Director, Safety/Security & Emergency Management, Saddleback Memorial Medical Centers.

Tools



The **Staging Recommendations Checklist** can be found in the *Community Care Clinics Operational Tools Manual*. The Staging Recommendations Checklist summarizes steps that clinics should take when planning for staging their resources.

Community Care Clinics

What methods of patient tracking can community care clinics use during healthcare surge?

Patient Tracking Community Care Clinics Volume, Section 11.1

C

Although electronic tracking systems are preferred, in cases where electronic systems are unavailable, paper-based tracking is a viable alternative. A variety of operational tools for paper-based patient tracking are provided in the *Community Care Clinics Volume* and the *Community Care Clinics Operational Tools Manual*.

- Recommendations in this section are based on the following major concepts:
 - **Collect minimum necessary data.** Given that an unanticipated disaster may severely limit the capability of the healthcare system to obtain and transfer information, a manual tracking system should be simple to use and focus on collecting minimum data elements.
 - **Patient tracking is a priority.** Tracking persons seeking treatment at healthcare system entry points (e.g. clinics, alternate care sites, and the emergency medical system) during a healthcare surge is a higher priority than tracking all persons within an affected area.
 - **Paper-based tracking is an essential contingency.** Although significant efforts are under way to develop robust electronic patient tracking systems for disaster and emergency purposes, manual back-up processes should be maintained in case of system failures. Paper-based processes reduce compatibility issues when sharing data and total cost associated with purchasing new technology.

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Tools



The **Patient Tracking Form** can be found in the *Community Care Clinics Operational Tools Manual*. Patient tracking forms can be used to track individuals seeking medical attention within a facility and the disposition of those transferred to other facilities during a healthcare surge.

The **Paper-Based Intra-Clinic Tracking Process** can be found in the *Community Care Clinics Operational Tools Manual*. The Paper-Based Intra-Clinic Tracking Process is an example of the type of process that could be instituted at a clinic for the purpose of tracking patients as they move through a facility when electronic systems are unavailable.

What downtime procedures can community care clinics use for registration and medical records during healthcare surge?

Downtime Procedures for Registration and Medical Record Numbers **Community Care Clinics Volume, Section 11.2**

C

During an emergency, computerized systems for completing registration and obtaining medical records numbers within clinics may be unavailable. Paper-based procedures may be required to maintain these administrative functions that are critical to business continuity and sustaining operations during a healthcare surge.

- **Registration Down-Time Procedures**
 - Back-up procedures may be required to maintain administrative functions that are critical to business continuity and sustaining operations during a healthcare surge.
 - Registration staff will manually complete pre-numbered (if available) face sheets which will provide a source of information by which the backlog of manual admissions and registrations can be entered retroactively into the computer once the system becomes available.
- **Minimum Requirements for Medical Record Documentation**
 - It may be reasonable to expect that most healthcare resources will be devoted to patient care and administrative functions will need to be reduced to minimum requirements under healthcare surge conditions.
 - A short form medical record should be utilized to capture pertinent assessment, diagnosis and treatment information.

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Tools



The **Sample Registration Log** can be found in the *Community Care Clinics Operational Tools Manual*. The Sample Registration Log can be used by clinics to prepare for times during a healthcare surge when computerized systems are unavailable.

The **Sample Paper-Based Face Sheet** can be found in the *Community Care Clinics Operational Tools Manual*. The Sample Paper-Based Face Sheet can be used by clinics to prepare for times during a healthcare surge when computerized systems are unavailable.

The **Short Form Medical Record** can be found in the *Community Care Clinics Operational Tools Manual*. The sample Short-Form Medical Record is an example of the type of patient medical record that could be implemented during a healthcare surge when electronic systems for documenting the provision of care are unavailable.

What reporting categories remain in effect during a surge?

Clinic Reporting Requirements **Community Care Clinics Volume, Section 11.2.3**

C

During a declared healthcare surge, it may be difficult for clinics to adhere to reporting requirements.

- It is recommended that the following reporting categories remain in effect for purposes of managing resources and mitigating the adverse health effects on the population:
 - **Disease Reporting/Notification**
 - **Birth and Death Reporting**
 - **Reporting Transfers of Patients**
 - **Inventories of Medical Supplies**
- For all remaining reporting requirements, a waiver of sanctions, penalties and/or time requirements during the declared healthcare surge period may be appropriate or become necessary.

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Community Care Clinics

To what degree will HIPAA regulations apply to community care clinics during healthcare surge?

Health Insurance Portability and Accountability Act of 1996 (HIPAA) Compliance during Healthcare Surge Community Care Clinics Volume, Section 11.3

C

The federal **Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule** protects individually identifiable health information held by "covered entities" which include health plans, healthcare clearinghouses, and healthcare providers who transmit any health information in electronic form in connection with a transaction as defined under the act.

- Emergency planners may need to share patient information in a catastrophic event to provide urgent care to an increased number of patients.
- HIPAA rules are not intended to prevent the delivery of healthcare during an emergency and as such the federal Department of Health and Human Services has indicated they will not be imposing HIPAA compliance fines on providers during a healthcare surge.
- Additionally, 45 CFR 164.510(b)(4) indicates that "a covered entity may use or disclose protected health information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating with such entities the uses or disclosures permitted by 45 CFR 164.510 (b)(1)(ii). [These are the uses or disclosures permitted to notify or assist in the notification of a family member or personal representative.]

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Reference



The federal Department of Health and Human Services issued additional guidelines on HIPAA emergency provisions. This guidance can be found at

<http://www.hhs.gov/ocr/privacy/hipaa/understanding/special/emergency/katrinahipaa.pdf>.

- Per 45 CFR 164.510(b)(4)
- 45 CFR 164.510 (b)(1)(ii)
- 45 CFR 164.510 (b)(2) and (3)

Tools



The **Decision-Making Tool for Disclosure of Protected Health Information (PHI)** can be found in the *Community Care Clinics Operational Tools Manual*. The Decision-Making Tool for Disclosure of Protected Health Information (PHI) was created by the US Office for Civil Rights to help answer the following central question for covered entities: "May I disclose protected health information for public health emergency preparedness purposes?"

How can community care clinics track patient valuables during a healthcare surge?

Patient Valuables Tracking **Community Care Clinics Volume, Section 11.4**

C

Clinics may establish a uniform and secure procedure for the collection, storage, safeguarding and release of patient valuables.

- During the admitting process, a designated staff member should advise the patient that valuables such as jewelry, credit cards and cash (more than \$20) will not be properly secured in the clinic.
- Patients should be strongly encouraged to arrange with family members or others to secure their valuables.
- A **patient-valuables control log** should be used to document, track, and audit valuables deposited or removed from the patient-valuables secured locations.

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Tools



The **Patient Valuables Control Log** can be found in the *Community Care Clinics Operational Tools Manual*. The Patient Valuables Control Log can be used to document, track, and audit valuables deposited or removed from secured locations.

What additional funding sources should community care clinics consider?

Other Funding and Reimbursement Considerations **Community Care Clinics Volume, Section 12.1.6**

C

To manage continuation of clinic services in the geographic areas of California affected by the state of emergency and healthcare surge, clinics should consider alternative funding sources during the planning processes.

- Additional funding sources include:
 - Federally Qualified Health Center (FQHC)
 - Federally Qualified Health Center Look-Alike
 - Breast and Cervical Cancer Control program
 - Expanded Access to Primary Care (EAPC)
 - Children Health and Disability Prevention Program (CHDP)
 - Ryan White CARE
 - California Endowment
 - California Healthcare Foundation
 - Sierra Health Foundation
 - The California Wellness Foundation
 - Rural Health Outreach Grant Program
 - Rural Health Services and Development

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How can community care clinics work with payers and other funding sources to maintain existing revenue streams during a surge?

Clinic Planning Considerations for Changes in Reimbursement during a Healthcare Surge Community Care Clinics Volume, Section 12.2

C

Maintaining existing revenue streams will be critical to clinics during a healthcare surge.

- A clinic's preparation should include advanced planning and collaboration with public payers and commercial health plan partners, developing detailed knowledge of the resources that are available to clinics during surge conditions, and understanding the methods to access additional financial resources from federal and state-funded programs.
- When working with health plan partners, clinics will want to reach agreement on revised contract language which focuses on streamlined reimbursement, simplified policies and procedures, and increased access and coverage for patients during a healthcare surge.
- Public payers can play a significant role during a healthcare surge through the issuance of waivers, which focus on streamlining reimbursement, reducing administrative complexities, and removing barriers to accessing patient care. Clinics that serve Medicare or Medi-Cal beneficiaries should be aware of the administrative and financial implications of these waivers and any applicable steps that need to be taken by clinics to fully benefit from these waivers and declarations.
- During the surge planning process, clinics should carefully consider various funding sources that will be relied upon for reimbursement during surge conditions.
- While each funding source has specific sets of requirements for eligibility and payment, these requirements may be relaxed or waived during surge conditions.

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Additional Notes



Two applicable waivers exist: **Section 1135 waivers** which impact programs managed by the Centers for Medicare and Medicaid Services and **Section 1115 demonstration waivers** which impact the Medi-Cal program.

These key waivers may be issued by the Secretary of Health and Human Services in response to a healthcare surge impacting the reimbursement process for clinics. While clinics benefit from the flexed rules and requirements that these waivers would afford, they have little influence over their issuance. Clinics should note that Section 1135 offers the greatest financial impact with the least amount of effort and time, while 1115 Demonstration Waivers are more cumbersome with less likelihood of significant and timely impact.

The **Section 1135 waiver** is designed to address the existing rules and requirements that may limit access to healthcare and impose financial barriers for providers during a healthcare surge. Under 42 U.S.C. Section 1320b-5 (Section 1135 of the Social Security Act), the Secretary of Health and Human Services has the authority to waive certain requirements of United States Centers for Medicare and Medicaid Services programs in an emergency area during an emergency period.

In addition to the Section 1135 waivers addressing Medicare, Medicaid, and the State Children's Health Insurance Program, **Section 1115 demonstration** waivers provide another mechanism to modify rules and requirements related to the California Medi-Cal program. Section 1115 waiver programs "serve as a precedent for federal and state officials who wish to make temporary changes to the Medicaid program in response to the unique circumstances resulting from catastrophic emergencies such as the devastation of Hurricane Katrina."

How can community care clinics work with payers and other funding sources to maintain existing revenue streams during a surge?

Clinic Planning Considerations for Changes in Reimbursement during a Healthcare Surge (*continued*) **Community Care Clinics Volume, Section 12.2**

C

Below are specific steps clinics may want to consider when working with their health plan partners to prepare for a healthcare surge. These suggested guidelines are applicable to commercial, Medicare Advantage, Medi-Cal Managed Care and Workers' Compensation products.

- **Reimbursement**
 - When appropriate, consider negotiating contract language to obtain an automatic increase in capitation during a surge.
 - Consider negotiating lump sum advance payments to facilitate and maintain cash flow.
- **Policies and Procedures**
 - Modify timely filing provisions to accommodate late or delayed claims, which may be due to lack of correct benefit and eligibility information.
 - Create new or modify existing contracts to include disaster provisions that address rights and obligations outside the typical force majeure clauses.
 - Create policies to expedite cash flow from payers during a declared healthcare surge.
 - Consider defining minimum required data elements for reimbursement purposes during a healthcare surge and incorporate these elements into health plan contracts.
 - Consider developing contract provisions to include third-party vendors who may assist facility with billing during an extended healthcare surge.
- **Access and Coverage**
 - For closed network models, revise pre-authorization and referral requirements to allow access to care when needed and where available.

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What issues do community care clinics need to consider with respect to workers' compensation during a healthcare surge?

Workers' Compensation for Clinic Staff Community Care Clinics Volume, Section 12.2.4

C

Workers' compensation covers injuries or illnesses that occur due to employment. Because clinic employees may be injured at work during a catastrophic emergency, workers' compensation is an important mechanism with which community care clinics should be familiar.

- While workers' compensation covers various types of catastrophic emergencies, injuries and illnesses including single events or injuries caused by repeated exposure, it does not cover first aid.
- Labor Code Section 5402 requires an employer to authorize medical care within one day of receipt of a claim form and to reimburse for all medical treatment in accordance with the American College of Occupational and Environmental Medicine's guidelines or utilization schedules adopted by the Division of Workers' Compensation administrative director.
- During a healthcare surge, medical provider networks and utilization schedules may pose challenges if the medical networks are unavailable or affected by the event.
- To facilitate prompt payment to providers, workers' compensation medical network requirements may need flexing during a healthcare surge.

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Additional Notes



While workers' compensation covers various types of catastrophic emergencies, injuries, and illnesses, including single events or injuries caused by repeated exposure, it does not cover first aid, which is defined in the California Labor Code 5401 as "any one-time treatment, and any follow-up visit for the purpose of observation of minor scratches, cuts, burns and splinters, or other minor industrial injury, which do not ordinarily require medical care. This one-time treatment, and follow-up visit for the purpose of observation, is considered first aid even though provided by a physician or registered professional personnel."

Reference



- Labor Code Section 5401
- Labor Code Section 5402
- Division of Workers' Compensation Forms can be found at <http://www.dir.ca.gov/dwc/forms.html>

For additional information on how to file a workers' compensation claim, how to request a qualified medical evaluation and other information, refer to the State of California Division of Workers' Compensation website at <http://www.dir.ca.gov/dwc/>.

Tools



The **Workers' Compensation Process Flow** can be found in the *Community Care Clinics Operational Tools Manual*. The Workers' Compensation Process Flow depicts how Workers' Compensation Insurance may play a role during a healthcare surge for general employees and Disaster Service Workers.

What information should community care clinics collect for charge capture, billing, and coding purposes during a healthcare surge?

Administrative and Procedural Guidelines: General Planning Considerations **Community Care Clinics Volume, Section 12.3**

C

Coordination and planning between clinics and payers may include modifying specific contract provisions related to administrative requirements, the selection of third-party vendors who may assist with billing on behalf of an existing facility during an extended healthcare surge, or the development of new policies to expedite cash flow during a declared surge.

- Minimum Required Data Elements and Templates for Charge Capture
 - During a healthcare surge, electronic systems regularly used for charge capture within existing facilities may be unavailable. As a result, paper-based processes for capturing charges may be the only method available.
 - The following recommended minimum data elements required for charge capture during a healthcare surge should be recorded:
 - Patient name
 - Medical record number
 - Date of service
 - Capture units/dose/quantity
 - Department services provided in
 - Service description
 - Disaster incident number
 - Work related injury Y/N

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What information should community care clinics collect for charge capture, billing, and coding purposes during a healthcare surge?

Administrative and Procedural Guidelines: General Planning Considerations *(continued)* Community Care Clinics Volume, Section 12.3

C

Billing processes may pose a challenge for clinics during a healthcare surge.

- **Minimum Required Data Elements for Billing**
 - Whenever possible, clinics should follow normal billing processes and submit complete data.
 - However, in the event that systems are impaired and/or staff are unavailable at provider sites, the use of minimum billing elements may become necessary.
 - In a healthcare surge, clinics may be unable to collect and transmit standard billing data and reducing required data elements may become necessary to facilitate payment. As such, it is recommended that clinics work with their health plan or program representatives directly to discuss minimum data elements for registration and billing in the event of a healthcare surge.
- **Additional Billing and Coding Guidance**
 - According to the Centers for Medicare and Medicaid Services' website, "The Administrative Simplification Compliance Act prohibits payment of services or supplies that a provider did not bill to Medicare electronically."
 - The Administrative Simplification Compliance Act Waiver Application allows for flexibility in this rule .

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Additional Notes



The following lists were derived from existing Uniform Billing Form 04 (UB-04, also known as federal Centers for Medicare and Medicaid Services Form 1450) and Centers for Medicare and Medicaid Services (CMS) Form 1500. Under normal conditions, the UB-04 form is used by institutional providers (e.g., community care clinics, skilled nursing facilities, hospices) to submit Medicare paper claims and the CMS 1500 form is used by licensed healthcare professionals (e.g., physicians) to submit Medicare paper claims. It is recommended that providers consider working with their payer partners on a similar list.

Institutional Providers - Unified Billing 04 Data Elements

- Subscriber identification/policy number
 - Time in, time out
 - Work related injury Y/N
- 1: Provider name, address, phone number
- 4: Type of bill
- 8b: Patient name
- 42: Revenue codes
- 43: Revenue description
- 44: Healthcare Common Procedure Coding System rates/codes
- 46: Units of service
- 47: Total charges
- 50: Payer

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56: National Provider Identifier

58: Insured's name

67: Principal diagnosis code

69: Admitting diagnosis

74: Principal procedure code

76: Attending

77: Operating

Noninstitutional Providers - Centers for Medicare and Medicaid Services 1500 Data Elements

- Subscriber identification/policy number

- Time in, time out

- Work related injury Y/N

1: Select which payer: Medicare / Medicaid / Champus Champva / Group Health Plan/ Federal Employees Compensation Act Black Lung / Other

1a: Insured's identification number

2: Patient name

3: Patient's birth date

5: Patient's address

21: Diagnosis or nature of illness or injury

24 A-G: Date of service, place of service, type of service, procedures/services/supplies, diagnosis code, \$ charges, days or units

24K: Condition code

25: Federal tax identification number

27: Accept assignment? (yes/no)

28: Total charge

33: Physician's/supplier's billing name, address, zip code, and phone number

What information should community care clinics collect for charge capture, billing, and coding purposes during a healthcare surge?

Administrative and Procedural Guidelines: General Planning Considerations (*continued*) Community Care Clinics Volume, Section 12.3

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- National Modifier and Condition Code To Be Used To Identify Disaster Related Claims
 - The new modifier is CR (Catastrophe/Disaster Related) and the new condition code is DR (Disaster Related).
 - Clinics can report either the modifier or condition code when submitting disaster related claims. The condition code would identify claims that are or may be impacted by specific payer policies related to a national or regional disaster, while the modifier would indicate a specific Part B service that may be impacted by policy related to the disaster.”¹
- ICD-9-CM Coding for External Causes of Injury
 - External Cause codes may be assigned to identify the cause of an injury(ies) incurred as a result of the disaster.
 - The use of E codes is limited to injuries, adverse effects, and poisonings.
 - Catastrophic emergencies, such as natural disasters, take priority over all other E codes except child and adult abuse and terrorism and should be sequenced before other E codes.
- Advancing and Expediting Payment
 - Clinics in need of expedited or advanced payment options will likely need to contact their health plan or program representative directly to discuss advancing and expediting payments and establish Memoranda of Understanding and protocols in advance or at the time funds are needed.

¹<http://www.nubc.org/R1810TN.pdf>

Reference



Additional information on the new modifier and condition codes can be found at:
<http://www.nubc.org/R1810TN.pdf>.

Tools



The **Advancing and Expediting Payment** table can also be found in the *Community Care Clinics Operational Tools Manual*. The Advancing and Expediting Payment Table outlines the possible opportunities for clinics to advance and expedite payment from a range of payers.

Community Care Clinics

What other funding considerations exist for community care clinics?

Other Funding Considerations for Providers Community Care Clinics Volume, Section 12.4

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- Patient Transfer and Coverage Rules During a Healthcare Surge
 - During a healthcare surge, public health issues or specific medical needs may require transfer of patients between healthcare facilities.
 - The Operational Tools Manual contains an outline of commercial health plans and public payers' coverage rules and requirements for reimbursement related to patient transfers during a healthcare surge.

¹Centers for Medicare and Medicaid Services, "Fact Sheet - Payment for Graduate Medical Education (GME) in the Wake of a National Disaster or Public Health Emergency," http://www.cms.hhs.gov/AcuteInpatientPPS/Downloads/Katrina_Fact_Sheet.pdf

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The **Patient Transfer Table** can be found in the *Community Care Clinics Operational Tools Manual*. The Patient Transfer Table outlines commercial health plans and public payers' coverage rules and requirements for reimbursement related to patient transfers during a healthcare surge.

Community Care Clinics

What other funding sources are available to community care clinics?

Other Available Funding Sources Community Care Clinics Volume, Section 12.5

C

- Federal Emergency Management Agency (FEMA) Public Assistance
 - The Federal Emergency Management Agency (FEMA) Public Assistance Grant Program provides supplemental federal disaster grant assistance to help State and local governments and certain private non-profit organizations recover after a disaster.
 - FEMA does not compensate for disaster-related stabilization and care administered in a private, for-profit healthcare setting.
 - To be eligible for rebuilding assistance, the repair and recovery work to be done must be a direct result of the disaster, be located within the designated disaster area, and be the legal responsibility of an eligible applicant.
 - FEMA compensates medical costs only when a disaster victim has made a point-of-service contact with the provider for stabilization of injuries as a direct result of the disaster or an illness that presents in a designated disaster area during the declared emergency time period.

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The **Federal Emergency Management Agency (FEMA) Public Assistance Process and Checklist** can be found in the *Community Care Clinics Operational Tools Manual*. To assist clinics with FEMA's application process, the Federal Emergency Management Agency (FEMA) Public Assistance Process and Checklist outlines the key steps that need to be taken by stakeholders during the application process.

Community Care Clinics

What other funding sources are available to community care clinics?

Other Available Funding Sources (continued) Community Care Clinics Volume, Section 12.5

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- Recommendations to Facilitate Payment
 - Document all services provided to patients as clearly and thoroughly as possible.
 - Develop Mutual Aid Agreements with neighboring healthcare facilities and/or local government entities.
 - Review Federal Emergency Management Agency (FEMA) funding policies and procedures to become educated on the available resources and mechanisms that can be deployed for healthcare surge pre-planning, preparation and response.
 - Review the Public Assistance Policy Digest - Federal Emergency Management Agency Report 321 and Applicant Handbook - Federal Emergency Management Agency Report 323.
- United States Small Business Administration Disaster Loan Assistance
 - Any business or nonprofit organization, regardless of size, that is located in a declared disaster area can apply for Small Business Administration disaster assistance.
 - Applications are available online at <http://www.sba.gov/services/disasterassistance/>, by calling the Small Business Administration, or at any Disaster Recovery Center or Business Recovery Center in the disaster impacted area.

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Additional Notes



Any business or nonprofit organization, regardless of size, that is located in a declared disaster area can apply for United States Small Business Administration (SBA) disaster assistance. The agency has two types of loans: 1) **physical disaster loans** and 2) **economic injury disaster loans**. Physical disaster loans cover all types of physical loss, including uninsured or underinsured damage to structures, equipment, and inventory. Economic injury disaster loans typically cover unmet financial obligations and are only available to small businesses (small business size standards vary according to North American Industry Classification System code and are available at <http://www.sba.gov/contractingopportunities/officials/size/index.html>). The SBA may loan a maximum of \$1.5 million to businesses with rates starting as low as 4% at terms of up to 30 years. If a clinic qualifies as a major source of employment in a disaster struck zone, the SBA can waive this statutory lending limit.

What additional California authority can be exercised during a healthcare surge?

California Authority Governing Commercial Health Plans during a Healthcare Surge and the Impact on Clinics Community Care Clinics Volume, Section 12.6

C

During the normal course of business, laws and rules prescribe what services health plans must make available to their members. Many of these laws and rules impact clinics. During a healthcare surge, additional authority may become necessary to address the needs of health plans, their members, and the community.

- The additional California authority that can be exercised during a healthcare surge includes Government Code Sections 8550 and 8567 which permit the Governor to issue orders and regulations necessary to carry out the provisions of the Emergency Services Act in order to protect the health and safety and preserve the lives and property of the people of the state.
- Under this authority, the Governor could address private payer administrative rules and requirements that may pose a barrier to financial viability and stability of the healthcare system, including community care clinics, and ultimately impact access to care.
- Within California, there are two agencies that regulate private health plans, the **California Department of Insurance** and the **California Department of Managed Health Care**.
- A review of the Insurance Code indicates no authority for the Commissioner of Insurance to suspend statutes during an emergency. Action by the Governor would be required to mandate payer action.

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What additional California authority can be exercised during a healthcare surge?

California Authority Governing Commercial Health Plans during a Healthcare Surge and the Impact on Clinics (continued) Community Care Clinics Volume, Section 12.6

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- The Department of Managed Health Care's Role in a Healthcare Surge
 - The Department of Managed Health Care licenses and regulates California health maintenance organizations (HMOs), preferred provider organizations (PPOs) and discount plans governed under the Health and Safety Code and 28 CCR.
 - While general powers of the Department may be exercised to address a large excess of demand over supply of healthcare services in a healthcare surge, additional authority may be necessary or appropriate to mitigate the effects of natural, man made, or war-caused emergencies greatly impacting the healthcare delivery system operated by healthcare service plans.
 - Depending upon the nature, breadth, and severity of the state of emergency, certain powers may have to be ordered or delegated by the Governor.
 - Additionally, the Governor could grant a limited transfer of authority to the Director of the Department of Managed Health Care to issue emergency rules and orders applying to healthcare service plans licensed by the Department of Managed Health Care.
 - This limited transfer of authority would authorize the Director to suspend certain statutes, regulations and healthcare service plan contract provisions and take other actions in order to facilitate mitigation of the emergency and healthcare surge, as indicated by the severity of the emergency.

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Wrap Up

Community Care Clinics Wrap Up

C

Now that you have completed this training course, you should:

- Understand the potential roles of community care clinics in a healthcare surge
- Understand the responsibilities of community care clinics to their patients, staff, and communities
- Be able to articulate the ethical and behavioral principles and practice guidelines required during surge planning and a healthcare surge event
- Be familiar with existing waivers and provisions to regulations as they pertain to a health emergency situation, and be able to locate those provisions
- Be able to locate and utilize regulatory information and other resources for planning and implementing a response to a healthcare surge

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