

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

Community Care Clinics Training Presentation

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Community Care Clinics Training Overview

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.

Community Care Clinics Training Overview and Learning Objectives



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

California's Healthcare System Response to a Healthcare Surge



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 |
|---|---|

- 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/>

Key Healthcare Surge Planning Concepts for California

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.

Key Healthcare Surge Planning Concepts for California (continued)

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.

Overview of Community Care Clinics Volume

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.

Overview of Community Care Clinics Volume (*continued*)

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.



Transitioning From Individual Care to Population-Based Care

Community Care Clinics Volume, Section 2.1

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.

Standard of Care Defined

Community Care Clinics Volume, Section 2.2

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.



National Incident Management System Implementation

Activities focused on Community Care Clinics

Community Care Clinics Volume, Section 3.1

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 |
|--|--|

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

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

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.

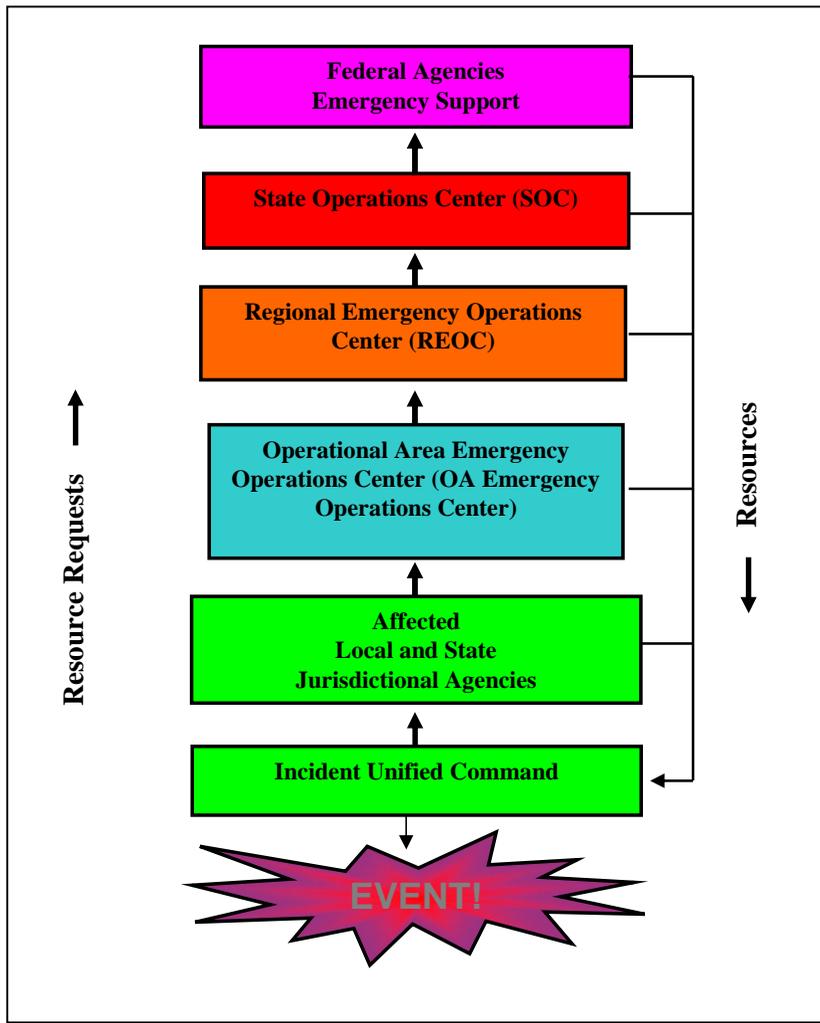
²Government Code Section 8607(e).

³Government Code Section 8605.

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

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

- 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.



How Community Care Clinics Connect to the Emergency Response Structure

Community Care Clinics Volume, Section 3.3

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

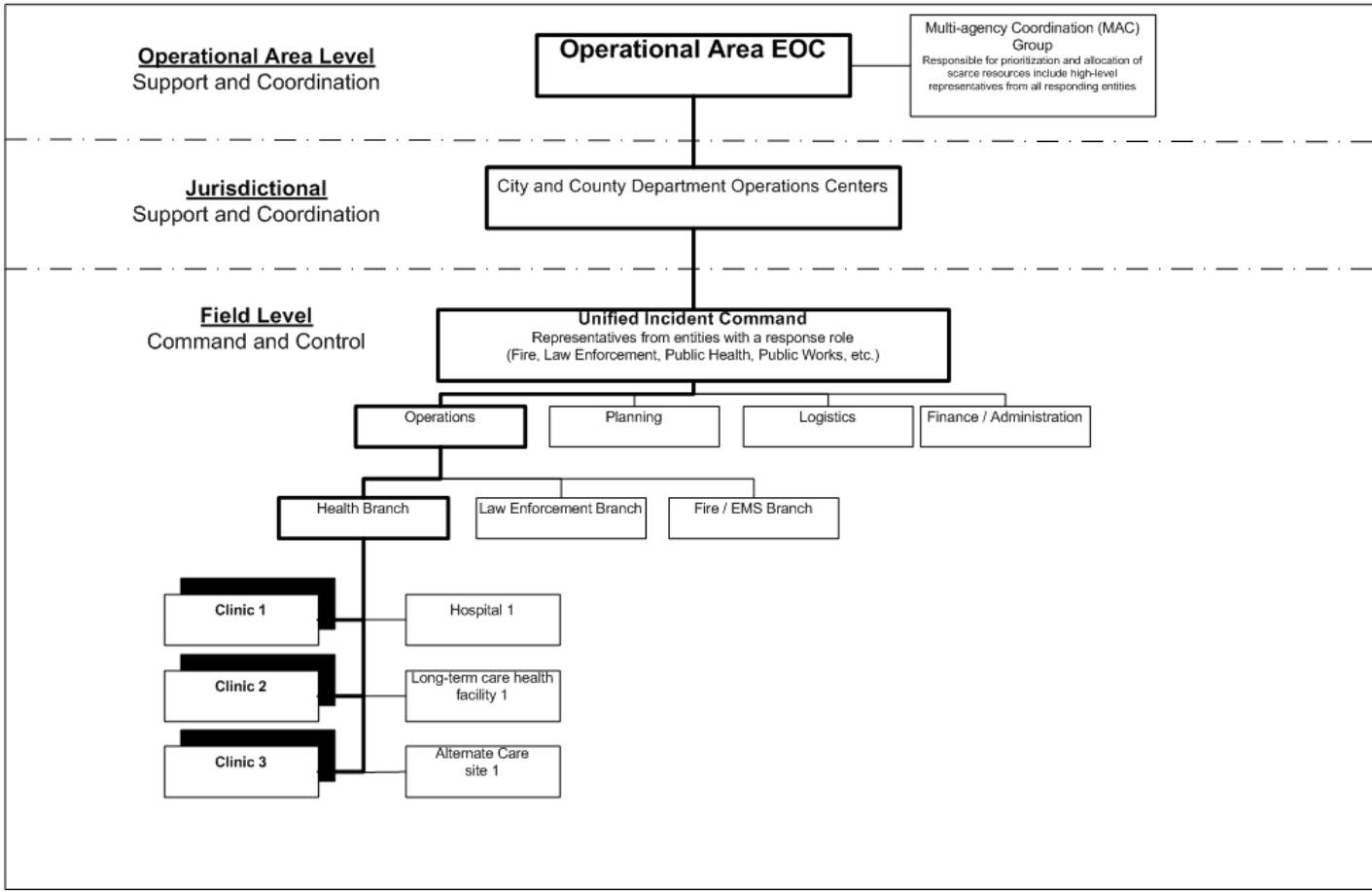
- It is recommended that at a minimum the following four roles be staffed at every community care clinic:
 - **Operations Section Chief**
 - **Planning Section Chief**
 - **Logistics Section Chief**
 - **Finance / Administration Chief**
- In determining who should serve these roles, community care clinics 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.



How Clinics Connect to the Emergency Response Structure

Community Care Clinics Volume, Section 3.3

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.



The Hospital Incident Command System and Hospital-Based Clinics

Community Care Clinics Volume, Section 3.4

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

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

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.

Community Surge Planning Community Care Clinics Volume, Section 3.6

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**

Clinic Expansion vs. Government-Authorized Alternate Care Sites

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.

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

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.

¹*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/emshg/>.

Clinic Emergency Management Community Care Clinics Volume, Section 4

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.

Increasing Surge Capacity in Community Care Clinics

Community Care Clinics Volume, Section 5.1

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.

Patient Management

Community Care Clinics Volume, Section 5.2

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.

Structural Safety

Community Care Clinics Volume, Section 5.4

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.

Infection Control

Community Care Clinics Volume, Section 5.5

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.

Decontamination Community Care Clinics Volume, Section 5.6

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.

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

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.

Fatality Management

Community Care Clinics Volume, Section 5.9

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.

Security Planning Community Care Clinics Volume, Section 5.10

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.

Security Planning (continued)

Community Care Clinics Volume, Section 5.10

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.

Traffic Control

Community Care Clinics Volume, Section 5.11

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.

Business Continuity Planning Community Care Clinics Volume, Section 5.12

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.

Facility Operations Recovery Community Care Clinics Volume, Section 5.12.2

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

Expanding the Workforce Community Care Clinics Volume, Section 6

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.

Expanding the Workforce (continued)

Community Care Clinics Volume, Section 6

- 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.



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

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:

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|---|---|
| <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 |
|---|---|

- 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.

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



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.

Special Considerations for Pharmacists (*continued*)

Community Care Clinics Volume, Section 7.2

- 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).

Credential Verification Community Care Clinics Volume, Section 7.4

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.

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

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

Maintaining the Workforce

Community Care Clinics Volume, Section 9

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 |
|---|--|

Maintaining the Workforce (continued)

Community Care Clinics Volume, Section 9

- 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.

Maximizing Sustainability

Community Care Clinics Volume, Section 10.1

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.

Acquiring Pharmaceuticals Community Care Clinics Volume, Section 10.2

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.

Supplies and Equipment Community Care Clinics Volume, Section 10.3

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).

Personal Protective Equipment Community Care Clinics Volume, Section 10.4

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.

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

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.

Use of Vendors and Suppliers for Supply, Pharmaceutical, and Equipment Procurement

Community Care Clinics Volume, Section 10.6

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.

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

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.

Staging Considerations Community Care Clinics Volume, Section 10.8

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.

Patient Tracking

Community Care Clinics Volume, Section 11.1

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.

Downtime Procedures for Registration and Medical Record Numbers

Community Care Clinics Volume, Section 11.2

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.

Clinic Reporting Requirements Community Care Clinics Volume, Section 11.2.3



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.

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

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.]

Patient Valuables Tracking Community Care Clinics Volume, Section 11.4

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.

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

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

Clinic Planning Considerations for Changes in Reimbursement during a Healthcare Surge

Community Care Clinics Volume, Section 12.2



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.

Clinic Planning Considerations for Changes in Reimbursement during a Healthcare Surge *(continued)*

Community Care Clinics Volume, Section 12.2



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.

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

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.

Administrative and Procedural Guidelines: General Planning Considerations

Community Care Clinics Volume, Section 12.3

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

Administrative and Procedural Guidelines: General Planning Considerations *(continued)*

Community Care Clinics Volume, Section 12.3

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 .

Administrative and Procedural Guidelines: General Planning Considerations *(continued)*

Community Care Clinics Volume, Section 12.3

- 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>

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

- 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

Other Available Funding Sources

Community Care Clinics Volume, Section 12.5

- 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.

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

- 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.

California Authority Governing Commercial Health Plans during a Healthcare Surge and the Impact on Clinics

Community Care Clinics Volume, Section 12.6

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.

California Authority Governing Commercial Health Plans during a Healthcare Surge and the Impact on Clinics (continued)

Community Care Clinics Volume, Section 12.6

- 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, manmade, 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.

Community Care Clinics Wrap Up

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