

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

Volume IV: Community Care Clinics

[Cover photograph to be inserted]

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

Foundational Knowledge

Volume I: Hospitals

Volume II: Government-Authorized Alternate Care Sites

Volume III: Payers

Volume IV: Community Care Clinics

Volume V: Long-Term Care Health Facilities

Volume VI: Licensed Healthcare Professionals (available 2010)

Hospitals Operational Tools Manual

Government-Authorized Alternate Care Sites Operational Tools Manual

Community Care Clinics Operational Tools Manual

Long-Term Care Health Facilities Operational Tools Manual

Licensed Healthcare Professionals Operational Tools Manual (available 2010)

Foundational Knowledge Training Guide

Hospitals Training Guide

Government-Authorized Alternate Care Sites Training Guide

Payers Training Guide

Community Care Clinics Training Guide

Long-Term Care Health Facilities Training Guide

Licensed Healthcare Professionals Training Guide (available 2010)

Reference Manual

Table of Contents

1. California’s Healthcare System Response to a Healthcare Surge9

1.1. California Department of Public Health Initiates Planning for Healthcare Surge11

1.2. Standards and Guidelines for Healthcare Surge Volumes, Operational Tools, and Training Curriculum12

1.3. Key Healthcare Surge Planning Concepts for California14

1.4. Overview of Community Care Clinics Volume15

1.4.1. California Community Care Clinics17

1.5. The Role of Clinics during a Healthcare Surge19

1.6. Why Community Care Clinics Should Develop a Surge Plan20

1.7. Clinic Surge Preparedness Self-Assessment20

2. Provision of Care During a Healthcare Surge31

2.1. Transitioning From Individual Care to Population-Based Care31

2.2. Standard of Care Defined34

3. General Emergency Response Planning36

3.1. National Incident Management System Implementation Activities focused on Community Care Clinics36

3.2. Standardized Emergency Management System (SEMS)37

3.3. How Community Care Clinics Connect to the Emergency Response Structure39

3.4. The Hospital Incident Command System and Hospital-Based Clinics41

3.5. Relationship Between the Incident Command System and the Standardized Emergency Management System42

3.6. Community Surge Planning42

3.6.1. Clinic Expansion vs. Government-Authorized Alternate Care Sites46

3.7. Developing a Hazard Vulnerability Analysis47

4. Community Care Clinic Emergency Management55

4.1. Health Resource and Services Administration (HRSA PIN 2007-15)55

4.2. Joint Commission Environment of Care Standards and AAAHC Guidelines for Community Care Clinics57

4.3. National Fire Protection Association Standards (NFPA 99 and NFPA 1600)58

4.4. California Code of Regulations Title 22, Division 5: Licensing and Certification of Health Facilities, Home Health Agencies, Clinics, and Referral Agencies61

5. Managing Facility Space and Operations During a Healthcare Surge62

5.1. Increasing Surge Capacity in Community Care Clinics62

5.2. Patient Management63

5.2.1. Patient Transfer from Hospitals to Community Care Clinics and from Community
Care Clinics to Hospitals63

5.3. Community Care Clinic Space Use Requirements and Existing Flexibility64

5.3.1. Space Conversion64

5.3.2. Flexibility for Clinic Expansion through Governor's Suspension64

5.4. Structural Safety65

5.4.1. Facility Post-Disaster Status Assessment65

5.5. Infection Control73

5.5.1. Cal/OSHA Infection Control Requirements74

5.5.2. Infection Control for Pandemic Influenza74

5.5.3. Grouping Contaminated Patients75

5.6. Decontamination76

5.7. Hazardous Waste Management.....77

5.8. Medical Waste Management.....78

5.9. Fatality Management.....80

5.9.1. State and County Fatality Response80

5.9.2. Community Care Clinic Fatality Management.....80

5.10. Security Planning81

5.10.1. Supplemental Security Staffing83

5.10.2. Lock-Down vs. Restricted Access/Visitation83

5.10.3. Chain-of-Custody Considerations89

5.11. Traffic Control.....90

5.12. Business Continuity Planning.....90

5.12.1. Development of Standard Operating Procedures for Maintaining Infrastructure during
a Healthcare Surge99

5.12.2. Facility Operations Recovery99

6. Expanding the Workforce103

6.1. Process Flow for Acceptance and Assignment of Additional Staff during a
Healthcare Surge104

6.2. Staffing Component Considerations for Development of a Mutual Aid/Mutual
Assistance Memoranda of Understanding with Neighboring Healthcare Facilities .106

6.3. Requesting Staff through the Standardized Emergency Management System108

6.4. Tracking Staff Providing Services in a Community Care Clinic112

6.4.1.	Staff Assignment Tracking Sheet.....	112
7.	Augmenting Clinical Staff and Other Staffing Strategies.....	114
7.1.	Scope of Practice and Liability Protections.....	114
7.1.1.	California Healing Arts Boards.....	114
7.1.2.	Flexed Scope of Practice.....	116
7.1.3.	Augmenting Staff Through Standby Orders.....	121
7.1.4.	Liability Protections during a Healthcare Surge.....	122
7.1.5.	Federal Tort Claims Act (FTCA) Coverage of Community Care Clinics during a Healthcare Surge.....	126
7.2.	Special Considerations for Pharmacists: The California State Board of Pharmacy Waiver of Pharmacy Practices.....	127
7.2.1.	Communication of the California State Board of Pharmacy Waiver.....	128
7.2.2.	California State Board of Pharmacy Disaster Policy Statement.....	128
7.2.3.	Distribution and/or Dispensing of Pharmaceuticals by Non-Licensed Pharmacists during a Healthcare Surge.....	130
7.2.4.	Out-of-State Licensed Pharmacists, Intern Pharmacists, and/or Pharmacy Technicians.....	130
7.2.5.	Furnishing Medications without a Prescription.....	131
7.3.	Credential Verification.....	131
7.3.1.	Credential Verification During a Healthcare Surge.....	131
7.3.2.	Streamlined Credentialing and Privileging during a Healthcare Surge.....	133
7.3.3.	Volunteer Application for Clinical Staff.....	135
7.3.4.	Credentialing Log for Licensed Healthcare Professionals.....	140
8.	Augmenting Non-Clinical Staff.....	142
8.1.	Verification of Non-Clinical Staff.....	142
8.2.	Non-Clinical Support Matrix.....	146
9.	Maintaining the Workforce.....	147
9.1.	Workforce Health and Safety and Workers' Rights.....	147
9.2.	Occupational Safety and Health Planning.....	148
9.3.	Support Provisions for Staff.....	149
9.4.	Staff Family Emergency Plan.....	160
10.	Pharmaceuticals, Supplies, and Equipment.....	162
10.1.	Maximizing Sustainability.....	162
10.2.	Acquiring Pharmaceuticals.....	163

10.2.1. Inventory-Based Pharmaceuticals by General Classifications164

10.2.2. Storage and Inventory Management of Pharmaceuticals.....170

10.2.3. Off-Label Drug Use172

10.3. Supplies and Equipment172

10.3.1. Determining Supply and Equipment Needs.....172

10.3.2. Inventory-Based Detailed Supplies and Equipment List.....173

10.3.3. Use of Supplies and Equipment beyond the Manufacturer's Recommended Use..180

10.4. Personal Protective Equipment.....180

10.4.1. Guidance on Selecting and Obtaining Personal Protective Equipment183

10.5. Storage and Inventory Management of Supplies and Equipment185

10.5.1. Supplies and Equipment185

10.6. Use of Vendors and Suppliers for Pharmaceutical, Supply, and Equipment Procurement.....187

10.6.1. Memoranda of Understanding with Vendors/Suppliers187

10.6.2. Donations of Supplies and Equipment.....188

10.7. Acquiring Additional Pharmaceuticals, Supplies, and Equipment through the Standardized Emergency Management System188

10.7.1. State Resources.....189

10.7.2. Federal and State Resources189

10.8. Staging Considerations190

11. Administration.....192

11.1. Patient Tracking192

11.1.1. Patient Tracking Form.....193

11.1.2. Paper-Based Intra-Clinic Patient Tracking Process.....196

11.2. Downtime Procedures for Registration and Medical Record Numbers197

11.2.1. Sample Registration Downtime Procedures197

11.2.2. Minimum Requirements for Medical Record Documentation200

11.2.3. Community Care Clinic Reporting Requirements.....202

11.2.4. Waived, Flexed, Amended, or Suspended Licensing Regulations for Community Care Clinics during a Healthcare Surge.....208

11.3. Health Insurance Portability and Accountability Act of 1996 (HIPAA) Compliance during Healthcare Surge211

11.4. Patient Valuables Tracking215

11.4.1. Sample Procedure for Patient Valuables Tracking.....215

11.4.2. Inventorying Valuables215

11.4.3. Patient Valuables Control Log.....216

12. Reimbursement.....217

12.1. Funding Sources for California Community Care Clinics217

12.1.1. Federally Qualified Health Center (FQHC)220

12.1.2. FQHC Look-Alike221

12.1.3. Rural Health Clinics.....222

12.1.4. Medicare.....222

12.1.5. Medi-Cal223

12.1.6. Other Funding and Reimbursement Considerations224

12.2. Community Care Clinic Planning Considerations for Changes in Reimbursement during a Healthcare Surge229

12.2.1. Healthcare Surge Response and Disaster Recovery229

12.2.2. Community Care Clinics and Public Payers229

12.2.3. Community Care Clinics and Health Plans231

12.2.4. Workers' Compensation for Clinic Staff233

12.3. Administrative and Procedural Guidelines: General Planning Considerations235

12.3.1. Minimum Required Data Elements for Billing235

12.3.2. Additional Billing and Coding Guidance.....237

12.3.3. Advancing and Expediting Payment239

12.4. Other Funding Considerations for Providers.....240

12.4.1. Patient Transfer and Coverage Rules During a Healthcare Surge240

12.5. Other Available Funding Sources242

12.5.1. Federal Emergency Management Agency Public Assistance242

12.5.2. United States Small Business Administration Disaster Loan Assistance.....247

12.6. California Authority Governing Commercial Health Plans during a Healthcare Surge and the Impact on Community Care Clinics.....248

12.6.1. The California Department of Managed Health Care's Role in a Healthcare Surge249

12.7. Community Care Clinic Reference Guide and Previous Responses to Healthcare Surge253

12.7.1. Medi-Cal: Previous Response to Healthcare Surge254

12.7.2. Medicare and Medicare Advantage Products: Previous Response to Healthcare Surge.....258

12.7.3. Previous Health Plan Response to Healthcare Surge and Other
Emergencies261
Endnotes.....271

DRAFT

1. California's Healthcare System Response to a Healthcare Surge

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 the statewide healthcare delivery system. California has built a strong network of healthcare services and agencies through public health departments, local emergency medical services agencies, hospitals, community care clinics, long-term healthcare facilities, and healthcare professionals. Developing a coordinated response to a catastrophic event and the resulting dramatic increase in the number of individuals requiring medical assistance, however, will be challenging. The overwhelming increase in demand for medical care arising out of such an event is called healthcare surge. While many hospitals, community care clinics, and other healthcare providers have developed individual healthcare surge plans, the magnitude of a large disaster or widespread disease requires a more in-depth 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:

- **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.
- **Response must bridge 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. During an emergency, healthcare providers and government agencies must view themselves as integrated components of a larger response system
- **Public health is 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.

- **Robust information processing is necessary.** 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.
- **Effective overall management is needed.** 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 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 systems must be resilient.** 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.

Healthcare providers may face several challenges in optimizing emergency preparedness efforts. The traditional approaches to delivering healthcare do not typically support an integrated community-wide response that is usually necessary during a healthcare surge. Therefore, it is critical that healthcare systems and providers be prepared not only to provide services on an individual basis, but also to participate in an overall community emergency response. A collective response will assure healthcare system resiliency, as well as the most efficient care for victims of the event.

1.1. California Department of Public Health Initiates Planning for Healthcare Surge

In order to assist communities and healthcare providers in successfully planning for a healthcare surge, the California Department of Public Health (CDPH) launched a project in 2007 to address the issues of surge capacity during an emergency. CDPH initiated the *Standards and Guidelines for Healthcare Surge during Emergencies* project to develop standards and guidelines to assist communities and healthcare providers in developing plans for responding to a healthcare surge.

A key predecessor to the *Standards and Guidelines for Healthcare Surge during Emergencies* project was the California Hospital Surge Capacity Survey conducted by CDPH in February 2006. Survey findings determined that many California healthcare providers could improve their planning process by identifying the resources that would be needed to treat patients during a healthcare surge. Based upon these findings, the State Budget Act for fiscal year 2006-2007 authorized CDPH to initiate the *Standards and Guidelines for Healthcare Surge during Emergencies* project to identify obstacles hindering healthcare delivery during a healthcare surge and to identify strategies and recommendations to mitigate the identified obstacles.

To identify key surge planning issues, CDPH undertook a multi-phase process that involved bringing together participants representing federal agencies, national organizations, state agencies, public health departments, healthcare providers, health plans, and community organizations to identify key obstacles and develop recommended approaches to surge planning. The project placed particular emphasis on:

- Developing a framework for standards of care and scope of practice during an emergency
- Understanding the liability of healthcare providers during a surge
- Understanding reimbursement of care provided during an emergency
- Planning for and operating government-authorized alternate care sites
- Developing guidelines for surge capacity operating plans at individual hospitals,

government-authorized alternate care sites, payers, community care clinics, long-term care health facilities, and licensed healthcare professionals

The results of these earlier activities form the basis for the *Standards and Guidelines Volumes*, *Operational Tools Manuals*, *Reference Manual*, and training curriculum which are intended to help every community and healthcare provider in California plan and put into operation an effective surge response to major emergencies.

1.2. Standards and Guidelines for Healthcare Surge Volumes, Operational Tools, and Training Curriculum

The surge planning materials have been assembled into the *Standards and Guidelines Volumes*, which contain recommendations and options for consideration by communities and providers planning for a healthcare surge. Materials should be evaluated for implementation based upon the specific needs of a potential emergency and should not be considered mandates or requirements issued by the State of California. Applicability of an individual guideline and recommendation will be dependent upon the specific emergency or the surrounding circumstances as well as the community and provider structure.

The *Standards and Guidelines Volumes* issued from this project are:

- **Foundational Knowledge.** This Volume defines healthcare surge and describes the existing emergency response system in California and how healthcare providers participate in this system. It also discusses transitioning patient care from individually-focused care to population-based care in a healthcare surge. This Volume is a prerequisite to the *Volumes I-VI*, operational tools, *Reference Manual*, and training curriculum described below.
- **Volume I: Hospitals.** Primarily developed for hospitals, but also beneficial for other providers and health plans, this Volume contains information on general emergency response planning and related integration activities for hospitals. This Volume also includes guidance for hospitals related to increasing capacity, expanding existing workforce during a surge, augmenting both clinical and non-clinical staff to address specific healthcare demands, and addressing challenges related to patient privacy and other relevant operational and staffing issues that may arise during surge conditions. This Volume also addresses the assets under a hospital's control that can be used to expand capacity and respond to a healthcare surge.
- **Volume II: Government-Authorized Alternate Care Sites.** This Volume contains planning information related to the establishment of government-authorized alternate care sites during a healthcare surge. It includes specific guidance and general planning considerations for coordinating site locations, developing staffing models, defining standards of care, and developing administrative protocols. Specific guidance on federal and state reimbursement at government-authorized alternate care sites is also provided.

- **Volume III: Payers.** This Volume outlines specific sets of recommendations for commercial health plans to consider when working with providers, employers, and others during the surge planning process. Recommended approaches to changes in contract provisions, which focus on simplifying administrative and reimbursement requirements, are included. This Volume also contains specific information on the impact that a healthcare surge may have on a health plan's administrative and financial relationship with Medicare Advantage, Medi-Cal Managed Care, and Workers' Compensation.
- **Volume IV: Community Care Clinics.** Primarily developed for community care clinics, but also beneficial for other providers and health plans, this Volume contains information on general emergency response planning and related integration activities for community care clinics. This Volume includes guidance for community care clinics related to increasing capacity and expanding existing workforce during a surge, augmenting both clinical and non-clinical staff to address specific healthcare demands, and addressing challenges related to patient privacy and other relevant operational and staffing issues that may arise during surge conditions. This Volume addresses the resources and assets under a clinic's control that can be used to expand capacity and respond to a healthcare surge.
- **Volume V: Long-Term Care Health Facilities.** Primarily developed for long-term care health facilities (skilled nursing facilities and large intermediate care facilities), but also beneficial for by other providers and health plans, this Volume contains information on general emergency response planning and related integration activities for long-term care facilities. This Volume also includes guidance for long-term care facilities related to increasing capacity and expanding existing workforce during a surge, augmenting both clinical and non-clinical staff to address specific healthcare demands, and addressing challenges related to patient privacy and other relevant operational and staffing issues during surge conditions. This Volume addresses the resources and assets under a long-term care health facility's control that can be used to expand capacity and respond to a healthcare surge.
- **Volume VI: Licensed Healthcare Professionals.** Primarily developed for licensed healthcare professionals, but also beneficial for other healthcare providers and health plans, this Volume contains information on general emergency response planning and related integration activities for licensed healthcare professionals. This Volume addresses the assets under a licensed healthcare professional's control that can be used to expand capacity and respond to a healthcare surge and provides guidance on how healthcare professionals can connect with a community surge response.
- **Other Reference Material:**
 - **Operational Tools Manuals:** The *Operational Tools Manuals* include forms, checklists, and templates that can be used by providers and health plans to assist in the implementation of recommendations and strategies outlined in the respective *Standards and Guidelines* Volume.
 - **Reference Manual:** The *Reference Manual* contains an overview of federal and

state regulations and compliance issues, including statutes, laws, regulations, standards, and their corresponding legal interpretations and potential implications for use during a healthcare surge. Included in the *Reference Manual* is detailed information regarding Hospital Incident Command System roles and responsibilities in assisting with planning for command staff at a hospital. In addition, information regarding funding sources that may be available during a declared healthcare surge is included, as well as funding sources that were used during previous states of emergency.

- **Training Curriculum:** The Training Curriculum outlines the intended audience, methods of delivery, and frequency of training for the information presented in the Volumes.

These Volumes are meant for active use by the community and providers when planning for a healthcare surge. The information contained in the Volumes will be updated as new information is gathered and community surge planning practices evolve.

1.3. Key Healthcare Surge Planning Concepts for California

The following key healthcare surge planning concepts provide the context and perspective to understand the information presented in the healthcare surge *Standards and Guidelines* Volumes for California. A major barrier to effective healthcare surge response is the complexity of the healthcare delivery system. The intent of the *Standards and Guidelines for Healthcare Surge during Emergencies* project is not to solve the challenges of the current healthcare delivery system but to operate within it. Thus, this project primarily considers the elements of response from an operational rather than a regulatory point of view.

During a catastrophic emergency, healthcare providers will focus on saving the maximum number of lives possible. This movement from individual-based care to population-based outcomes challenges the professional, regulatory, and ethical paradigms of the healthcare delivery system. Under current state statutes and regulations, a move to a population-based healthcare response may be challenging. When a state statute or regulation does not provide flexibility during a healthcare surge, Executive Standby Orders issued by the Governor of California, following a declaration of emergency, may result in suspensions that allow for flexibility. The *Standards and Guidelines* Volumes provide examples of Executive Standby Orders and possible suspensions that may be put into effect to allow altered standards of care during surge conditions.

In California, a healthcare surge is proclaimed in a local jurisdiction when an authorized local official, such as a Local Health Officer or other appropriate designee,² 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. This demand may affect hospitals, long-term care health facilities, community care clinics, public health departments, other primary and secondary care providers, emergency medical services, and/or other healthcare system resources. The local health official uses situational assessment information provided from the healthcare delivery system partners to determine overall medical and health status of the local jurisdiction or Operational Area. 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 accomplishing the goal of surge healthcare.

The coordination of activities during a healthcare surge entails significant responsibilities for local government, community healthcare professionals. Local government will be responsible for determining the state of the healthcare surge and the identification of and planning for the operations of government-authorized alternate care sites. While the ultimate determination regarding surge-related activities will be made by local government, healthcare providers and payers will be kept informed to support a coordinated and integrated response.

While the current healthcare delivery system is complex, several areas can be simplified, including professional scope of practice, recruitment of staff, and patient tracking for clinical and administrative purposes. These simplifications reflect the operational realities of a coordinated response in a catastrophic event.

Preserving the overall financial liquidity of the healthcare delivery system during a catastrophe is an issue that is larger than any single stakeholder. There are practical ways that community care clinics can take proactive steps to preserve a revenue stream during a surge event, and payers (government and commercial) can more effectively meet their obligations for their covered beneficiaries under the traditional third-party payer system.

Ultimately, effective surge response requires all stakeholders to accept new responsibilities, respond differently than they may have been trained, and cooperate with each other in unprecedented ways. The purpose of these and future *Standards and Guidelines* materials is to proactively engage California communities in advance planning for a healthcare surge and to provide tools and training to support the surge planning process.

1.4. Overview of Community Care Clinics Volume

Given the unpredictable nature of an emergency and its potential to significantly impact the healthcare delivery system, sufficient planning and coordination between providers, payers, and funding sources will be essential to maintaining business continuity and sustaining operations at medical care facilities.

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 standard of care community will be on responding to the emergency and caring for the ill and injured. These changes will require community care 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.

“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.

For more information on the transition from normal healthcare operations to healthcare surge see *Foundational Knowledge*, "Tool 2: Surge Monitoring Guidelines."

As a 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. Key guidance from *Volume IV: Community Care Clinics* includes the following:

- A general community response to a healthcare surge may include many different entities, including hospitals, public health entities, community care clinics, and long-term care facilities, with 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 potential actions of the federal and state governments, regulatory actions and the potential funding available during surge conditions should play an integral role in a clinic's planning efforts. Information provided in *Volume IV: Community Care Clinics* will enable clinics to better understand the options available and how they may integrate into the overall emergency response.
- Understanding the opportunities available to community care clinics when developing an approach to surge planning will enable clinics to develop a surge facility plan which addresses many aspects of the operation including increasing access to care and expanding the clinic workforce.

Throughout this volume, reference is made to laws, rules, and regulations that apply to licensed healthcare clinics. While some community care clinics are exempt from state licensure (e.g., tribal health clinics), planning in accordance with these laws, rules, and regulations will help a clinic to build a coordinated emergency response that will best serve its community's health needs during a healthcare surge.

1.4.1. California Community Care Clinics

Throughout the *Community Care Clinics Volume*, reference is made to different categories of community care clinics and specific rules, regulations, or issues that may apply to specific categories of clinics, but not all clinics. Described below are the major categories of community care clinics discussed throughout the Volume. This list is not all-inclusive. There are clinics in California that do not fit into the following categories, and these clinics may still use the *Community Care Clinics Volume* to guide their surge planning efforts.

Community Clinic and Health Center (CCHC)

Community clinics and health centers (CCHCs) are non-profit organizations whose mission requires the clinic to serve every patient, regardless of their ability to pay. In many California communities CCHCs are essential "safety net" providers and provide a significant proportion of primary care services to uninsured, underinsured, and publicly subsidized patients.³ The majority of CCHC patients have household incomes below the federal poverty level. CCHCs provide a range of services to their patients, including medical care, dental care, and mental health care. Community services include education, outreach, nutrition services, and social services. There are over 800 CCHCs across California.

Federally Qualified Health Center (FQHC)⁴

Federally Qualified Health Centers (FQHCs) are one category of Community Clinics and Health Centers. The designation "Federally Qualified Health Center" was created within the Medicare program in 1991 under Section 1861 (aa) of the Social Security Act. The FQHC Program seeks to enhance the provision of primary care services in underserved urban and rural communities. FQHCs generally receive an all-inclusive per visit payment for covered services provided to Medicare beneficiaries.

To qualify as an FQHC, clinics must receive grants under Section 330 of the Public Health Service Act. Tribal clinics operating outpatient health programs under the Indian Self-Determination Act or receiving funds under Title V of the Indian Health Care Improvement Act also qualify as FQHCs.

*FQHC Look-Alike*⁵

The FQHC Look-Alike program recognizes that some clinics may not receive grants under Section 330 of the Public Health Service Act and therefore do not qualify as Federally Qualified Health Centers (FQHC), but these clinics may still provide services similar to grant-funded programs. To ensure that appropriate numbers of health centers are available to serve uninsured and underinsured populations, FQHC Look-Alike status was made available to these clinics. FQHC Look-Alike entities are expected to demonstrate the same commitment to serve all populations residing in their Medically underserved community and to satisfy all other requirements that apply to FQHCs. Like FQHCs, FQHC Look-Alikes generally receive an all-inclusive per visit payment for covered services provided to Medicare beneficiaries.

*Rural Health Clinic (RHC)*⁶

The Rural Health Clinic (RHC) Program was established in 1977 to address the inadequate supply of physicians who serve Medicare and Medicaid beneficiaries in rural areas. The program provides qualified RHCs with enhanced reimbursement for outpatient physician and certain nonphysician services provided to Medicare and Medicaid beneficiaries.

To qualify as an RHC, a clinic must operate in a non-urbanized area, as defined by the United States Census Bureau, and also serve a Medically underserved area or certified shortage area. Additionally, an RHC must employ a healthcare professional who is available to furnish services, provide routine diagnostic and laboratory services, provide first response emergency care, and establish arrangements with providers and supplies to furnish Medically necessary services that are not available at the clinic. Clinics cannot be concurrently approved as an RHC and a Federally Qualified Health Center (FQHC).

Tribal Clinic

There are 109 federally-recognized Native American tribes in California. The United States government recognizes tribes as domestic, dependent nations with the right to self-governance, tribal sovereignty, and self-determination. Tribal governments are responsible for the protection and preservation of life, property, and the environment on tribal lands. As such, many tribal nations operate clinics to provide healthcare to their populations.⁷ Some tribal clinics may also qualify as Federally Qualified Health Centers (FQHCs), as discussed above.

Because tribal governments are sovereign nations, they are not subject to local ordinances or State law. Tribal clinics are not required to obtain licensure through the State of California, and some tribal clinics may be federally administered through the Indian Health Service. To facilitate coordination during a response to healthcare surge, it is recommended that California

clinics and other healthcare providers develop Memoranda of Understanding or Memoranda of Agreement with local tribal clinics.

1.5. The Role of Clinics during a Healthcare Surge

California's community care clinics are a diverse group of healthcare providers. When operating under normal conditions, California's clinics play very different roles in their communities' healthcare systems. Some clinics may be the primary or sole healthcare provider in the community, other clinics may be associated with a large hospital or health system, and others may offer a specialty service or serve special populations. The role of a clinic in the community healthcare system will usually determine the services the clinic provides, the levels and types of staffing in the clinic, and the other medical assets (supplies, equipment, etc.) available in the clinic facility. These operating attributes under normal conditions will likely determine the community care clinic's role in a community surge response.

Depending on the needs of the community and the resources available to a community care clinic, some clinics may be asked to provide inpatient care during a healthcare surge. During a surge response, these clinics may need to convert exam rooms to patient rooms or utilize procedure rooms as surgical suites to meet the demand for acute care in the community. These clinics should consider what supplies and equipment are needed to provide inpatient care during a healthcare surge and should plan with their communities for how these supplies will be obtained.

Other community care clinics may not have the equipment and staff necessary to provide inpatient care or may reside in communities that do not expect clinics to provide inpatient care during a healthcare surge. These clinics may instead focus their surge plans on providing first-aid or basic primary care services to as many people as possible so as to keep patients out of the hospital and alleviate demand on the healthcare system. Other community care clinics may focus on delivering their usual services to an existing patient population so as to avoid a "secondary disaster" when chronic conditions go untreated.

When planning for participation in a surge response, clinic planners and/or clinic leadership should engage with community planning organizations and community health partners to discuss the clinic's role in the community surge response. It will be important for clinics to both understand the community's expectations for the clinic's operations under surge conditions and communicate to the community the capabilities of the clinic's facility, staff, and medical assets. Based on these conversations, each community care clinic must define its own potential roles during a healthcare surge. This decision should be made at the outset of surge planning and will guide the other decisions made by the clinic during the surge planning process.

The *Community Care Clinics Volume* provides guidance for a range of clinics and discusses different surge response possibilities. Not all recommendations will apply to all community

care clinics. Clinic planners should use Section 1.7, "Community Care Clinic Surge Preparedness Self-Assessment Guide" to identify the guidance and recommendations relevant to a particular clinic's surge planning process.

1.6. Why Community Care Clinics Should Develop a Surge Plan

22 CCR 75057 requires that licensed healthcare clinics develop and maintain a disaster program. While a surge plan is not currently an explicit requirement for CDPH licensing (and therefore would not be assessed during a facility survey), planning for a surge event is consistent with the "all hazards" planning requirement implied by these regulations.

Additionally, community care clinics that adequately plan and prepare for a healthcare surge following an emergency might achieve the following benefits as a result:

- Financial and operational survival during and following a surge
- Enhanced understanding of clinic's planning and recovery needs
- Facilitated communication with clinic board through surge planning efforts
- Enhanced reputation within healthcare system and community
- Strengthened community relationships and community support network
- Improved community understanding of clinic services
- Enhanced understanding of legal requirements for California community care clinics
- Knowledge transfer of positive practices and lessons learned among community care clinics
- Support of staff members (personal preparedness, family security)
- Compliance with mission and ethical responsibilities as a healthcare provider
- Unified and coordinated community response to better meet patient and clinic needs
- Avoidance of a secondary disaster due to unmet health needs

1.7. Clinic Surge Preparedness Self-Assessment

As mentioned above, California's community care clinics constitute a diverse group of healthcare providers. Some clinics are affiliated with major medical centers; others may be the primary or sole medical provider in their community. Some clinics are urban, some are rural; some are tribal clinics serving native populations across California. Some community care clinics offer a broad spectrum of services, some provide mental health and behavioral care or

another specialty service, and some specialize in primary care services. Each clinic is shaped by its environment, its approach to care, and the special needs of its patient population. Community care clinics may vary in the following ways:

- **Geography:** rural vs. urban, frontier locations and border issues, geographic barriers to patient access
- **Designation/Classification:** licensure status, Federally Qualified Health Center (FQHC) status, Rural Health Clinic status, tribal affiliation, relationship to the judicial system, Red Cross shelter designation
- **Patient Mix:** payment source, acuity, languages, cultures
- **Medical Resources:** staffing (licensure of staff, number of staff, volunteer support), spectrum of services and programs, other operational resources
- **Integration with Healthcare Systems:** proximity to acute care hospital, relationships with other healthcare facilities, single sites vs. multiple sites, contractual obligations
- **Integration with Emergency Response Systems:** relationships with local and county response agencies, integration into community planning efforts, emergency communication capability

The level of preparedness and the particular surge planning needs of any given community care clinic will vary across the types of clinics and across individual organizations. The level of surge preparedness in any particular community care clinic can be described by the following continuum:

Level 1:	"Starting to plan for Surge"	Basic internal emergency plan
Level 2:	"Surge plan in progress"	Surge awareness with limited planning with external stakeholders
Level 3:	"Integrated communitywide surge planning"	Internally and externally integrated community surge plan, exercised and annually updated

Community care clinics across all stages of surge preparedness must continually revise and update their surge plans. Surge planning, like all emergency planning, is a continuous process, and should involve as many different representatives as possible. Including staff representatives across different clinic departments will contribute to a more robust surge plan.

The *Community Care Clinics Volume* provides guidance for the full range of California

community care clinics. The Community Care Clinic Surge Preparedness Self-Assessment Tool is designed to guide a clinic in assessing its current surge preparedness level and to assist planners in identifying ways to advance a particular clinic's surge preparedness through the use of *Standards and Guidelines* material.

The Self-Assessment Tool can be supplemented by the CDPH Gap Analysis Tool. The Gap Analysis Tool groups tasks according to the four stages of comprehensive emergency management: mitigation, preparedness, response, and recovery. Each identified issue is based on one of the three overarching elements within the continuum of care: roles, responsibilities, and resources. Issues are further organized based on public health, healthcare, and/or public safety disciplines. The Gap Analysis Tool can be found at: <http://www.mycdlhn.com> (Gap Analysis tab, then Community Clinics tab)

The Community Care Clinic Surge Preparedness Self-Assessment Tool is shown below. The complete tool can be found in the Clinic Operational Tools Manual on pages 5-14.

Community Care Clinic Surge Preparedness Self-Assessment

Instructions

Using the Community Care Clinic Surge Preparedness Self-Assessment Tool, identify a community care clinic's current stage of surge planning efforts:

1. Starting to Plan for Surge:

- Clinic staff are not yet familiar with issues surrounding surge.
- Clinic leadership and planning staff have not yet considered the impact of surge events in clinic emergency plans.
- Clinic leadership and planning staff want to update clinic emergency operations plans to incorporate surge issues and reflect the potential regulatory flexibility during surge events.

2. Surge Plan in Progress:

- Clinic staff and leadership are aware of many topics surrounding healthcare surge and have begun to incorporate surge issues into clinic emergency operations plans.
- Clinic leadership and/or planning staff want to develop deeper understanding of surge issues or consider more advanced surge topics.
- Clinic leadership and/or planning staff want to advance clinic surge planning efforts to a more advanced stage.

3. Involved in Integrated Community-wide Surge Planning:

- Clinic emergency operations plans address detailed aspects of surge planning.
- Clinic leadership and/or planning staff regularly update surge plans and routinely train clinic staff on policies and procedures.
- Clinic leadership and/or planning staff test clinic surge plans and incorporate "lessons learned" into plan revisions.
- The clinic is fully integrated in community-wide planning efforts and works closely with community partners in both the public and private sectors.

After identifying the clinic's current stage of surge planning preparedness, use the charts on the following pages to identify which specific chapters or tools can be used to assist you in advancing the clinic's level of surge planning from one stage to the next. While clinic planning staff may wish to focus on the actions items for their facility's current level of surge preparedness, planners should review all items across all categories to identify gaps in current surge plans.

Starting to Plan for Surge:

Checkbox	Topics to consider when starting to plan for a healthcare surge:	Reference to <i>Standards & Guidelines</i> Volumes, Operational Tools, and Training:
A. Is the community care clinic aware of healthcare surge as an issue that should be addressed in an emergency preparedness plan?		
<input type="checkbox"/>	Recognize surge planning as a necessary business activity	<i>Foundational Knowledge; Community Care Clinics</i> pp. 14-20, and Training Materials
<input type="checkbox"/>	Create awareness of surge planning concepts and principles among staff and leadership	<i>Foundational Knowledge; Community Care Clinics</i> , and Training Materials
B. Do clinic staff and leadership understand the basic principles and definitions underlying a surge response?		
<input type="checkbox"/>	Understand the shift from individual care to population-based care during a healthcare surge	<i>Foundational Knowledge</i> Section 8; <i>Community Care Clinics</i> pp.

Starting to Plan for Surge:

Checkbox	Topics to consider when starting to plan for a healthcare surge:	Reference to <i>Standards & Guidelines</i> Volumes, Operational Tools, and Training:
		31-34 and Training Materials
<input type="checkbox"/>	Understand the Standardized Emergency Management System (SEMS) and the National Incident Management System (NIMS)	<i>Foundational Knowledge; Community Care Clinics</i> pp. 36-39 and Training Materials
<input type="checkbox"/>	Understand how your facility will connect to the SEMS/NIMS system during an emergency	<i>Community Care Clinics</i> pp. 39-41, Operational Tools, and Training Materials
C. Has the community care clinic considered how a healthcare surge would impact operations and incorporated a surge response into existing policies and procedures?		
<input type="checkbox"/>	Develop a facility Hazard Vulnerability Analysis	<i>Community Care Clinics</i> pp. 47-54 and Operational Tools
<input type="checkbox"/>	Understand the range of roles a community care clinic might play during a healthcare surge	<i>Community Care Clinics</i> pp. 19-20, 42-45 and Operational Tools
<input type="checkbox"/>	Consider potential needs for increased staffing during a healthcare surge	<i>Community Care Clinics</i> pp. 103-104 and Operational Tools
<input type="checkbox"/>	Understand how to submit staffing requests through the SEMS/NIMS structure	<i>Community Care Clinics</i> p. 108 and Training Materials
<input type="checkbox"/>	Develop an employee health and safety plan as part of emergency preparedness planning	<i>Community Care Clinics</i> pp. 148-149
<input type="checkbox"/>	Understand workers' rights and workforce protections in effect during a healthcare surge	<i>Community Care Clinics</i> pp. 147-148 and Training Materials
<input type="checkbox"/>	Understand Workers' Compensation Insurance applicability to clinic employees and volunteers during a healthcare surge	<i>Community Care Clinics</i> pp. 233-234, Operational Tools, and Training Materials
<input type="checkbox"/>	Understand the impact of a healthcare surge on a clinic's supply chains and resource usage	<i>Community Care Clinics</i> pp. 162-171

Starting to Plan for Surge:

Checkbox	Topics to consider when starting to plan for a healthcare surge:	Reference to <i>Standards & Guidelines</i> Volumes, Operational Tools, and Training:
<input type="checkbox"/>	Understand potential off-label use of supplies and pharmaceuticals to compensate for shortages during a healthcare surge	<i>Community Care Clinics</i> pp. 172, 180, and Training Materials
<input type="checkbox"/>	Consider a healthcare surge's impact on a community care clinic's ability to comply with public health reporting requirements	<i>Community Care Clinics</i> pp. 202-208
<input type="checkbox"/>	Understand existing flexibility of licensing requirements during a healthcare surge	<i>Community Care Clinics</i> pp. 208-211 and Training Materials
<input type="checkbox"/>	Understand regulatory flexibility to accommodate clinic expansion during a healthcare surge	<i>Community Care Clinics</i> pp. 62-64 and Training Materials
<input type="checkbox"/>	Understand existing statutory scope of practice flexibility and liability protections	<i>Community Care Clinics</i> , pp. 114-120 and Training Materials
<input type="checkbox"/>	Understand existing flexibility of HIPAA requirements during a healthcare surge	<i>Community Care Clinics</i> pp. 211-213 and Training Materials
D. Have considered how a surge response might impact clinic finances?		
<input type="checkbox"/>	Understand the range of funding sources available to community care clinics	<i>Community Care Clinics</i> pp. 217-220 and Training Materials
<input type="checkbox"/>	Understand the importance of revenue stream maintenance during a healthcare surge	<i>Community Care Clinics</i> pp. 229-234 and Training Materials
<input type="checkbox"/>	Understand the impact of patient transfer on insurance coverage and claims reimbursement during a healthcare surge	<i>Community Care Clinics</i> pp. 240-241, Operational Tools, and Training Materials
<input type="checkbox"/>	Understand health plans' responses to previous healthcare surge events	<i>Community Care Clinics</i> pp. 253-261
<input type="checkbox"/>	Understand public assistance available through FEMA and the Small Business Administration	<i>Community Care Clinics</i> pp. 242-248, Operational Tools, and Training Materials

Starting to Plan for Surge:

Checkbox	Topics to consider when starting to plan for a healthcare surge:	Reference to <i>Standards & Guidelines</i> Volumes, Operational Tools, and Training:
<input type="checkbox"/>	Understand the importance of the recovery phase of an emergency management program	<i>Community Care Clinics</i> pp. 99-100

Surge Plan in Progress:

Checkbox	Topics to consider once a surge plan is in progress:	Reference to <i>Standards & Guidelines</i> Volumes, Operational Tools, and Training:
A. Has the community care clinic developed policies and procedures that support an effective surge response?		
<input type="checkbox"/>	Consider impact of facility policy (e.g., privileging guidelines) on the efficiency of care during a healthcare surge	<i>Foundational Knowledge</i> Section 8; <i>Community Care Clinics</i> pp. 133-145
<input type="checkbox"/>	Develop a facility emergency operations plan	<i>Community Care Clinics</i> pp. 36-42 and Training Materials
<input type="checkbox"/>	Integrate Incident Command System principles into facility emergency plan	<i>Community Care Clinics</i> pp. 36-42, Operational Tools, and Training Materials
<input type="checkbox"/>	Incorporate an infection control plan (including a pandemic influenza plan) into the facility emergency plan	<i>Community Care Clinics</i> pp. 73-79 and Training Materials
<input type="checkbox"/>	Develop procedures to evaluate structural safety following an emergency	<i>Community Care Clinics</i> p. 65, Operational Tools, and Training Materials

Surge Plan in Progress:

Checkbox	Topics to consider once a surge plan is in progress:	Reference to <i>Standards & Guidelines</i> Volumes, Operational Tools, and Training:
<input type="checkbox"/>	Develop procedures to evaluate facility system functionality during an emergency	<i>Community Care Clinics</i> pp. 65-73 and Operational Tools
<input type="checkbox"/>	Understand the key criteria for the creation of government-authorized alternate care sites by local and regional government	<i>Community Care Clinics</i> pp. 46-47 and Training Materials
<input type="checkbox"/>	Develop facility security plans to address increased traffic during healthcare surge	<i>Community Care Clinics</i> pp. 81-83, 90, Operational Tools, and Training Materials
<input type="checkbox"/>	Develop written policies and procedures to direct triage services and facility use during a healthcare surge	<i>Community Care Clinics</i> pp. 62-64
<input type="checkbox"/>	Develop plans for paper-based patient tracking systems for use during a healthcare surge	<i>Community Care Clinics</i> pp. 192-199, Operational Tools, and Training Materials
<input type="checkbox"/>	Develop plans for downtime registration and medical record documentation procedures	<i>Community Care Clinics</i> pp. 200-201 and Operational Tools
<input type="checkbox"/>	Incorporate patient transfer scenarios (in and out) into emergency operations plan	<i>Community Care Clinics</i> pp. 63-64, 240-241, and Training Materials
<input type="checkbox"/>	Develop plan for radioactive, biological, and chemical isolation and decontamination	<i>Community Care Clinics</i> pp. 75-77 and Training Materials
<input type="checkbox"/>	Develop hazardous waste management plan	<i>Community Care Clinics</i> pp. 77-78 and Training Materials
<input type="checkbox"/>	Develop medical waste management plan	<i>Community Care Clinics</i> pp. 78-79 and Training Materials
<input type="checkbox"/>	Develop policy on the use of personal protective equipment	<i>Community Care Clinics</i> pp. 180-184 and Training Materials

Surge Plan in Progress:

Checkbox	Topics to consider once a surge plan is in progress:	Reference to <i>Standards & Guidelines</i> Volumes, Operational Tools, and Training:
<input type="checkbox"/>	Develop facility fatality response plan for mass casualty events	<i>Community Care Clinics</i> pp. 80-81 and Training Materials
<input type="checkbox"/>	Develop policies and procedures to integrate augmented staff into facility operations during a healthcare surge	<i>Community Care Clinics</i> pp. 103-147, Operational Tools, and Training Materials
<input type="checkbox"/>	Develop plan for pharmaceutical, supplies, and equipment storage	<i>Community Care Clinics</i> pp. 170-171, 185-187, Operational Tools, and Training Materials
<input type="checkbox"/>	Develop facility policies and procedures to comply with reporting, licensing, and privacy requirements during a healthcare surge	<i>Community Care Clinics</i> pp. 202-215 and Training Materials
<input type="checkbox"/>	Develop policies and procedures to govern documentation and billing submission during a healthcare surge	<i>Community Care Clinics</i> pp. 235-238, Operational Tools, and Training Materials
<input type="checkbox"/>	Develop policies and procedures for patient valuables tracking during a healthcare surge	<i>Community Care Clinics</i> p. 216 and Operational Tools
B. Is the community care clinic prepared for an effective surge response?		
<input type="checkbox"/>	Execute Memoranda of Understanding with neighboring facilities or staffing services	<i>Community Care Clinics</i> pp. 106-107, Operational Tools, and Training Materials
<input type="checkbox"/>	Identify facility space that can be converted for use as patient treatment areas	<i>Community Care Clinics</i> pp. 46-47, 62-64
<input type="checkbox"/>	Make advance arrangements for support provisions for staff during a healthcare surge	<i>Community Care Clinics</i> pp. 149-161, Operational Tools, and Training Materials
<input type="checkbox"/>	Acquire personal protective equipment for healthcare surge stockpile	<i>Community Care Clinics</i> pp. 183-184, and Training

Surge Plan in Progress:

Checkbox	Topics to consider once a surge plan is in progress:	Reference to <i>Standards & Guidelines</i> Volumes, Operational Tools, and Training:
		Materials
<input type="checkbox"/>	Acquire pharmaceuticals for a healthcare surge stockpile	<i>Community Care Clinics</i> pp. 163-169, 188-190, Operational Tools, and Training Materials
<input type="checkbox"/>	Acquire supplies and equipment for a healthcare surge stockpile	<i>Community Care Clinics</i> pp. 172-180, 188-190, and Operational Tools
C. Has the community care clinic made plans for business recovery after a surge event?		
<input type="checkbox"/>	Develop business continuity plan	<i>Community Care Clinics</i> pp. 90-99 and Operational Tools
<input type="checkbox"/>	Develop a checklist for recovery planning activities	<i>Community Care Clinics</i> pp. 99-102
D. Are clinic staff fully trained on surge response issues?		
<input type="checkbox"/>	Conduct awareness training on surge planning principles for administrative and clinical staff	<i>Foundational Knowledge, Community Care Clinics Training Materials</i>

Involved in Integrated Community-wide Surge Planning:

Checkbox	Topics to consider when involved in integrated community-wide surge planning:	Reference to <i>Standards & Guidelines</i> Volumes, Operational Tools, and Training:
A. Is the clinic's surge plan updated and exercised?		
<input type="checkbox"/>	Organize training simulations for clinical staff to practice decision-making under conditions of limited resources and information	<i>Foundational Knowledge</i> Section 8
<input type="checkbox"/>	Revise emergency operations plan annually	<i>Community Care Clinics</i> pp. 36-42
<input type="checkbox"/>	Conduct exercises of emergency operations plan and integrate corrective actions into plan revision	<i>Community Care Clinics</i> pp. 36-42
<input type="checkbox"/>	Incorporate surge planning into the clinic culture	<i>Community Care Clinics</i> pp. 36-42 and Training Materials
B. Are the community care clinic's surge planning efforts coordinated with community-wide surge planning efforts?		
<input type="checkbox"/>	Integrate facility planning with community-wide preparedness planning	<i>Foundational Knowledge</i> and <i>Community Care Clinics</i> pp. 42-45
<input type="checkbox"/>	Integrate isolation and decontamination planning with community-wide efforts	<i>Foundational Knowledge</i> and <i>Community Care Clinics</i> pp. 76-77
<input type="checkbox"/>	Integrate clinic fatality response plan with community-wide planning efforts	<i>Foundational Knowledge</i> and <i>Community Care Clinics</i> pp. 80-81
<input type="checkbox"/>	Integrate workforce expansion plans with community-wide planning efforts	<i>Foundational Knowledge</i> and <i>Community Care Clinics</i> , pp. 103-106

Involved in Integrated Community-wide Surge Planning:

Checkbox	Topics to consider when involved in integrated community-wide surge planning:	Reference to <i>Standards & Guidelines</i> Volumes, Operational Tools, and Training:
<input type="checkbox"/>	Integrate procurement of pharmaceutical, supply, and equipment, stockpiles with community-wide planning efforts	<i>Foundational Knowledge and Community Care Clinics</i> pp. 185-190
<input type="checkbox"/>	Work with health plan partners to revise contract language to streamline reimbursement policies and procedures during a healthcare surge	<i>Foundational Knowledge and Community Care Clinics</i> pp. 217-234

2. Provision of Care During a Healthcare Surge

Disaster response involves many different community resources from police and fire departments to medical providers, engineers, and transportation and housing experts. Community care clinics of all types will play a crucial role in this larger picture. Community care clinics have long served as primary care resources within their respective communities and can serve as an important asset during a healthcare surge both as a care site and as a primary care provider. During a healthcare surge event, clinics may have to quickly expand from their current care capacity to handle the maximum patient load possible, given the limited resources that might be available.

2.1. Transitioning From Individual Care to Population-Based Care

During catastrophic emergencies, the demand for medical care may exceed available resources. Healthcare surge capacity planning must therefore consider a departure from the individual patient-based outcomes that clinicians have been conditioned to uphold in favor of an approach that saves the most lives. In other words, clinicians may need to "balance the obligation to save the greatest possible number of lives against that of the obligation to care for each single patient."⁸ This migration from individual-based responsibility to population-based outcomes should adhere to longstanding principles of ethical practice. Those rendering care

must be informed of surge status in their community, any necessary proclamations of emergency, and any emergency orders so that they can adjust their practices accordingly and to the fullest extent possible.

Ethical Guidelines for Care during a Healthcare Surge

Community care clinics and healthcare providers managing the excess of demand over supply of services during a healthcare surge will likely need to allocate resources in ways that are unique to the surge emergency. In 1993, the American Medical Association published *Ethical Considerations in the Allocation of Organs and Other Scarce Medical Resources among Patients*,⁹ a report that gives guidance to physicians who must make critical allocation decisions due to a limited supply of available resources. Guidelines from this report have been extracted and made applicable to a healthcare surge environment. The guidelines that follow give ethical guidance to healthcare facilities and licensed healthcare professionals for both acceptable and inappropriate criteria for making resource allocation decisions during a healthcare surge emergency.

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

Volume I: Foundational Knowledge Section 8.4, "Scarce Resource Allocation," provides more detail around each of the appropriate and inappropriate criteria for resource allocation.

Volume I: Foundational Knowledge Section 8.1, "Healthcare Surge-Related Ethical Principles," includes an in-depth discussion of the ethical principles that should guide a surge response.

A Shift to Population-Based Care

Under normal conditions, a healthcare professional employs appropriate health and Medical resources and responses to improve the health status and/or save the life of an individual patient. During a healthcare surge, however, the goal of care may shift from focusing on patient-based outcomes to population-based outcomes. According to a report by Health Systems Research Inc.,¹⁰ providers should anticipate "a shift to providing care and allocating scarce equipment, supplies, and staff in a way that saves the largest number of lives in contrast to the traditional focus on saving individuals."

Examples of these shifts in care may include:

- **Triage efforts that will need to focus on maximizing the number of lives saved.** Instead of treating the sickest or the most critically injured first, triage will focus on identifying and reserving immediate treatment for individuals who have a critical need for treatment and are likely to survive. The goal will be to allocate resources in order to maximize the number of lives saved. Complicating conditions, such as underlying chronic disease, may have an impact on an individual's ability to survive.
- **Triage decisions that will affect the allocation of all available resources across the spectrum of care.** From the scene, to hospitals, to community care clinics, to long-term care facilities, to government-authorized alternate care sites, many organizations may compete for available resources. For example, hospital space may rapidly reach capacity, and long-term care health facilities may be unable to transfer patients to hospital facilities for many days.
- **Resources used by current patients may need to be redistributed.** For example, resources used by patients recovering from surgery or intensive care units may be returned to the pool of overall resources. Current hospital inpatients may have to be discharged early or transferred to another setting, such as a nearby clinic. Hospice patients or patients who require supervision but less acute Medical care (e.g. patients with Alzheimer's disease or other dementias) may need to be discharged to their families. In addition, certain lifesaving efforts may have to be discontinued.
- **Usual scope of practice standards that may not apply.** Nurses, physicians, and other licensed healthcare providers may function outside their specialties. Credentialing of providers may be granted on an emergency or temporary basis.
- **Equipment and supplies that may be rationed and used in different ways.** Equipment and supplies may be rationed or used in new ways consistent with achieving the ultimate goal of saving the most lives (e.g., disposable supplies may be reused, adult supplies may be used for pediatric patients).
- **Staffing shortages that will impact patient care.** Staff may be fearful to leave home and/or may find it difficult to travel to work. Burn-out from stress and long hours can occur, and replacement staff may be needed. Some scarce and valuable equipment, such as ventilators, may be unusable without staff available that is trained to operate them.
- **The psychological impact of the emergency on providers.** Short and long-term stress management measures (e.g., Critical Incident Stress Management programs) are essential for providers and their families.
- **Providers may need to make treatment decisions based on clinical judgment.** For example, if laboratory resources for testing or radiology resources for x-rays are exhausted, treatment based on physical exam, history, and clinical judgment may occur.

- **Current documentation standards that may be impossible to maintain.** Providers may not have time to obtain informed consent or have access to the usual support systems to fully document the care provided, especially if the healthcare setting is damaged by the emergency.
- **Policies and procedures for processing fatalities that will be unsustainable.** It may not be possible to accommodate cultural sensitivities and attitudes toward death and handling bodies. Numbers of fatalities may make it difficult to find and notify next of kin quickly. Burial and cremation services may be overwhelmed. Standards for completeness and timeliness of death certificates may need to be lifted temporarily.”¹¹ (See Section 5.9 "Fatality Management" for more information on fatality management in the community care clinic setting.)

It is anticipated that certain legal requirements within statutes, regulations, and professional standards of practice may be waived or suspended by government authorities during a healthcare surge. Potential waivers or suspensions could relate to:

- Obtaining informed consent;
- Honoring advance healthcare directives,
- Communicating with healthcare agents, surrogates, and next of kin;
- Providing services to special needs populations;
- Withdrawing care; and
- Honoring cultural preferences and rituals in the process of disposing of human remains.

2.2. Standard of Care Defined

The "standard of care" in California is based on what a reasonably prudent person with similar knowledge and experience would do under similar circumstances. Standard of care is a legal concept that requires licensed healthcare professionals, when caring for patients, to adhere to the customary skill and care that is consistent with good Medical (or other healthcare) practice. As such, it is dependent to a certain degree on the type of provider and the respective scope of practice each provider is licensed or authorized to provide. 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.¹² Standard of care is a legal concept that encompasses the diagnosis and treatment of patients and the overall management of patients.¹³ 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.

DRAFT

3. General Emergency Response Planning

The planning activities required for general emergency response include planning at the facility, local, state, and national levels. This section provides an overview of the general emergency response structure in which community care clinics operate during a healthcare surge, including the National Incident Management System (NIMS), the Standardized Emergency Management System (SEMS), and the Incident Command System (ICS).

3.1. National Incident Management System Implementation Activities focused on Community Care Clinics

Homeland Security Presidential Directive/HSPD-5 Management of Domestic Incidents called for the establishment of a single, comprehensive National Incident Management System (NIMS). As a system, NIMS improves response operations through the use of the Incident Command System (ICS) and other standard procedures and preparedness measures. It also promotes the development of multi-jurisdictional, statewide, and interstate regional mechanisms for coordinating incident management and obtaining assistance during large-scale or complex incidents. Homeland Security Presidential Directive/HSPD-5 mandates that federal departments and agencies make adoption of NIMS a requirement for the provision of federal preparedness assistance funds.

Homeland Security Presidential Directive/HSPD-5 also establishes and designates the NIMS Resource Center (previously The NIMS Integration Center) as the lead federal agency to coordinate NIMS compliance. One of the primary functions of the NIMS Resource Center is to ensure NIMS remains an accurate and effective management tool through refining and adapting compliance requirements to address ongoing preparedness needs. To accomplish this, the NIMS Resource Center relies on input from federal, state, local, tribal, multi-disciplinary, and private authorities to assure continuity and accuracy of ongoing efforts. The NIMS Resource Center, in conjunction with the federal Department of Health and Human Services and ICS working group, developed NIMS implementation activities, which were released on September 12, 2006¹⁴. Staff at many community care clinics throughout the state have received training on NIMS and ICS as the result of complying with preparedness and Homeland Security grants and funds.

Community care clinics receiving federal Federally Qualified Health Center (FQHC) grants and/or the FQHC Look-Alikes designation are strongly encouraged to implement NIMS by the Bureau of Primary Health Care, which provides the federal grant and/or designation. Please refer to the National Association of Community Health Center (NACHC) document titled “Essential Components of Emergency Management Plans at Community Health Centers Crosswalk of Plan Elements” for further details on recommendations for community care clinics meeting some of the core NIMS objectives. This document is available at

<http://www.nachc.com/> (Search for "Essential Components of Emergency Management Plans at Community Health Centers, Crosswalk of Plan Elements").

3.2. Standardized Emergency Management System (SEMS)

The Standardized Emergency Management System (SEMS) is a system for managing the response to multi-agency and multi-jurisdictional emergencies in California.¹⁵ 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.¹⁶ 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.¹⁷ This means that local emergency plans must also incorporate SEMS, assuming the local government wants to be reimbursed for emergency personnel costs.

SEMS is based on the concept of the Incident Command System.¹⁸ 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.

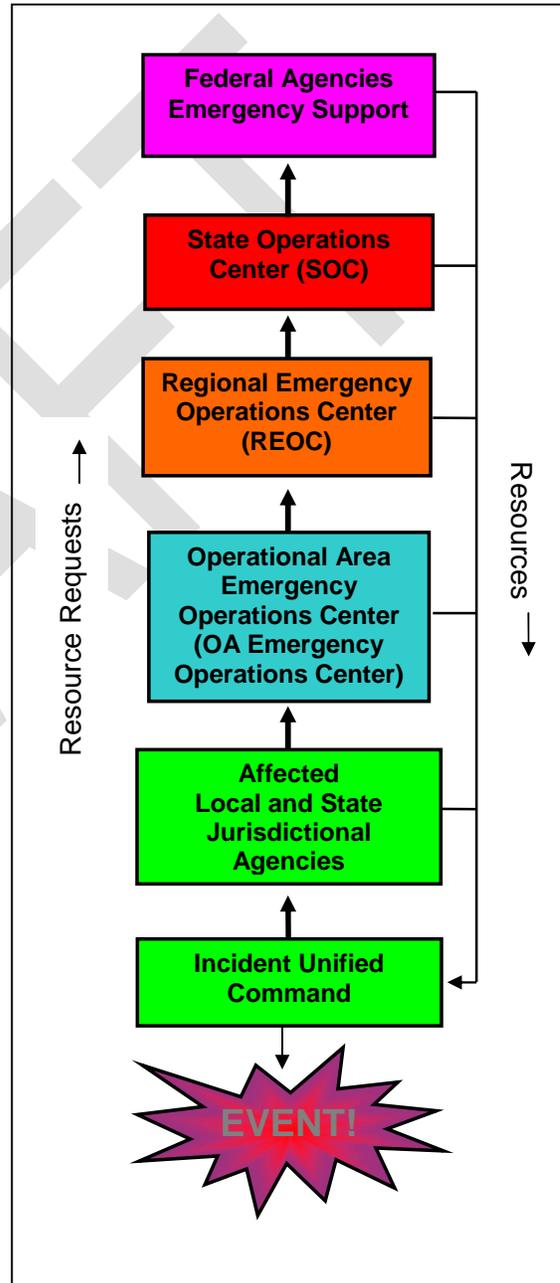
1. **Management:** the function of setting priorities and policy direction and coordinating the response
2. **Operations:** the function of taking responsive actions based on policy
3. **Planning/Intelligence:** the function of gathering, assessing, and disseminating information
4. **Logistics:** the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

Unified Command is a management concept under the Incident Command System that applies when there is more than one agency with jurisdictional responsibility for the emergency (for example, public health, law enforcement, and fire) or when emergency incidents expand across multiple political boundaries. Agencies work through the designated members of the Unified Command located at an Incident Command Post to establish a common set of objectives and strategies and a single Incident Action Plan.

SEMS is designed to foster the coordination of public and private sector resources at all levels of its structure. As such, requests for resources flow upward from the local level to the federal level and assistance to meet these request 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. The diagram to the right depicts this flow of request and assistance for resources using SEMS during catastrophic emergencies.

The Operational Area, defined in the Emergency Services Act, is a required concept of SEMS.¹⁹ In accordance with SEMS and the Emergency Services Act, the Operational Area consists of a county and all political subdivisions within the county area, and serves as an intermediate level of the state emergency response organization.²⁰ The governing bodies of each county and the political subdivisions within the county are authorized to organize and structure their 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.²¹ In addition to the Operational Area, political subdivisions within a county may have their own Emergency Operations Center.

Under SEMS, an Operational Area Emergency Operations Center does not manage the emergency operations of any single government entity but exists as an organization to facilitate the



emergency management coordination of all government entities within the Operational Area. At the Operational Area level, a multi-agency coordination group, comprised of high-level decision makers from governmental agencies with responsibilities to mitigate the impact of an emergency, establishes policies and sets priorities for management of the emergency response.

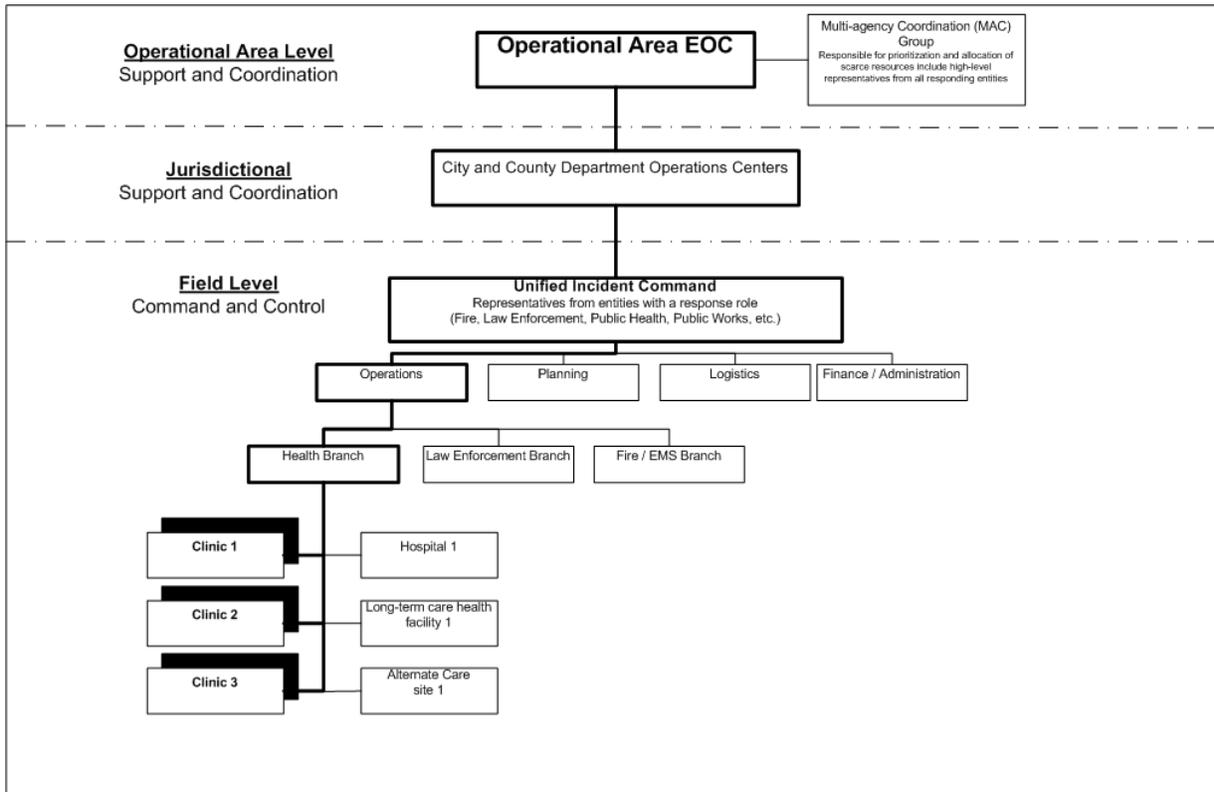
The Operational Area Emergency Operations Center must be distinguished from department operations centers. Under SEMS, a department operations center is an emergency operations center used by a district discipline (e.g., flood operations, fire, Medical, hazardous material) or a governmental unit (e.g., Department of Public Works or Department of Health). Depending on the impact of the emergency, department operations centers may be used at all SEMS levels above the field response level (the level at which diverse local response organizations use their own resources to carry out tactical decisions and activities).²² There may be as many department operations centers as there are public agencies involved in the response above the field level.

California SEMS meets NIMS requirements. Therefore, SEMS will be referred to as SEMS/NIMS from this point forward.

3.3. How Community Care Clinics Connect to the Emergency Response Structure

Under the SEMS/NIMS structure, 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 close to the incident to manage the tactical operations of mitigating the response.

All community care clinics must be integrated into this Unified Command, which coordinates the movement of patients, establishes priorities, and allocates scarce resources, services, and supplies among all healthcare providers. To accomplish this, an authorized local official or designee will notify healthcare facilities that the Unified Command has been established. The authorized local official or designee will also provide a contact within the Operations Section of the Unified Command for coordination of patient movement and requests for resources, services and supplies. The chart below illustrates how a community care clinic connects to the emergency response structure through the Unified Command.



In order to successfully implement the Incident Command System, key roles must be planned for ahead of time. The first step in planning should include determining which roles a clinic will staff. It is recommended that, at a minimum, the following five roles be staffed at every clinic:

1. Incident Commander
2. Operations Section Chief
3. Planning Section Chief
4. Logistics Section Chief
5. Finance/Administration Chief

When staffing these key roles, consider the scalability of the staffing structure. It is recommended that clinics plan key roles to be at least two or three-people deep to ensure that each key role will be adequately staffed during a healthcare surge. In determining who should serve in these roles, clinics may want to keep in mind that during a healthcare surge, executive managers may need to continue to fulfill their responsibilities as clinic managers and may not

be the best choices for managing the Incident Command System. Clinics may want to consider reserving these executives for policy decisions and instead staffing the Incident Command System with experienced clinic operations managers. The chart below can be used to document existing staff's skill-set and operational responsibilities to determine the most appropriate role for clinic staff within the emergency response team. It will also facilitate the completion of the Job Action Sheets.

The Emergency Response Team Position Assignment Form is shown below. The complete tool can be found in the *Community Care Clinics Operational Tools Manual* on pages 15-16.

Emergency Response Team Position Assignments

Instructions

Complete the Emergency Response Team Position Assignments chart when assigning Incident Command System roles.

Role	Name & Contact Information	Position	Day-to-Day Responsibilities

3.4. The Hospital Incident Command System and Hospital-Based Clinics

Clinics that are hospital-based 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. The August 2006 update to the *Hospital Incident Command Guidebook*²³ 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 response to an incident

HICS can be used as a guide for clinics in developing their emergency management plan, but it is not a template or an emergency operations plan. For additional information on the use of HICS during surge events, see the *Reference Manual*, Section 4: "Emergency Management."

Additional HICS resources and training materials can be found at <http://www.hicscenter.org> and <http://www.emsa.ca.gov/HICS/>.

3.5. Relationship Between the Incident Command System and the Standardized Emergency Management System

The SEMS concept recommends that 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.

3.6. Community Surge Planning

According to the Joint Commission report, *Health Care at the Crossroads*: "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 . . . healthcare organizations."²⁴

Some emergencies can escalate unexpectedly and strain not only an organization but the entire community. In order to mitigate risks and sustain an effective response, a community care clinic must prepare its staff and collaborate with the community, suppliers, and external response partners. Such an approach will aid the organization in developing a scalable response capability and in defining the timing and criteria for decisions on sheltering in place, patient transfer, clinic closings, and evacuation.

The Bureau of Primary Health Care (BPHC) provides some of California's community care clinics with a Federally Qualified Health Center (FQHC) grant and/or a Federally Qualified Health Center Look-Alike designation. In exchange for the grants or designation, the Bureau of Primary Health Care provides their grantees or designees with program requirements to meet

on a variety of issues. In August 2007, the Bureau of Primary Health Care issued Program Information Notice (PIN) 2007-015 which outlined emergency management expectations for their grantees and designees. This PIN included the expectation for community planning efforts and asked clinics to develop relationships with public health departments and hospitals. For more information about BPHC PIN 2007-15, please visit:

<http://bphc.hrsa.gov/policy/pin0715/>.

Community care clinics should monitor Joint Commission standards and the standards of the Accreditation Association for Ambulatory Health Care (<http://www.aaahc.org>) to stay abreast of changing reporting requirements as it relates to emergency preparedness. The following chart outlines the Joint Commission’s recommendations for community-planning activities and the community organizations that should take action and be accountable for each result.²⁵

Joint Commission Recommendations:	
Tactics	Accountability
Initiate and facilitate the development of community-based emergency preparedness programs across the country.	<ul style="list-style-type: none"> • Municipalities • Emergency management agencies • Public health agencies • Healthcare providers
Constitute a community organization that comprises local government officials, emergency management officials, public health authorities, health care organizations, police, fire, public works (e.g., water, electricity), emergency Medical services, local industry leaders, and other key participants appropriate to the community to develop the community-wide emergency preparedness program.	<ul style="list-style-type: none"> • Community organization participants
Encourage the transition of community healthcare institutions from an organization-focused approach to emergency preparedness to one that encompasses the community.	<ul style="list-style-type: none"> • Community organization
Provide the community organization with necessary funding and other resources and hold it accountable for overseeing the planning, assessment, and maintenance of the preparedness program.	<ul style="list-style-type: none"> • Federal and state government agencies

<p>Encourage the pursuit of substantive collaborative activities that will also serve to bridge the gap between the Medical care and public health systems.</p>	<ul style="list-style-type: none"> • Health care and public health membership organizations • Federal government agencies
<p>Develop and distribute emergency planning and preparedness templates for potential adaptation by various types of communities.</p>	<ul style="list-style-type: none"> • Federal and state government agencies

In order to respond effectively, community care clinics, hospitals, and other healthcare provider organizations must be able to work both within their own organization and collaboratively as a cohesive local team during an emergency. These efforts should focus on integrating individual healthcare facilities, including community care clinics, with each other and with non-Medical organizations within each jurisdiction or Operational Area. Local coalitions should convene planning groups and are encouraged to include representatives from the following organizations to participate. This list is not meant to be definitive or limiting but serves as a suggested guide of representatives to include in preparedness planning.

- Public health department Public Health Emergency Preparedness Coordinators
- Healthcare facilities, including hospitals, community care clinics, and long-term health care facilities
- The Medical/Health Operational Area Coordinator or other appropriate designee
- Regional Disaster/Medical Health Coordinator or other appropriate designee
- Local emergency medical services agencies
- The Operational Area Emergency Operations Center staff
- First responders, including law enforcement, fire, public and private ambulance providers, metropolitan Medical response system, and hazardous materials resource teams
- Local emergency management systems (e.g., local Office of Emergency Services, Disaster Councils, etc.)
- Regional disaster Medical health specialists
- Mental health programs
- Private sector healthcare professionals
- Poison control
- Regional and county clinic councils or associations
- Maternal and child health programs
- Universities and community colleges
- County Medical societies

- Tribal entities, especially tribal health programs and health centers
- Veterans Health Administration
- Social services agencies
- Large employers or other private entities that may impact the emergency response (e.g., federal Indian Health Services working with Indian owned casinos and other tribal enterprises on tribal land as well as representatives from those enterprises, clinics in a business complex working with the complex's security to establish perimeters)
- Others as relevant

The CNA Corporation, a non-profit research organization that operates the Center for Naval Analysis and the Institute for Public Research, reports that, " Research has shown that most individual healthcare facilities possess limited surge supplies, staff, and equipment, and that vendors or anticipated 'backup systems' for these critical assets are often shared among local and regional healthcare facilities. This 'double counting' of resources diminishes the ability to meet individually projected surge demands across multiple institutions during a healthcare surge."²⁶

Therefore, community partners such as those listed on the previous page must collaboratively develop plans to increase jurisdictional capacity.

Collaborative planning does not preclude or diminish the need for individual community care clinics to have a comprehensive emergency management program that addresses mitigation, preparedness, response, and recovery activities. To ensure the clinic is an active participant in the community planning process, those involved with clinic emergency planning should identify key contacts within their Operational Area prior to an emergency. Contact information for the following organizations should be maintained in the clinic's emergency operations plan:

- Public health department and Local Health Officer
- Medical/Health Operational Area Coordinator or other appropriate designee (for more information, see *Foundational Knowledge*, Section 3.10.6: "Medical Health Operational Area Coordinator")
- Local Emergency Medical Services Agency Administrator and Medical Director
- Operational Area Emergency Operations Center staff

To integrate with other public and private healthcare and non-healthcare assets in the community, clinics should consider developing Memoranda of Understanding to formalize partnerships to assist in managing the treatment of patients during a healthcare surge.

3.6.1. Clinic Expansion vs. Government-Authorized Alternate Care Sites

When a catastrophic emergency occurs, patients requiring care will be transported to or seek care at local healthcare facilities. As time passes, these healthcare facilities may experience an influx of patients that exceeds capacity. When this occurs, there are two ways to address the increased demand for healthcare: 1) expand existing healthcare facilities to increase capacity for patient care, or 2) establish temporary healthcare facilities to provide care in non-traditional healthcare locations.

Clinic expansion involves the immediate steps required to increase capacity in order to meet the needs of an increase in patient load, which include converting parking lots, storage areas, conference rooms, etc. into temporary facilities for patient care. Community care clinics should activate emergency operations plans and mobilize to manage the actual or anticipated influx of patients and the increased resource demand. If conditions within clinics are sufficiently strained, clinics may consult with state regulatory agencies to determine if specific requirements related to staffing and patient management can be flexed to expand the clinic's response capabilities.

Upon facility overload, individuals may be transferred to other healthcare facilities within the jurisdiction. When the healthcare resources within the jurisdiction are overwhelmed, state and/or federal resources will be requested through the SEMS/NIMS structure to help alleviate the patient demand on the local healthcare system. When it is anticipated that all other healthcare resources will be exhausted, government-authorized alternate care sites may be established.

A government-authorized alternate care site is defined as:

A location that is not currently providing healthcare services and will be converted 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) but rather are designated under the authority of 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 health facilities) can manage the demands for patient care. 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 community care clinics and their staff may play in a response effort, see *Volume II: Government-Authorized Alternate Care Sites*.

When the demand for patient care within the system subsides and there is no ongoing healthcare surge increased capacity need, patients will either be discharged or transported back to existing facilities for continued care, and the alternate care site will be closed.

3.7. Developing a Hazard Vulnerability Analysis

The Hazard Vulnerability Analysis is a needs assessment which facilitates the development of an organization's emergency preparedness program and is required by the Bureau of Primary Healthcare. Conducting a Hazard Vulnerability Analysis involves identifying all hazards that may affect a community care 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. The vulnerability relates to both the impact on organizational function (staff, suppliers, operational systems, infrastructure, and the like) and the service demands created by the hazard impact.

It is strongly recommended that all clinics consider adopting the following principles and practices, even if a clinic is not required to conduct a Hazard Vulnerability Analysis. The National Association of Community Health Centers (NACHC) provides guidance for clinics on conducting a Hazard Vulnerability Analysis. This guidance is available at <http://www.nachc.com/client/documents/HVA%2012.16.08.pdf>.

*Emergency Management Principles and Practices for Healthcare Systems*²⁷ includes the following points to illustrate how the nature of a community care clinic contributes to its 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.

The diagrams that follow are an example of a Hazard Vulnerability Analysis, which identifies the risk of the catastrophic emergency by quantifying the probability of disaster occurrence and then estimating its potential severity. Community care clinics can use this information to assess which hazards are most likely to impact their specific facility in order to focus preparedness and mitigation activities on those hazards with the highest relative threat.

A Sample Hazard Vulnerability Analysis is shown below. The complete tool can be found in the *Community Care Clinics Operational Tools Manual* on pages 17-23.

Hazard Vulnerability Analysis

This document is a sample Hazard Vulnerability Analysis tool. It is not a substitute for a comprehensive emergency preparedness program. Individuals or organizations using this tool are solely responsible for any hazard assessment and compliance with applicable laws and regulations.

INSTRUCTIONS:

Within the analysis there are four categories used to calculate the potential impact of each hazard. These are:

- Probability
- Magnitude
- Mitigation
- Risk

The first three categories use a point system for each hazard, ranging from zero (N/A) to three (high). The last category, risk, is calculated based on the points given in the first three categories. This calculation is explained below.

Issues to consider for probability include:

- Known risk
- Historical data
- Manufacturer/vendor statistics

Issues to consider for magnitude include:

- Human Impact:
 - Potential for staff death or injury
 - Potential for patient death or injury
- Property Impact:
 - Cost to replace
 - Cost to set up temporary replacement
 - Cost to repair
 - Time to recover
- Business Impact:
 - Business interruption
 - Employees unable to report to work
 - Customers unable to reach facility
 - Company in violation of contractual agreements
 - Imposition of fines and penalties or legal costs
 - Interruption of critical supplies
 - Interruption of product distribution
 - Reputation and public image
 - Financial impact/burden

Issues to consider for mitigation include:

- Preparedness
 - Status of current plans
 - Frequency of drills
 - Training status
 - Insurance
 - Availability of alternate sources for critical supplies/services
- Internal Response:
 - Time to marshal an on-scene response
 - Scope of response capability
 - Historical evaluation of response success
 - Types of supplies on hand
 - Volume of supplies on hand
 - Staff availability
 - Coordination with any medical office buildings (e.g., doctors' offices and clinics)

- Availability of back-up systems
- Internal resources ability to withstand disasters/survivability
- Types of agreements with community agencies/drills
- Coordination with proximal healthcare facilities
- Coordination with treatment specific facilities
- External Response:
 - Coordination with local and state agencies
 - Community resources

The risk associated with each hazard, or the relative threat of each hazard to the organization, can be calculated using the following equation: Risk = Probability X Severity, where Severity is Magnitude - Mitigation.

DRAFT

Hazard Vulnerability Analysis - Natural Hazards

EVENT	PROBABILITY	SEVERITY = (MAGNITUDE - MITIGATION)						RISK
		HUMAN IMPACT	PROPERTY IMPACT	BUSINESS IMPACT	PREPARED-NESS	INTERNAL RESPONSE	EXTERNAL RESPONSE	
	<i>Likelihood this will occur</i>	<i>Possibility of death or injury</i>	<i>Physical losses and damages</i>	<i>Interuption of services</i>	<i>Preplanning</i>	<i>Time, effectiveness, resouces</i>	<i>Community/ Mutual Aid staff and supplies</i>	<i>Relative threat*</i>
SCORE	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = High 2 = Moderate 3 = Low or none	0 = N/A 1 = High 2 = Moderate 3 = Low or none	0 = N/A 1 = High 2 = Moderate 3 = Low or none	0 - 100%
Hurricane								0%
Tornado								0%
Severe Thunderstorm								0%
Snow Fall								0%
Blizzard								0%
Ice Storm								0%
Earthquake								0%
Tidal Wave								0%
Temperature Extremes								0%
Drought								0%
Flood, External								0%
Wild Fire								0%
Landslide								0%
Dam Inundation								0%
Volcano								0%
Epidemic								0%
AVERAGE SCORE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0%

*Threat increases with percentage.

RISK = PROBABILITY * SEVERITY
0.00 0.00 0.00

Hazard Vulnerability Analysis - Technologic Events

EVENT	PROBABILITY <i>Likelihood this will occur</i>	SEVERITY = (MAGNITUDE - MITIGATION)						RISK <i>Relative threat*</i>
		HUMAN IMPACT <i>Possibility of death or injury</i>	PROPERTY IMPACT <i>Physical losses and damages</i>	BUSINESS IMPACT <i>Interruption of services</i>	PREPARED-NESS <i>Preplanning</i>	INTERNAL RESPONSE <i>Time, effectiveness, resources</i>	EXTERNAL RESPONSE <i>Community/ Mutual Aid staff and supplies</i>	
SCORE	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = High 2 = Moderate 3 = Low or none	0 = N/A 1 = High 2 = Moderate 3 = Low or none	0 = N/A 1 = High 2 = Moderate 3 = Low or none	0 - 100%
Electrical Failure								0%
Generator Failure								0%
Transportation Failure								0%
Fuel Shortage								0%
Natural Gas Failure								0%
Water Failure								0%
Sewer Failure								0%
Steam Failure								0%
Fire Alarm Failure								0%
Communications Failure								0%
Medical Gas Failure								0%
Medical Vacuum Failure								0%
HVAC Failure								0%
Information Systems Failure								0%
Fire, Internal								0%
Flood, Internal								0%
Hazmat Exposure, Internal								0%
Supply Shortage								0%
Structural Damage								0%
AVERAGE SCORE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0%

*Threat increases with percentage.

RISK = PROBABILITY * SEVERITY
0.00 0.00 0.00

Hazard Vulnerability Analysis - Human-Related Events

EVENT	PROBABILITY	SEVERITY = (MAGNITUDE - MITIGATION)						RISK
		HUMAN IMPACT	PROPERTY IMPACT	BUSINESS IMPACT	PREPAREDNESS	INTERNAL RESPONSE	EXTERNAL RESPONSE	
	<i>Likelihood this will occur</i>	<i>Possibility of death or injury</i>	<i>Physical losses and damages</i>	<i>Interruption of services</i>	<i>Preplanning</i>	<i>Time, effectiveness, resources</i>	<i>Community/Mutual Aid staff and supplies</i>	<i>Relative threat*</i>
SCORE	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = High 2 = Moderate 3 = Low or none	0 = N/A 1 = High 2 = Moderate 3 = Low or none	0 = N/A 1 = High 2 = Moderate 3 = Low or none	0 - 100%
Mass Casualty Incident (trauma)								0%
Mass Casualty Incident (medical/infectious)								0%
Terrorism, Biological								0%
VIP Situation								0%
Infant Abduction								0%
Hostage Situation								0%
Civil Disturbance								0%
Labor Action								0%
Forensic Admission								0%
Bomb Threat								0%
AVERAGE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0%

*Threat increases with percentage.

RISK = PROBABILITY * SEVERITY
0.00 0.00 0.00

Hazard Vulnerability Analysis - Events Involving Hazardous Materials

EVENT	PROBABILITY	SEVERITY = (MAGNITUDE - MITIGATION)						RISK
		HUMAN IMPACT	PROPERTY IMPACT	BUSINESS IMPACT	PREPARED-NESS	INTERNAL RESPONSE	EXTERNAL RESPONSE	
		<i>Likelihood this will occur</i>	<i>Possibility of death or injury</i>	<i>Physical losses and damages</i>	<i>Interruption of services</i>	<i>Preplanning</i>	<i>Time, effectiveness, resources</i>	
SCORE	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = Low 2 = Moderate 3 = High	0 = N/A 1 = High 2 = Moderate 3 = Low or none	0 = N/A 1 = High 2 = Moderate 3 = Low or none	0 = N/A 1 = High 2 = Moderate 3 = Low or none	0 - 100%
Mass Casualty Hazmat Incident (From historic events at your MC with >= 5 victims)								0%
Small Casualty Hazmat Incident (From historic events at your MC with < 5 victims)								0%
Chemical Exposure, External								0%
Small-Medium Sized Internal Spill								0%
Large Internal Spill								0%
Terrorism, Chemical								0%
Radiologic Exposure, Internal								0%
Radiologic Exposure, External								0%
Terrorism, Radiologic								0%
AVERAGE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0%

*Threat increases with percentage.

RISK = PROBABILITY * SEVERITY
0.00 0.00 0.00

The Hazard Vulnerability Spreadsheet can be found online at the website of the California EMS Authority:
http://www.calhealth.org/public/press/Article%5C103%5CHazard%20%20vulnerability%20Analysis_kaiser_model.xls.

4. Community Care Clinic Emergency Management

Emergency management is defined as “a program that implements the organization’s mission, vision, management framework, and strategic goals and objectives related to emergencies. 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.”²⁸ The emergency management program is applicable to all functions, departments, and units within the organization that have defined roles in responding to a potential emergency. Emergency management standards provide community care clinics with a structure for the development of emergency management programs, including emergency management plans, to adequately prepare and effectively respond to a catastrophic event. These emergency management standards, while promulgated by a variety of organizations, have many commonalities and some of the standards most critical to surge planning are described in this section.

Building a clinic emergency management program includes the development of an emergency operations plan. The emergency operations plan provides the structure, defines the processes, and outlines the activities clinics may use during a response to and recovery from any event that could severely challenge or exceed the normal healthcare system management and/or operations. The clinic emergency management program provides clinics with an understanding of activities the organizations can implement during an emergency response while continuing an effective interface with outside emergency response systems.

The following sections outline the components of emergency management programs listed in:

- Federal Health Resource and Services Administration Policy Information Notice 2007-15 (HRSA PIN 2007-15)
- Joint Commission Environment of Care Standards and Accreditation Association for Ambulatory Health Care (AAAHC) Guidelines for Clinics
- National Fire Protection Association Emergency Planning Standards (NFPA 99)
- California Code of Regulations (Title 22)

4.1. Health Resource and Services Administration (HRSA PIN 2007-15)

The Health Resource and Services Administration Policy Information Notice 2007-15 (HRSA PIN 2007-15) informs clinics of emergency management expectations regarding planning and preparing for future emergencies. A health center’s core planning and preparation

responsibilities are to protect patients and staff while preserving its ability to continue healthcare delivery.

This PIN applies to Federally Qualified Health Center (FQHC) Look-alikes as well as clinics funded under the Health Center Program authorized in section 330 of the Public Health Service (PHS) Act (42 U.S.C. 254b), as amended, specifically: Community Health Center (CHC) Programs, funded under section 330(e); Migrant Health Center (MHC) Programs, funded under section 330(g); Health Care for the Homeless (HCH) Programs, funded under section 330(h); and Public Housing Primary Care (PHPC) Programs, funded under section 330(i).

These clinics are expected to maintain policies and procedures that anticipate possible future risks. The following guidance is addressed in PIN 15:

- **Emergency management planning:** An emergency management plan (EMP) is critical to minimizing the disruption in patient service, ensuring the health center's ongoing well-being, and linking the health center to the local community response in the event of an emergency. Clinics should engage in an ongoing planning process to ensure that EMPs are appropriate.
 - The EMP should address the four phases of emergency management:
 - Mitigation
 - Preparedness
 - Response
 - Recovery
 - EMPs should address the following components, as appropriate:
 - Continuity of operations
 - Command and control
 - Staffing
 - Surge patients
 - Medical and non-medical supplies
 - Pharmaceuticals
 - Security
 - Evacuation
 - Decontamination
 - Isolation
 - Power supply
 - Transportation
 - Water/Sanitation
 - Communications
 - Medical records security and access

- **Linkages and collaborations:** It is critical that clinics establish linkages and collaborations with other community organizations. This integration with the emergency management system at the state, local, and community level should be outlined in the EMP.
- **Communications and information sharing:** During an emergency, clinics may not have access to standard communication systems, thus a well defined communications plan will be critical to an effective EMP. The EMP should identify the health center's policies and procedures for communicating with internal (staff, patients, special populations, governing board) and external (appropriate federal, state, local, and tribal agencies) stakeholders as well as with the public during emergencies.
- **Maintaining financial and operational stability:** Clinics are likely to face many obstacles in their efforts to regain financial stability after an emergency. Adequate planning prior to the emergency will minimize the time it takes for the health center to recover and become fully operational. Clinics should develop business plans to address the financial response to an emergency, including goals for maintaining cash reserves and plans to insure against business interruptions and property loss. Preserving operational records and documents will also be critical to resumption of operations during and after an emergency. Clinics should have backup systems to ensure that electronic financial and medical records will be available.

For more information about BPHC PIN 2007-015, please visit <http://bphc.hrsa.gov/policy/pin0715/>.

4.2. Joint Commission Environment of Care Standards and AAAHC Guidelines for Community Care Clinics

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.

An emergency which impacts a healthcare organization or its community can suddenly and significantly affect demand for its services or its ability to provide those services. The organization's emergency management program defines a comprehensive approach to identifying risks and mobilizing an effective response within the organization and in collaboration with essential response partners in the community.

- **Joint Commission - Environment of Care 4.12:** The organization develops and maintains an emergency operations plan.
- **AAAH - Chapter 8, Facilities and Environment:** The organization has a comprehensive emergency plan to address internal and external emergencies.

A successful response relies on adequate planning in six critical areas: communications, resources and assets, safety and security, staffing, utilities, and clinical activities. While the emergency operations plan can be formatted in a variety of ways, it must address these six critical areas to serve as a blueprint for managing care and safety during an emergency.

- **Joint Commission - Environment of Care 4.14:** The organization establishes strategies for managing resources and assets during emergencies.
- **AAAH - Chapter 4, Quality of Care Provided:** A credible organization provides healthcare services in accordance with the principles of professional practice and ethical conduct.

During emergencies, healthcare providers who continue to provide care, treatment, and services to their patients must sustain essential resources, materials, and facilities. The emergency operations plan should identify how resources and assets will be solicited and acquired from a range of possible sources, including vendors, neighboring healthcare providers, other community organizations, state affiliates, or a regional parent company.

4.3. National Fire Protection Association Standards (NFPA 99 and NFPA 1600)

National Fire Protection Association (NFPA) emergency planning standards have gained international recognition and consensus between the public and private sectors. The standards are voluntary but carry significant credibility across disciplines, including the healthcare industry.

Two major NFPA emergency planning standards apply to community care clinics:

- NFPA 99: Standard for Healthcare Facilities
- NFPA 1600: Standard on Disaster/Emergency Management and Business Continuity Programs

NFPA Standard 99 establishes minimum criteria for healthcare facilities in the development of a program for effective disaster preparedness, response, mitigation, and recovery. NFPA Standard 1600 articulates the generic elements of disaster preparedness programs and serves

as the basis for emergency management program evaluation and accreditation by state, local, and tribal governments.

The 9/11 Commission recommends that NFPA Standard 1600 be adopted by the private sector and that insurance and credit-rating industries look closely at a company's compliance with the NFPA standard in assessing its insurability and creditworthiness. The 9/11 Commission further recommends that compliance with the NFPA standards should define the standard of care a company provides to its employees and the public for legal purposes.

*National Fire Protection Association 99: Standard for Healthcare Facilities*²⁹

National Fire Protection Association (NFPA) Standard 99 establishes criteria for minimizing the hazards of fire, explosion, and electricity in healthcare facilities providing services to human beings. The 2005 revision to *NFPA 99, Standard for Health Care Facilities* Chapter 12, "Health Care Emergency Management", incorporated the "program" emphasis of NFPA 1600, serving to differentiate an "emergency management program" for healthcare systems from the current emphasis by other standards on an "emergency management plan." This chapter defines minimum criteria for healthcare facility emergency management in the development of a program for effective disaster preparedness, response, mitigation, and recovery, which includes the following:

- Each healthcare organization will have plans necessary to respond to a disaster or emergency and will have an individual or group (Emergency Management Committee) with the authority for developing, implementing, exercising, and evaluating an emergency management program.
- The Emergency Management Committee will model the emergency operations plan on an Incident Command System in coordination with local emergency response agencies.
- When a facility declares itself in disaster mode, or when a state of emergency exists, the emergency operations plan will be activated.
- All personnel designated or involved in the emergency operations plan of the healthcare facility will be supplied with a means for identification including specific identification for Incident Command System staff (i.e., vests).
- Healthcare facilities will establish contingency plans for the continuity of essential building systems.
- Planning shall include the alerting and managing of all staff and employees in a disaster.
- Planning shall include provisions for patient management.
- Planning shall include minimum stockpiling or ensuring immediate and uninterrupted access to critical materials such as pharmaceuticals, Medical supplies, food, linens, and water.
- Planning shall include provisions to meet the security needs of the facility.

- The facility shall have plans to restore operational capability.
- Facilities shall have an educational program with an overview of the emergency management program and components of the Incident Command System.
- The emergency management program shall include drills of the emergency operations plans including one mass casualty event.

National Fire Protection Association 1600: Standard on Disaster/Emergency Management and Business Continuity Programs³⁰

According to National Fire Protection (NFPA) Standard 1600, the emergency management program should include the following elements to prevent, mitigate, prepare for, respond to, and recover from disasters and emergencies:

- The entity shall implement a strategy for addressing the need for revisions due to legislation, regulations, directives, policies, and industry codes of practice.
- The entity shall identify hazards; monitor those hazards, the likelihood of their occurrence, and the vulnerability of people, property, the environment, and the entity itself to those hazards.
- The entity shall conduct an impact analysis to determine potential detrimental impacts of the hazards on the health and safety of persons in the affected area at the time of the incident (injury and death) and that of personnel responding to the incident.
- The entity shall develop a strategy to prevent an incident that threatens people, property, and the environment.
- The entity shall develop and implement a mitigation strategy that includes measures to be taken to limit or control the consequences, extent, or severity of an incident that cannot be reasonably prevented.
- The entity shall establish resource management objectives consistent with the overall program goals and objectives for identified hazards and procedures to locate, acquire, store, distribute, maintain, test, and account for services, personnel, resources, materials, and facilities procured or donated to support the program.
- The need for mutual aid/assistance shall be determined and, as needed, agreements shall be established.
- The program shall follow a planning process that develops plans for the strategy, prevention, mitigation, emergency operations and response, business continuity, and recovery.
- The entity shall develop an incident management system to direct, control, and coordinate response and recovery operations.
- Communications systems shall be established and regularly tested to support the program.

- The entity shall develop, coordinate, and implement operational procedures to support the program and execute its plans.
- The entity shall establish a primary and an alternate emergency operations center (physical or virtual) capable of managing continuity, response, and recovery operations.
- The entity shall develop and implement a training/educational curriculum to support the program.
- The entity shall evaluate program plans, procedures, and capabilities through periodic reviews, testing, and exercises.
- The entity shall develop procedures to disseminate and respond to requests for pre-incident, incident, and post-incident information, as well as to provide information to internal and external audiences, including the media, and deal with their inquiries.
- The entity shall develop financial and administrative procedures to support the program before, during, and after an emergency or a disaster.

4.4. California Code of Regulations Title 22, Division 5: Licensing and Certification of Health Facilities, Home Health Agencies, Clinics, and Referral Agencies

22 CCR 75057 requires licensed healthcare clinics, as a condition of licensure, to develop and maintain a written disaster program and instruct clinic personnel as to its requirements.

The program should cover disasters occurring in the community as well as widespread disasters and provide for, at least, the following:

- The program shall provide plans for disasters occurring within the facility. The written program shall include at least the following:
 - Administrative procedures, including designated authority and staff duty assignments. There shall be provisions for simulated fire drills at least semi-annually and records to indicate that such drills were conducted.
 - Plans for evacuation of patients when necessary, including means of egress, methods of handling and transporting patients, and disposition and care of patients after removal.
- The program shall be reviewed annually and updated as needed.

While some community care clinics are exempt from state licensure (e.g., tribal clinics), development and ongoing revision of a written disaster and mass casualty plan is a positive practice for all community care clinics.

5. Managing Facility Space and Operations During a Healthcare Surge

During a healthcare surge, it is likely that community care clinics will face facility space and operational challenges. Patient care capacity may be expanded to set up care areas for the influx; this may impact a clinic's ability to comply with certain regulatory requirements and standards, including:

- Facility capacity
- Space conversion
- Infection control
- Decontamination
- Hazardous waste management
- Medical waste management
- Fatality management
- Structural safety
- Pharmaceutical

A clinic's ability to accommodate a healthcare surge will depend on the clinic configuration and the availability of assets. Initially, community care clinics may surge within their own facility, then to their organizational assets (affiliated clinics, hospitals, long-term care facilities), next to other healthcare facilities inside and outside of their system, and lastly to government-authorized alternate care sites.

5.1. Increasing Surge Capacity in Community Care Clinics

If a community care clinic determines it is experiencing a healthcare surge, it should use the following guidelines to assess, prepare, and mobilize to meet the need for increased patient care capacity.³¹

- Establish a triage call center to assist patients in determining whether it is appropriate for them to come to the clinic for evaluation.
- Triage at the door to separate the worried well from the critically ill or injured.
- Reprioritize services; cancel non-urgent appointments.
- Reprioritize staff; shift staff from non-urgent dental, optometry, and health education services to support acute care.
- Reallocate resources; move staff from non-impacted sites or areas of the clinic to impacted sites and services.

- Provide all medication refills by phone.
- Streamline clinical services by implementing standing orders for nursing and Medical assistants to pre-order tests, provide monitoring, or record vital signs.
- Streamline clinician time by allocating staff to provide all case management, education, dispensing, and follow-up.
- Extend clinic hours and/or stagger shifts to both expand capacity and decrease the number of individuals in the clinic at any one time.

Community care clinics should identify specific areas and spaces that might be opened and/or converted for use as patient treatment areas. These potential treatment areas may include:

- Waiting rooms
- Conference rooms
- Storage areas
- Medical office buildings
- Temporary shelters on facility premises (e.g., cots in tents)

Procedures for accomplishing clinic expansion should be included in the clinic's emergency operations plan. Areas should be selected according to the intensity of the incident and the anticipated number of healthcare surge patients a clinic may receive. Collaboration with local emergency operations centers, emergency Medical services, and first responders will provide clinics with the necessary information to establish the appropriate number of outpatient and inpatient healthcare surge capacity treatment areas.

5.2. Patient Management

5.2.1. Patient Transfer from Hospitals to Community Care Clinics and from Community Care Clinics to Hospitals

In some circumstances, hospital emergency departments may need to divert patients to alternative triage sites, urgent care clinics, or primary care clinics to reserve the emergency department for life-threatening emergencies. During surge events, a community care clinic may also need to transfer patients to other facilities to meet the demand for patient care. Clinic emergency operations plans should incorporate both of these scenarios into their plans and determine the point at which patient transfers are coordinated through the Unified Command structure to ensure coordination of response efforts.

The patient-transferring healthcare facility (community care 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.

5.3. Community Care Clinic Space Use Requirements and Existing Flexibility

This section provides an overview of the current compliance requirements for the use of expanded patient care areas as well as a list of applicable waivers and available liability protections.

5.3.1. Space Conversion

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

22 CCR 75072 requires that licensed primary care clinics have space designated to specific uses per licensure. Mobile clinics are exempt from this regulation, per the California Health and Safety Code on Physical Plant requirements.

5.3.2. Flexibility for Clinic Expansion through Governor's Suspension

To the extent that existing program flexibility provisions would not adequately allow community care clinics to expand licensed capacity, to convert space for Medical use, or to waive structural safety standards during a surge, it may be necessary to invoke Government Code Section 8571. Government Code Section 8571 provides the Governor with the authority, during a state of emergency or a state of war emergency, to suspend any regulatory statute, any statute prescribing the procedure for conduct of state business, or the orders, rules or regulations of any state agency, where the Governor determines and declares that strict compliance with any statute, order, rule, or regulation would in any way prevent, hinder, or delay the mitigation of the effects of the emergency.

5.4. Structural Safety

Prior to any clinic expansion to meet the demand for patient care after an emergency, community care clinics must determine if the healthcare facility is structurally sound. The California Building Standards Code (24 CCR 102, Part 2, Volume 1) states that buildings or structures are structurally unsafe if they do not provide adequate egress, constitute a fire hazard, or are otherwise dangerous to human life. Any use of buildings or structures that constitute a hazard to safety, health, or public welfare by reason of inadequate maintenance, dilapidation, obsolescence, fire hazard, disaster, damage, or abandonment is an unsafe use. This code applies to all clinics.

California Health and Safety Code Section 129990 establishes the authority of the Office of Statewide Health Planning and Development (OSHPD) to order the vacating of any building or structure, including a clinic building or structure, found to have been in violation of OSHPD's adopted regulations. In addition, OSHPD may order use of the building or structure discontinued within the time prescribed upon the service of notice to the owner or other person having control or charge of the building and structure. Any owner or person having control of the building who makes a request within 15 days of receipt of the written notice is entitled to a hearing pursuant to California Government Code Section 11506.

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.

5.4.1. Facility Post-Disaster Status Assessment

It is recommended that community care clinics develop plans to determine whether a facility should continue operating or should be abandoned due to a degrading environment. These plans should identify designated staff to perform an immediate assessment which should include a list of "fatal deficiencies/flaws" that would trigger immediate evacuation. The following tools can be used by clinics to assess the safety and functionality of their facilities during and in response to a catastrophic event. Three separate tools, which offer varying levels of analysis that clinics can use based on the level of assessment, are provided.

These tools include:

- Facility Damage Report (Limited Assessment)
- Facility On-Site Damage/Operability Report (Comprehensive Assessment)
- Facility System Status Report

The Facility Damage Report is a high-level assessment of the structural integrity of a facility during a catastrophic emergency. This tool is to be completed by the clinic representative in consultation with CDPH Licensing and Certification District Office.

The Facility Damage Report (Limited Assessment) is shown below. The complete tool can be found in the *Community Care Clinics Operational Tools Manual* on pages 24-25.

Facility Damage Report (Limited Assessment)

Facility Name & Type: _____

Address: _____

Date and Time report given: _____ Census: _____

Contact Person: _____ Title/Location: _____

Preferred Contact Method: _____ Preferred Contact Number: _____

Complete the worksheet through interview or fax to facility completion and return ASAP.

#	Answer:	Questions:	Comments:
1	Y/N Partial	Can you provide essential patient care? (routine as well as management of injuries or disaster-related conditions, if any)	
2	Y/N Partial	Is your facility intact? (structural integrity intact, no obvious damage, access to all areas)	
3	Y/N Partial	Are essential services intact? (power, water, gas, communication)	
4	Y/N Partial	Do you have adequate staff, supplies and equipment for the next 72 hours? (food, water, medicines, O2, hygiene, fuel)	

5	Y/N Unsure	Can you function without assistance for the next 72 hours?	
---	---------------	--	--

If the answer to any question is “Partial” or “No,” the CDPH Licensing and Certification District Office will ask the clinic to describe its plan for resolving the issue. If clinic is preparing to evacuate, the Licensing and Certification District Office monitors the implementation of the clinic’s emergency response plans, including evacuation as necessary and offers assistance with relocation if necessary.

The district office contact information is available at:

<http://www.cdph.ca.gov/certlic/facilities/Pages/LCDistrictOffices.aspx>

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

The Facility On-Site Damage/Operability Report (Comprehensive Assessment) is a comprehensive assessment that will aid in the decision for keeping a community care clinic open or evacuating patients and staff. A partial to total evacuation should be considered if the overall damage assessment is yellow or red. This tool should be completed by a clinic representative in consultation with CDPH Licensing and Certification local District Office, however it is important to note that the Office of Statewide Health Planning and Development (OSHPD) has overriding legal authority regarding the structural integrity of facilities.

The Facility On-Site Damage/Operability Report (Comprehensive Assessment) is shown below. The complete tool can be found in the *Community Care Clinics Operational Tools Manual* on pages 26-28.

Facility On-Site Damage/Operability Report (Comprehensive Assessment)

Facility Name: _____ Date of Visit: _____

Address: _____ Evaluator Names: _____

City: _____

Overall Damage Assessment:

(See OSHPD Placards*) GREEN YELLOW RED

AVAILABLE EXAM ROOMS: MALE FEMALE

PATIENT EVACUATION ORDERED BY: _____ TITLE: _____

TYPE OF EVACUATION: TOTAL PARTIAL

BUILDING	YES	NO
PARTIAL COLLAPSE		
TOTAL COLLAPSE		
PHOTOS TAKEN		

COMMUNICATIONS	YES	NO
EXTERNAL		
INTERNAL		
ELEVATORS OPERATIONAL		

WATER AVAILABILITY	YES	NO
FROM UTILITY		
DRINKING WATER		
HOT WATER		

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

SUPPLIES	YES	NO
FOOD		
MEDICATIONS		
MEDICAL SUPPLIES		
OTHER SUPPLIES		

STAFF AVAILABILITY	YES	NO
ADMINISTRATION		
NURSING		

EVALUATOR COMMENTS AND DIAGRAM (IF NECESSARY):

Recommend Referral To: _____

*Green: Habitable, minor or no damage

Yellow: Damage which represents some degree of threat to occupants

Red: Not habitable, significant threat to life safety

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

The Hospital Incident Command System (HICS) provides a tool (Form 251) to thoroughly assess facility status for the operational period of the incident. Per HICS instructions, it should be completed by the person(s) designated as the Infrastructure Branch Director at the start of the operational period, as conditions change, or more frequently as indicated by the situation. Additional guidance, including instructions, is available through the HICS Guidebook which can be found through the Emergency Medical Services Authority website, <http://www.emsa.ca.gov/>.

The HICS Facility System Status Report supports periodic reporting on facility status during an emergency or healthcare surge. The form should be completed at regular intervals and disseminated to facility leadership to keep key decision-makers informed of facility operational status during an emergency.

The Facility System Status Report is shown below. The complete tool can be found in the *Community Care Clinics Operational Tools Manual* on pages 29-34.

Facility System Status Report

Instructions

Purpose: Record facility status for operational period for incident

Origination: Infrastructure Branch Director

Original to: Situation Unit Leader.

Copies to: Operations Section Chief, Business Continuity Branch Director, Planning Section Chief, Safety Officer, Liaison Officer, and Documentation Unit Leader

Print legibly and enter complete information.

- 1. OPERATIONAL PERIOD DATE/TIME:** Identify the operational period during which this information applies. This is the time period established by the clinic's Incident Commander, during which current objectives are to be accomplished and at the end of which they are evaluated. For example, a 12-hour operational period might be 2006-08-16 18:00 to 2006-08-17 06:00.
- 2. DATE PREPARED:** Use the international standard date notation YYYY-MM-DD, where YYYY is the year, MM is the month of the year between 01 (January) and 12 (December), and DD is the day of the month between 01 and 31. For example, the fourteenth day of February in the year 2006 is written as 2006-02-14.
- 3. TIME PREPARED:** Use the international standard notation hh:mm, where hh is the number of complete hours that have passed since midnight (00-24), and mm is the

number of complete minutes that have passed since the start of the hour (00-59). For example, 5:04 PM is written as 17:04. Use local time.

4. **BUILDING NAME:** Provide name or other identifier of building for which this status report is being prepared.
5. **SYSTEM STATUS CHECKLIST:** For each system listed, use the following definitions to assign operational status:
 - Fully functional:** 100% operable with no limitations
 - Partially functional:** Operable or somewhat operable with limitations
 - Non-functional:** Out of commission

Comment on location, reason, and time/resource estimates for necessary repair of any system that is not fully operational. If inspection is completed by someone other than as defined by policy or procedure, identify that person in the comments.
6. **CERTIFYING OFFICER:** Use proper name and identify the position title of the person preparing this form.
7. **FACILITY NAME:** Use when transmitting the form outside of the clinic.

When to Complete: At start of operational period, as conditions change, or more frequently as indicated by the situation.

Helpful Tips: Data may be obtained from inspections by Infrastructure staff. The community care clinic representatives determine overall facility functionality.

FACILITY SYSTEM STATUS REPORT

1. Operational Period Date/Time		2. Date Prepared	3. Time Prepared	4. Building Name:
5. SYSTEM STATUS CHECKLIST				
COMMUNICATION SYSTEM	OPERATIONAL STATUS	COMMENTS <i>(If not fully operational/functional, give location, reason, and estimated time/resources for necessary repair. Identify who reported or inspected.)</i>		
Fax	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional			
Information Technology System (email/registration/patient records/time card system/intranet, etc.)	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional			
Paging - Public Address	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional			
Radio Equipment	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional			

Satellite System	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional	
Telephone System, External	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional	
Telephone System, Proprietary	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional	
Video-Television-Internet-Cable	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional	
Other	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional	
INFRASTRUCTURE SYSTEM	OPERATIONAL STATUS	COMMENTS (If not fully operational/functional, give location, reason, and estimated time/resources for necessary repair. Identify who reported or inspected.)
Ingress/Egress	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional	
Fire Detection/Suppression System	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional	
Food Preparation Equipment	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional	
Ice Machines	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional	
Structural Components (building integrity)	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional	
Other	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional	
PATIENT CARE SYSTEM	OPERATIONAL STATUS	COMMENTS (If not fully operational/functional, give location, reason, and estimated time/resources for necessary repair. Identify who reported or inspected.)
Ethylene Oxide (EtO)/Sterilizers	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional	
Isolation Rooms (positive/negative air)	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional	
Other	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional	

SECURITY SYSTEM	OPERATIONAL STATUS	COMMENTS (If not fully operational/functional, give location, reason, and estimated time/resources for necessary repair. Identify who reported or inspected.)
Door Lock-down Systems	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional	
Surveillance Cameras	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional	
Other	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional	
UTILITIES, EXTERNAL SYSTEM	OPERATIONAL STATUS	COMMENTS (If not fully operational/functional, give location, reason, and estimated time/resources for necessary repair. Identify who reported or inspected.)
Electrical Power-Primary Service	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional	
Sanitation Systems	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional	
Water	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional	(Reserve supply status)
Natural Gas	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional	
Other	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional	
UTILITIES, INTERNAL SYSTEM	OPERATIONAL STATUS	COMMENTS (If not fully operational/functional, give location, reason, and estimated time/resources for necessary repair. Identify who reported or inspected.)
Air Compressor	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional	
Electrical Power, Backup Generator	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional	(Fuel status)
Elevators/Escalators	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional	
Hazardous Waste Containment System	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional	
Heating, Ventilation, and Air Conditioning (HVAC)	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional	
Medical Gases, Other	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional	

Steam Boiler	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional	
Sump Pump	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional	
Well Water System	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional	
Vacuum (for patient use)	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional	
Water Heater and Circulators	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional	
Other	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional	
6. CERTIFYING OFFICER		
7. FACILITY NAME		

5.5. Infection Control

During recent decades, healthcare facilities across the nation have seen a steady increase in the risk of healthcare acquired infections. The risk of infection is even greater following a catastrophic event due to the dramatic increase in patient volume.

Community care clinics are an important resource for the continued functioning of a community. A clinic's ability to deliver care, treatment, and services is threatened when it is ill-prepared to respond to an epidemic or increased risk of infection. It is important, therefore, for a community care clinic to have emergency plans in place to prevent the introduction of infections, to quickly identify whether existing patients have become infected, and/or to contain the risk or spread of infection.

These emergency plans may include a broad range of options and changes in procedure, including the temporary halting of services and/or admissions, delaying transfer or discharge, limiting access to the clinic, or fully activating the clinic's emergency management plan. The actual response depends on many issues, such as the extent to which the community is impacted by the epidemic or infection, the types of services the clinic offers, and the clinic's capabilities.

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 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.

5.5.1. Cal/OSHA Infection Control Requirements

Cal/OSHA provides community care clinics with guidance on how to implement infection control programs. These standards, critical under normal operations, become increasingly important during an emergency, particularly one in which infectious material is prominent (e.g., pandemic influenza).

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. These requirements include, but are not limited to, guidelines for hygiene, personal protective equipment, and eye protection.

5.5.2. Infection Control for Pandemic Influenza

The following infection control principles apply in any setting where persons with pandemic influenza might seek and receive healthcare services. These principles should be considered during surge planning:

- Limit contact between infected and non-infected persons.
 - Isolate infected persons (i.e., confine patients to a defined area as appropriate for the healthcare setting).
 - Limit contact between nonessential staff and other persons (e.g., social visitors) and patients who are ill with pandemic influenza.
 - Promote spatial separation in common areas (i.e., sit or stand as far away as possible and at least three feet from potentially infectious persons) to limit contact between symptomatic and non-symptomatic persons.
- Protect persons caring for influenza patients in healthcare settings from contact with the pandemic influenza virus. Persons who must be in contact should:
 - Wear a surgical or procedure mask for close contact with infectious patients.
 - Use contact and airborne precautions, including the use of N95 respirators, when appropriate.
 - Wear gloves (gown if necessary) for contact with respiratory secretions.
 - Perform hand hygiene after contact with infectious patients.
- Contain infectious respiratory secretions.
 - Instruct persons who have “flu-like” symptoms to use respiratory hygiene/cough etiquette.
 - Promote use of masks by symptomatic persons in common areas (e.g., clinic waiting rooms, conference rooms) or when being transported (e.g., in emergency vehicles).

For additional information 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>.

5.5.3. Grouping Contaminated Patients

During any infectious disease outbreak, natural or bioterrorist, other respiratory viruses may be circulating concurrently in the community. To prevent cross-contamination of respiratory viruses, clinics should assign only patients with confirmed respiratory ailments of the same type to the same room. Clinics should:

- Implement grouping early in the course of an outbreak to accommodate an anticipated surge of patients.
- Identify areas to group patients and consult with facility engineers to identify ventilation systems that are not shared with other areas or rooms.

- Ensure that staff assigned to group units do not “float” or otherwise work in other patient care areas.
- Limit the staff members entering the group areas to those necessary for patient care and support.

5.6. Decontamination

Similar to infection control, community care clinics should have a plan or program for radioactive, biological, and chemical isolation and decontamination as a component of their emergency management plan. Any planning should include recommendations for protecting healthcare professionals and managing patients in the event of a hazardous materials exposure. 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>.

To the extent that resources are available and community care clinics have the capability, the following recommendations should be considered:

- Clinics should establish relationships and notification procedures with appropriate local agencies (e.g., emergency Medical services, Office of Emergency Services, and public health department) in order to:
 - Facilitate communication between the agency and clinic.
 - Ensure that properly trained and equipped field/pre-clinic responders decontaminate patients in the field in order to protect the clinic as much as possible.
 - Understand the local protocols and capabilities for field decontamination of patients.
 - Ensure proper notification of a healthcare surge to appropriate local agencies.
- The primary roles of a community care clinic in a hazardous materials catastrophic emergency should be to:
 - Triage, treat, decontaminate, and Medically screen patients as necessary.
 - Work collaboratively with the community and local government to meet the challenges of a surge of contaminated patients.
 - Prepare clinics for potentially contaminated patients who self-refer and present to the clinic.
- Additional planning considerations may include:
 - Establishing a “fast track” decontamination line for patients with severe or life-threatening symptoms.

- Delivering basic life-saving treatment during decontamination if time and situation allow.
- Establishing a separate decontamination area for patients that require secondary and/or technical decontamination if primary decontamination is not adequate.
- Establishing a separate “lane” for patients arriving by Emergency Medical Services transport who have already been decontaminated so that these patients can be quickly assessed for adequacy of decontamination and be triaged to Medical screening more quickly.

5.7. Hazardous Waste Management

Just as a plan or program for decontamination would be critical after a catastrophic emergency such as a nuclear attack, a plan for hazardous waste management is necessary as well. This section provides community care clinics with an overview of the current standards and regulations that are applicable to hazardous waste management and offers resources for additional information. In planning for and responding to a healthcare surge, community care clinics should take these regulations and standards into consideration and implement plans and/or programs accordingly.

Emergency first responders at the site of the release are covered under Cal/OSHA State Plan Standards 8 CCR 5192(e). Depending on their roles, some clinic employees also are covered by the Cal/OSHA standard or the parallel federal Occupational Safety and Health Administration (OSHA) Standard on Hazardous Waste Operations and Emergency Response.

Federal Occupational Safety and Health Administration 1910.120 "Hazardous Waste Operations and Emergency Response" requirements apply to community care 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.

The designation of an “emergency” under these provisions is dependent upon several factors, including the hazards associated with the substance, the exposure level, the potential for danger, and the ability to contain the substance.

In addition to Cal/OSHA and federal OSHA regulations, the Veterans Health Administration Center for Engineering and Occupational Safety and Health, in its *Emergency Management Program Guidebook*, 2009, provides extensive guidance around hazardous waste management (<http://www1.va.gov/EMSHG/page.cfm?pg=154>) and discusses key OSHA hazardous materials regulations related to hazardous waste management.

5.8. Medical Waste Management³²

Community care clinics should develop and implement a plan to effectively address medical waste management during a healthcare surge. California Health and Safety Code 117690 provides the legislative definition of medical waste. Waste must satisfy three critical criteria in order to be classified as medical waste:

- **"The material must actually be a waste product.** This precludes materials that have intrinsic value (such as outdated pharmaceuticals that are returned for credit) from being classified as a Medical waste. On the other hand, outdated pharmaceuticals sent for treatment as waste would be classified as medical waste.
- **The waste must be either biohazardous or sharps waste.** Various forms of waste are defined as biohazardous because of the actual or presumed presence of pathogenic microorganisms. Wastes such as laboratory waste and fluid blood fall into this category and are therefore biohazardous waste. Some chemically hazardous wastes produced in healthcare have been removed from the jurisdiction of the hazardous waste laws in favor of being treated as biohazardous waste. Trace amounts of chemotherapeutic agents, outdated pharmaceutical wastes, and tissues with trace amounts of fixatives fall into this category of biohazardous waste classification. Objects which have been used in invasive procedures such as hypodermic needles and broken glass items contaminated with blood or other biohazardous waste are considered to be sharps waste.
- **The waste must be produced as a result of a specified action in the delivery of health care.** The medical Waste Management Act (California Health and Safety section 117690) defines this as the ...diagnosis, treatment, or immunization of human beings or animals... Some actions such as medical research, production or testing of biologicals, accumulation of home-generated sharps waste and the removal of trauma scene waste are specifically included in the definition of medical waste." ³³

The regulations for medical waste management under normal operations can be found in California's medical Waste Management Act (Health and Safety Code, Division 194, Part 14). During a catastrophic emergency, however, the potential for overloading the waste handling capacity at community care clinics is greatly increased. A situation may occur which causes a secondary disaster if the medical waste is not properly managed. Clinics should therefore develop protocols that go beyond existing waste management plans to address the challenges associated with increased volume of medical waste during an emergency.

Issues to consider in developing 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

In regard to planning for waste storage during a healthcare surge, community care clinics are encouraged to consider the following options:

- Clinics should consult with their medical waste disposal vendors for details of the vendor's ability to provide continued waste disposal services during a catastrophic emergency.
- Clinics should consult with their county/environmental management office for protocols or storage of medical waste during a catastrophic emergency.
- Medical waste may need to be stored under refrigeration (<32°F) to limit nuisance conditions. If a clinic has exhausted its refrigeration resources, it should request assistance through the SEMS/NIMS structure.
- Medical waste should be separated from the solid waste stream.
- Combined waste streams must be handled as medical waste.
- Chemical and radiological wastes must be separated and segregated from medical waste in order to avoid dual contamination.
- Waste stored on the premises of the clinic must be secure to prevent access by unauthorized persons and to prevent accidental spread of contamination.
- The designated storage area for medical waste must display the appropriate warning signs using wording required by California Health and Safety Code Section 118310.
- Refrigerated storage areas must be located away from external air intakes or need to be maintained with negative airflow.

5.9. Fatality Management

5.9.1. State and County Fatality Response

Each California county has a Sheriff-Coroner, Coroner, or Medical Examiner to manage fatalities. These local government officials rely on California'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. The 2006 Coroners Mutual Aid Plan is available for download at:

[http://www.oes.ca.gov/Operational/OESHome.nsf/0d737f261e76eeb588256b27007ac5ff/a3f586fd13d795c788256b7b0029bbff/\\$FILE/CoronersMutualAidPlan2006.pdf](http://www.oes.ca.gov/Operational/OESHome.nsf/0d737f261e76eeb588256b27007ac5ff/a3f586fd13d795c788256b7b0029bbff/$FILE/CoronersMutualAidPlan2006.pdf)

Recognizing that this plan is not a complete, statewide fatality management plan, the Office of Emergency Services (now CalEMA) 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.

During a healthcare surge, 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. If needed, the State of California may request a federal Disaster Mortuary Operational Response Team to assist with the management of mass fatalities (see <http://oep-ndms.dhhs.gov/teams/dmort.html> for more information).

Until assistance can be obtained from local government resources to manage fatalities, community care clinics must implement internal plans to manage the deceased.

5.9.2. Community Care Clinic Fatality Management

Community care clinics are generally not accustomed to managing patient fatalities. When a catastrophic emergency occurs, however, clinics may experience a large number of fatalities at their facilities. Because public coroners/medical examiners and private mortuaries may not be available during a healthcare surge to rapidly remove the deceased, community care clinics should develop an internal clinic fatality management plan for use during an emergency.

To accommodate a surge in fatalities during a mass casualty event, some community care clinics can convert areas into temporary morgues or enter into a Memorandum of Understanding with outside vendors (e.g., trucking companies to provide refrigerated trucks).

Community care clinics should plan for the appropriate bagging and storage of the dead and consider evidentiary needs (bodies stored with some space/distance between bodies, appropriate identification/labeling of the body). If a body is contaminated by infectious disease, radiation, or other exposure, special bagging, handling, and labeling procedures must be ensured.

The clinic's plan for the management of mass fatalities should include a procedure to communicate with families and allow viewing of the deceased. Careful identification and tracking of the dead must be documented by the clinic and provided to authorities upon request.

As indicated in the CalEMA Mass Fatality Plan, a temporary morgue may need to be established if the number of deceased exceeds the resources of the local mortuaries. Community care clinics should be in contact with the Operational Area Emergency Operations Center to determine where temporary morgue sites have been established in their community.

5.10. Security Planning

Heightened security during a healthcare surge is necessary to protect clinic staff, patients, visitors, and clinic facilities and assets. Security resources are typically limited in community care clinics, therefore planning for an increase in security is essential. Community care clinics must assess their current security status and project the security needs during multiple emergency scenarios that may result in a patient surge event. During planning efforts, community care clinics should consider how they might respond to increased security needs if outside resources become unavailable.

During planning, community care clinics may also want to consider the potential psychological impact of increased security on both patients and staff. Staff members may feel threatened by the presence of unfamiliar security staff in their facility, and both staff and patients and their families may be unsettled if armed guards are used in security efforts. Thus, a facility security plan should be coordinated with the facility plan for staff support, as discussed in Section 9.3, Support Provisions for Staff.

The clinic's Hazard Vulnerability Analysis can provide valuable information on high-risk or high probability events and should be used during planning to conduct security assessments (see Section 3.7 "Developing a Hazard Vulnerability Analysis" for more information). Community care clinics can also 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 staff during a healthcare surge.

The standardized Security Assessment/Vulnerability Tool is shown below. The complete tool can be found in the *Community Care Clinics Operational Tools Manual* on pages 35-36.

Security Assessment/Vulnerability Tool

Instructions

Complete all sections of the assessment form to identify potential gaps in security and vulnerability at a community care clinic.

#	Recommendation:	If No,				
		Yes	No	Why / Action Plan	By Whom	By When
1	The facility has a security plan, which identifies: designated security staff					
2	...additional security staff who can be deployed					
3	...protocols to provide security staffing in a sustained emergency					
4	Security staff have: vests for identification purposes					
5	...designated assignments					
6	...periodic training					
7	...job action sheets					
8	The facility has a "lock-down" protocol.					
9	The facility has a protocol for the identification of staff that will enter the facility during a lock-down.					
10	The facility has a protocol for the identification of others such as fire, law enforcement, public health, etc. who will enter the facility during a lock-down.					
11	The facility has established a plan to set up a security perimeter and has the cooperation of law enforcement in the establishment and enforcement of this perimeter.					
12	There are designated ingress and egress routes into and out of the facility.					
14	The security plan includes signage that is ready to be posted.					
15	The facility has a plan to call-in security staff.					
16	Traffic flow patterns have been established in cooperation with law enforcement.					
17	The facility has public address systems to communicate with potential crowds outside the facility.					
18	Security knows where to direct media.					
19	Security has a log for all persons entering the facility through the security perimeter at which people log in time of entrance and time of departure.					
20	There is a protocol developed in collaboration with law					

	enforcement on when and how to search persons or their belongings and who will be responsible for this function.						
21	There is a plan for communications with and among security personnel.						
22	There is a plan for armed security personnel.						

5.10.1. Supplemental Security Staffing

Community care clinics should develop plans for how they will address security during a healthcare surge. Depending on the type and duration of the incident, supplemental personnel may be needed to assist the on-duty security staff. This need may be met by calling personnel in from home, reassigning non-security personnel to select tasks, and/or requesting help from private security firms or local law enforcement.

Planning should consider when law enforcement will be able to assist and how they will be integrated into facility operations and the facility's Incident Command System. Deployment assignments and pertinent response procedures, including rules of engagement, should be discussed upon law enforcement arrival along with what support might be required (e.g., personal security protective equipment, phone access). During a healthcare surge, it may be difficult to get law enforcement officers on-site because of their responsibilities elsewhere and competing demands for their services.

In addition to using local law enforcement to supplement staffing shortfalls, consideration should be given to having a contingency contract(s) with local or national private security firms to provide trained personnel during an emergency. Planning should address the deployment, supervision, and needed support for these personnel along with associated utilization expenses. Planners should consider the need for armed security.

In developing plans for security staffing during a healthcare surge, community care 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 community care clinics should work within their community's plan.

5.10.2. Lock-Down vs. Restricted Access/Visitation

Limiting or restricting visitors may be necessary during a surge event to protect patient privacy and facility assets. Surge planning should include the development of policies and procedures for securing the facility. Implementing a lock-down prohibits entrance to and exit from the clinic. A clinic lock-down may require large numbers of staff and resources, which will

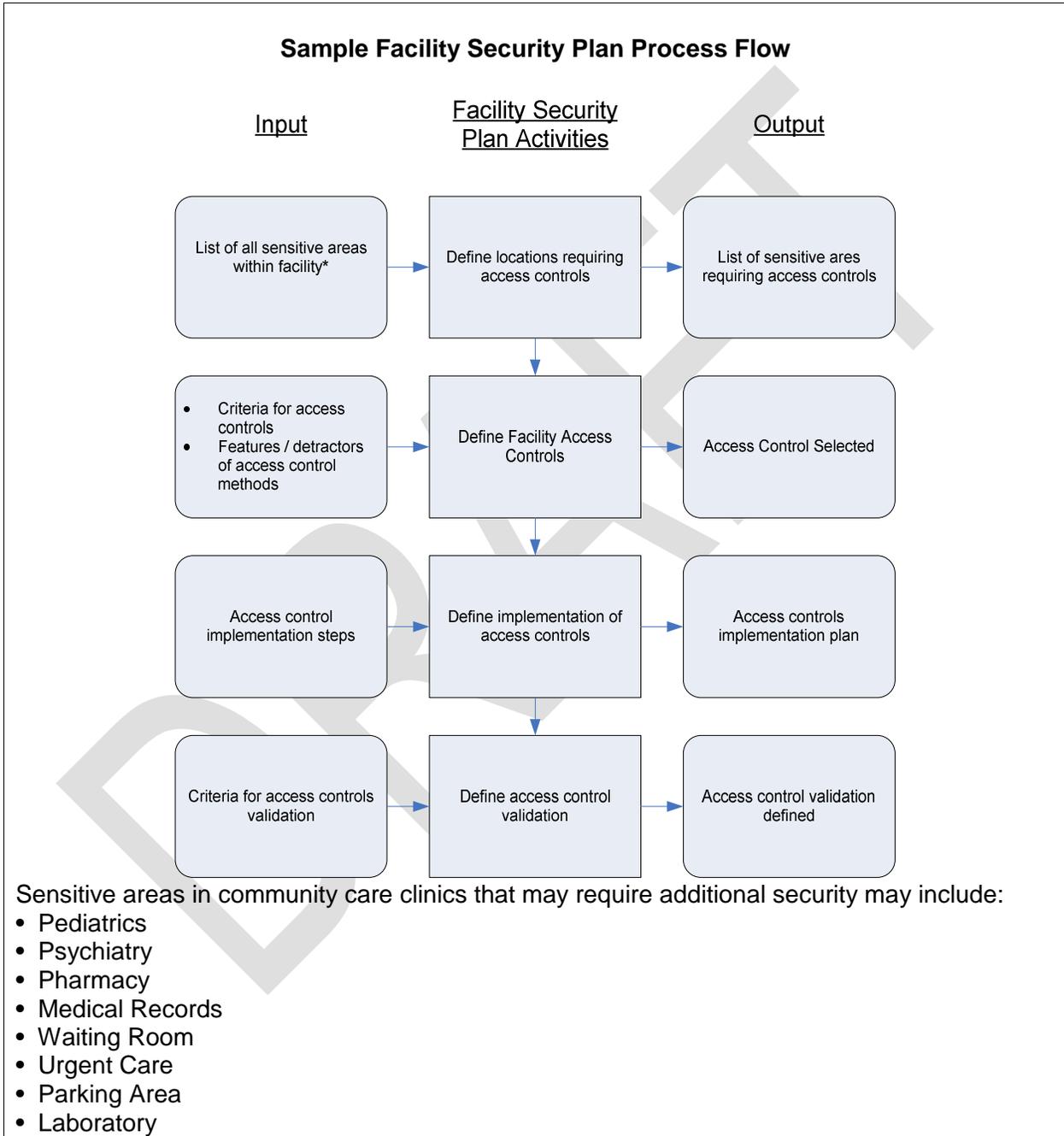
significantly impact clinic operations. Other types of events, with minimal community impact, may only require restricted access. Restricting access to the facility, with a focus on controlling and directing the flow of people into and out of the clinic through points of access, therefore, may be more feasible than a lock-down. Each community care clinic should outline the conditions which would trigger a clinic lock-down or restricted access in its emergency operations plan. If an emergency results in community civil unrest, a lock-down may be required to protect clinic resources and staff. Clinics should also prepare supporting incident-specific clinic plans, policies, and procedures to accompany the plan.

Security measures, restrictions, and procedures implemented should be announced to the staff, patients, visitors, and the public. Staff assigned to implement security measures should be trained or provided “just in time” training to ensure effective security. Internal and external signage indicating the doors are NOT to be opened (and, where appropriate, redirecting would-be entrants) should be posted as soon as possible. Such signage can be created in advance and stored, ideally, near doors for rapid deployment. It is crucial to involve Life-Safety Engineers in the planning and response to ensure adequate egress in the event of a fire or other internal emergency.

Clinics may have electronically controlled doors or areas that can enhance security measures, but these areas should be regularly monitored to ensure no compromise occurs. Heightened surveillance procedures may need to be implemented, including inspection of suspect packages; closer scrutiny of staff members at checkpoints; verification that each individual, including staff, is wearing a proper identification badge; and assignment of properly protected staff to patient arrival points, including the decontamination sector if activated. Certain areas such as waiting rooms, triage areas, pharmacies, and the Clinic Incident Command Center should receive enhanced security support. Steps may need to include restricting staff entry into certain areas because of security concerns, unsafe conditions, or because no additional staff is required. While it is not practical or feasible for some community care clinics to develop complex security measures in the event of an emergency, it is critical for clinics to consider basic security protocols, including the use of proper identification badges, in their planning efforts.

The Sample Facility Security Plan Process Flow on the following page can help clinics identify and secure sensitive areas within their facilities that may require restricted access during a healthcare surge.

The Sample Facility Security Plan Process Flow is shown below. The complete tool can be found in the *Community Care Clinics Operational Tools Manual* on pages 37-38.



A Sample Lock-Down Policy and Procedure is provided below to assist community care clinics when a complete lock-down of the facility is required during a healthcare surge. A lock-down check list is included to document completion of the steps outlined in the procedure.

The Sample Lock-Down Policy and Procedure is shown below. The complete tool can be found in the *Community Care Clinics Operational Tools Manual* on pages 39-43.

Sample Lock-Down Policy and Procedure

I. PURPOSE

To provide policy and procedure guidance when the need to lock-down the facility exists for any reason; this type of situation could involve mass contamination, picketing, demonstrations, acts of violence, sit-ins, passive resistance, civil disobedience, gang activity, or other disturbances.

II. POLICY

The primary goal in a lock-down situation is to isolate and control access to the facility while caring for the safety of the patients, visitors, staff, and property.

III. RESPONSIBILITIES

A. LAW ENFORCEMENT

Management of a civil disturbance itself will be accomplished by law enforcement.

B. SECURITY

Security staff, augmented if necessary, will conduct the internal response in the event of a need for lock-down and will take measures to control access to and from the facility, whenever possible.

C. STAFF

All staff should separate themselves, if at all possible, from any involvement in a civil disturbance.

IV. PERSONNEL

This policy applies to all staff members

V. PROCEDURES

A. GENERAL CIVIL DISTURBANCE

1. Regardless of how peaceful the intent or how righteous the cause of a civil disturbance, because of the strong emotional nature of the issues involved, these manifestations, on many occasions, end in rioting, violence, and destruction/looting of property.

2. Based on the nature of the disturbance, it will be managed by security staff until the decision is made that management of the situation requires the activation of the Facility Incident Command System.
3. Upon becoming aware of a civil disturbance situation, the facility administrator or senior administrative person in the facility will be notified immediately.

B. MASS CONTAMINATION

1. The risk of contaminated individuals/equipment entering the facility may require the total closure of operations of all or part of the facility.
2. In a mass contamination situation, only individuals or equipment that are KNOWN to be free of contamination will be allowed in the building

C. ACTIVATION/NOTIFICATION

1. The decision to initiate lock-down will be made by the Administrator based on information provided by security and other staff members. In accordance with the policy established in the emergency management plan, the following individuals, in order of position rank, may initiate lock-down in the absence of the administrator:
 - a. Administrator-on-call
 - b. Appropriate Administrative Directors
 - c. Safety Officer or designee
 - d. Emergency management Chairperson
 - e. Operations supervisor during off-hours and weekends
2. Announcement/Notification
 - a. Upon specific guidance from the Administrator or designee, a designated staff person will announce the civil disturbance three times via the public address system. (If no public address system exists, the clinic should develop an alternate plan to communicate the civil disturbance and lock-down.) The proper announcement is:

"<<Code Name for Lock-Down>>, Nature and Location of Disturbance"

Repeat the statement every 15 minutes for the first hour, or as often as the Incident Commander directs.
 - b. When directed by the Incident Commander, the designated staff person will contact the appropriate law enforcement office and request immediate assistance.
 - c. When so directed by the Incident Commander or the senior administrative individual in the facility, the "All Clear" will be announced via the public address system as follows:

"<<Code Name for Lock-down>>, Location, ALL CLEAR" (three times)
3. Upon announcement of lock-down, the Incident Command Center and other designated portions of the Incident Command System organization will be activated. This will normally include, at a minimum, a portion of the planning section and the Public Information Officer.

D. SECURITY OPERATIONS

1. In the case of a civil disturbance, the senior security representative present will immediately assess the situation and provide that information to the Administrator or Incident Commander.
2. In the case of a mass contamination situation, the Medical Director or designated clinical staff member will assess the situation and recommend appropriate action.
3. If required, security augmentation will be initiated either through recall of off-duty security, appointing other available staff to perform security duties, or by obtaining augmentation from security companies.
4. Security will immediately commence locking all exterior doors and will advise staff to close ground-floor window coverings if possible.
5. A single entry point will be established. Staff guarding other exterior doors will be instructed to not allow anyone in or out of those doors. A security representative or other designated individual will allow individuals with legitimate reason into and out of the single entry point based on the situation. In the case of mass contamination, only those individuals KNOWN to be free of contamination will be allowed in the building.
6. A security officer will be stationed in the primary treatment area.
7. If anyone exits the building, a staff or security member must ensure the door is firmly closed and locked after the individual.
8. Security representatives will provide escorts for staff members to and from the parking areas. In the case of mass contamination, anyone leaving the building, including security representatives, must be determined to be free of contamination before being allowed to re-enter the building.

E. COMMAND CENTER OPERATIONS

1. All information from local law enforcement, fire departments, and other sources will be provided to the Incident Command Center.
2. Actions to be taken will be based on the evaluation of this information by the Incident Commander.
3. The Incident Commander will determine what information will be disseminated to facility staff.
4. The Public Information Officer will coordinate all releases of information to the media.
5. In the case of mass contamination, decontamination procedures will be initiated.
6. In the event the disturbance is in one of the area's prisons and/or jails and the clinic is to receive a large number of prisoners to be treated, plans will be developed to set aside an area for these patients to remain under guard in order to preclude interfering with other facility operations.
7. In the event of an extended disturbance causing all or part of the staff to remain in the clinic, provisions will be made for housing and feeding these individuals.

F. FACILITY OPERATIONS

1. Patients, visitors, and staff will be moved from the immediate area of the disturbance if at all possible.
2. Access to patient care areas will be limited to staff and others authorized by the Incident Commander to be in those areas.
3. Staff will be informed to avoid the area and to not involve themselves in the disturbance.

G. POST-CRISIS MANAGEMENT

After cancellation of the lock-down, a debriefing by a crisis intervention team and/or mental health professionals should be provided, as needed, for all individuals involved in managing the disturbance.

LOCK-DOWN CHECKLIST

Mission: The primary goal in a lock-down situation is to isolate and control the situation while caring for the safety of the patients, visitors, staff and property. The following checklist should be filled out by security or other appropriate staff to confirm that lock-down has been completed.

- Staff discovering the lock-down situation will promptly notify their supervisor, who will pass the information to the Administrator or designee.
- Staff will not become involved in any manner with the civil disturbance.
- Staff will isolate the situation by locking all exterior doors to clinic units and closing all ground-floor windows.
- Security staff will not allow any entry or exit from any point other than the single entry point.
- Only individuals KNOWN to be free of contamination will be allowed to enter the building in a mass contamination event.
- If exiting the building, staff will request an escort to and from the parking lot areas.
- Staff will allow law enforcement to quell the civil disturbance.

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

5.10.3. Chain-of-Custody Considerations

For suspicious incidents, specific chain-of-custody procedures must be followed. "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. Community care clinics should make efforts to comply with chain-of-custody procedures.

The clinic emergency operations plan should outline a fundamental strategy for chain of

custody procedures. These procedures should address everything from handling a patient's personal effects to packaging and transferring laboratory specimens. Local law enforcement should be consulted when developing these procedures to ensure the outlined steps are consistent with accepted local practice. During an incident it will be important for community care clinics to identify which procedures must be employed and to quickly disseminate easily understood instructions.

5.11. Traffic Control

Depending on the situation, individuals will likely arrive in private vehicles and will often be accompanied by a number of family and friends. The media may also arrive and request special parking locations for outside interviews and "live shots."

For larger community care clinics, traffic patterns may need to be revised to optimize the arrival of emergency medical services and other emergency vehicles. The area in front of the clinic should be kept clear along with areas assigned for decontamination. All available parking areas should be opened.

Plans for a surge event should address situations with abandoned vehicles, including those with possible chemical contamination. It should also be anticipated that law enforcement may request vehicle information (e.g., tag number, make, and model of the car and location) for the patients being seen.

5.12. Business Continuity Planning

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 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 staff and familiarize them with emergency operations

The plan should consider various types of emergencies, various levels of casualties, and varied durations of interruption of operations. It should detail actions to be taken based on the level of damage that the clinic has sustained rather than on an individual type of loss.

The business continuity planning process should cover three main areas:

- **Business Planning:** Determine which aspects of the clinic's operations are most essential to its ability to provide care. This preliminary analysis phase assesses potential risks and impacts on clinic operations, identifies recovery requirements, and lists alternative strategies. Different functions that comprise the clinic's business should be analyzed and prioritized according to what is most critical to the clinic's survival.
- **Technical Support:** Determine the feasibility of the plan from a technical standpoint and ensures that the different departments within the clinic have the equipment and technical support to provide care.
- **Implementation:** Ensure that clinic staff are able and willing to implement the plan. The plan should take staff cross-training into account in order to avoid the situation where only one person knows the equipment, processes, and other needs of a function.

The business continuity plan is a dynamic document that must reflect the continuing changes in daily operations of the clinic. Constant testing and modification are needed to ensure its continued viability and relevance. The Joint Commission's Environment of Care Standards require clinics to address continuity of business operations as part of their emergency operations plan. Health Resources and Services Administration (HRSA) expects clinics to ensure business continuity by developing plans for maintaining financial and operational stability as part of the Emergency Management Plan. For more information on HRSA requirements, see Section 4.1, "Health Resource and Services Administration (HRSA PIN 2007-15)", or the Health Resources and Services Administration website at <http://www.bphc.hrsa.gov/policy/pin0715/>.

The checklist on the next page summarizes areas to consider when developing a business continuity plan (BCP).

The Sample Business Continuity Plan Checklist is shown below. The complete tool can be found in the *Community Care Clinics Operational Tools Manual* on pages 44-46.

Sample Business Continuity Plan Checklist

Instructions

Review the following checklist when developing or evaluating a community care clinic's business continuity plan.

Sample Business Continuity Plan Checklist: Areas to Consider when Developing a Business Continuity Plan	
<input type="checkbox"/>	Identify essential functions within facility that must be maintained during an emergency. These essential functions will drive the business continuity plan.
<input type="checkbox"/>	Clearly define individual responsibilities, including who has the authority to initiate the business continuity plan procedures.
<input type="checkbox"/>	Identify staff that live in close proximity to the clinic and identify any staff members that may experience difficulty reaching the clinic during an emergency.
<input type="checkbox"/>	Provide instruction on when, where, and how to use the backup site including, but not limited to:
<input type="checkbox"/>	<ul style="list-style-type: none"> Procedures for establishing information systems processing in an alternate location, including arrangements for office space
<input type="checkbox"/>	<ul style="list-style-type: none"> Replacement equipment
<input type="checkbox"/>	<ul style="list-style-type: none"> Telecommunications
<input type="checkbox"/>	<ul style="list-style-type: none"> Supplies
<input type="checkbox"/>	<ul style="list-style-type: none"> Transportation
<input type="checkbox"/>	<ul style="list-style-type: none"> Housing
<input type="checkbox"/>	<ul style="list-style-type: none"> Food and water
<input type="checkbox"/>	Issue notification to personnel at the selected backup site.
<input type="checkbox"/>	Maintain a list of contacts with work, home, cellular phone, and pager numbers.
<input type="checkbox"/>	Identify vital system software documentation at the backup site.

<input type="checkbox"/>	Develop procedures for retrieving and restoring medical record information and data from off-site storage.
<input type="checkbox"/>	Maintain a list of vendor contact personnel.
<input type="checkbox"/>	Identify the site of remote storage and related information.
<input type="checkbox"/>	Maintain a current listing of hardware and software.
<input type="checkbox"/>	Compile backup equipment requirements (contracts, compatibility, timeliness, availability).
<input type="checkbox"/>	Establish interim procedures to be followed until systems are restored and procedures for catching up when systems are back in operation.
<input type="checkbox"/>	Evaluate maximum outage tolerable for each major system and develop a restoration priority listing indicating the order in which to restore systems.
<input type="checkbox"/>	Verify that a copy of the business continuity plan is stored off-site.

The Sample Business Continuity Plan Template can be used for business continuity planning. The template contains key elements that will enable an organization to perform its routine day-to-day operations in the event of an unforeseen incident. Business continuity planners should utilize the template and collect the elements as instructed below. The elements include critical entity contact information, roles and responsibilities, vendor contact information, critical recovery functions, minimal resource requirements for the functions, dependent activities/entities of the function, vital records information, site requirements for business relocation, emergency notification protocols, security strategies, designated plan coordinator, and review date.

The Sample Business Continuity Plan Template is shown below. The complete tool can be found in the *Community Care Clinics Operational Tools Manual* on pages 47-53.

Sample Business Continuity Plan Template

Section 1 – Critical Contact Information: Identify personnel, vendors and entities* that are critical to maintaining business operations following a disaster.

Critical Personnel and Entities

Entities could include governmental agencies and members of the clinic's Incident Command structure.

Position	Name	Work Phone	Cell Phone	Home Phone	Personal e-mail	Site and Alternate Site Responsibilities
Critical Position #1:						
Alternate 1:						
Alternate 2:						
Alternate 3:						
Critical Position #2:						
Alternate 1:						
Alternate 2:						
Alternate 3:						
Critical Position #3:						
Alternate 1:						
Alternate 2:						
Alternate 3:						
Critical Position #4:						
Alternate 1:						
Alternate 2:						
Alternate 3:						

Critical Vendors

The business continuity plan should identify at least one contact for each vendor and provide both a work phone number and a cell phone number. If possible, contact information should be documented for at least two contacts per vendor.

Vendor	Location	Contact	Work Phone	Cell Phone
Vendor Name				
Alternate Contact:				
Comments:				

Vendor Name				
Alternate Contact:				
Comments:				
Vendor Name				
Alternate Contact:				
Comments:				
Vendor Name				
Alternate Contact:				
Comments:				

Section 2 – Essential Functions and Recovery Objectives: Identify the essential functions that are critical to business continuity and the corresponding rationale for selecting these functions. Recovery objectives outline why continuity of these functions will promote overall business continuity following a catastrophic event.

Essential Functions	Recovery Objectives
Function 1	
Function 2	
Function 3	
Function 4	
Function 5	
Function 6	
Function 7	

Section 3 – Minimum Resource Requirements: Identify the minimum resources needed to complete the critical functions identified above.

Minimum Resource Requirements		
	Minimum	Full Function
Function 1		
• Space Requirements		
• Equipment Requirements		
• Supplies Requirements		
• Essential Service Requirements		
• Personnel Requirements		
Function 2		
• Space Requirements		
• Equipment Requirements		
• Supplies Requirements		
• Essential Service Requirements		
• Personnel Requirements		
Function 3		
• Space Requirements		
• Equipment Requirements		
• Supplies Requirements		
• Essential Service Requirements		
• Personnel Requirements		
Function 4		
• Space Requirements		
• Equipment Requirements		
• Supplies Requirements		
• Essential Service Requirements		
• Personnel Requirements		
Function 5		
• Space Requirements		
• Equipment Requirements		
• Supplies Requirements		

• Essential Service Requirements		
• Personnel Requirements		
Function 6		
• Space Requirements		
• Equipment Requirements		
• Supplies Requirements		
• Essential Service Requirements		
• Personnel Requirements		
Function 7		
• Space Requirements		
• Equipment Requirements		
• Supplies Requirements		
• Essential Service Requirements		
• Personnel Requirements		

Section 4 – All Agencies, Divisions and Vendors upon which Function Is Dependent: Identify the activities upon which the above functions are dependent for completion.

Essential Function	Dependent Activity/Entity	Business Continuity Plan (BCP) in place?	Comments
Function 1		Y/N	
Function 2		Y/N	
Function 3		Y/N	
Function 4		Y/N	
Function 5		Y/N	
Function 6		Y/N	
Function 7		Y/N	

Section 5 – Vital Records: Identify the type or category of vital record (e.g., electronic medical record, financial record), a brief description of record, and the location where the record is backed-up or stored for emergencies.

Name/#	Description	Location

Section 6 – Alternate Site for Function: Identify alternate site(s) for essential clinic function(s). The number and location of alternate sites will depend on the clinic and the emergency. Some functions can be moved to other locations within the clinic, and others may need to be moved to an entirely new facility.

Functions	Alternate Site
Function 1	
Function 2	
Function 3	
Function 4	
Function 5	
Function 6	
Function 7	

Section 7 – Designated Plan Coordinator: Identify a Business Continuity Plan Coordinator. This may be someone from the clinic's Incident Command or a specifically designated Business Continuity Plan Coordinator.

Name	Work Phone	Pager or Cell	Home Phone	Personal Email
Alternates:				

Section 8 – Review Date: Record the last date the business continuity plan was reviewed.

The plan should be reviewed periodically based on staff / vendor turnover and other changes within the environment.

Source: Adapted from Enterprise Business Continuity Planning, Department of Administrative Services, State of Oregon.

5.12.1. Development of Standard Operating Procedures for Maintaining Infrastructure during a Healthcare Surge

Standard operating procedures for key equipment, plant, and utilities activities should be developed as part of a clinic's business continuity planning. It is essential to involve clinic engineering staff in the patient management planning processes in order to ensure that a safe clinic environment is maintained for both clinic staff and patients. Areas within the expertise of engineering that must be included in the planning process are:

- Alarm systems
- Electrical backup power
- Elevators/Vertical transport
- Heating
- Ventilation and air conditioning
- Room/hood exhaust
- Internal transport system
- Medical gases system
- Roads and grounds
- Waste and debris
- Water delivery/portability
- Electric doors and gates

5.12.2. Facility Operations Recovery³⁴

The recovery phase of an emergency management program for community care clinics focuses on returning the clinic to baseline levels of functioning. Well-executed recovery activities can significantly improve the ability of the recovering clinic to function. In some cases, recovery must include new building construction, geographic re-location, radical change in methods for conducting business, more stringent security arrangements, and/or other drastic measures. Aspects of the recovery phase include:

- **Identifying a starting point for recovery.** The planning for incident recovery begins early in a response, and occurs as soon as the response management is organized. Recovery activities begin well before most response objectives are accomplished.
- **Determining the endpoint to recovery.** The point when the recovery phase is complete can be difficult to recognize and may extend for very prolonged periods of time, even years. For example, a community impacted by a large earthquake may require years to recover to its pre-event status.
- **Return to readiness.** For organizations with emergency response roles such as community care clinics, the completion of “return to readiness” tasks must be expeditiously completed during recovery.
- **Recovery as part of a larger effort.** Recovery for an organization is rarely conducted in isolation. Frequently, recovery is impacted by the larger community at the local, state, and federal levels. Organizational recovery should be coordinated with this larger system, and community authorities should be notified when the healthcare system is recovered. This may be simple (e.g., an organization officially notifying the jurisdiction that it has achieved baseline status) or complex (e.g., extensive interaction required for allocation of federal resources in a post-event environment).

Activities that recovery planning should address include:

- Staff recovery
 - Completion of activities initiated during demobilization
 - Accountability of staff
 - Debriefings as necessary
 - Ensuring adequate rehabilitation time and actions for those participating in the response
 - Rescheduling as necessary for shift workers
 - Documentation of potential exposures (as appropriate)
 - Attending to acute and long-term physical and psychological health effects incurred by healthcare system staff during response (e.g., conducting long-term health surveillance for exposed staff, providing counseling services).
- Non-personnel resources: Recovery of mission-critical systems and return to readiness of response resources
 - Physical structure recovery
 - Evaluating, cleaning, repairing damage to the facilities, or rebuilding.

- Rehabilitation of incident facilities, such as cleaning the decontamination areas or returning to normal function the area used to support the Clinic Incident Command Center
- The recertification of facilities that have received hazard impact (e.g., professional evaluation of a facility in a post-earthquake environment to certify structural integrity for occupation and use, certification that a contaminated area is clean)
- Equipment and supply cache recovery
 - Replacing or servicing equipment used during response
 - Conducting an inventory of supplies and replacement of expended materials
- Financial recovery
 - Accurately accounting for all costs incurred as a result of a hazard impact and incident response and recovery
 - Loss of normal business revenue due to the voluntary suspension of certain services in order to provide incident services (e.g., cancellation of routine physicals and non-urgent appointments)
 - Overtime staff costs
 - Loss of durable medical equipment
 - Structural impact
 - Loss of business due to patients avoiding an ‘impacted clinic’
 - Completion of applications for reimbursement of costs from appropriate resources (e.g., insurance policies, the Federal Emergency Management Agency)
 - Tracking of costs and reimbursements and impact on regularly budgeted operations
- Critical business systems recovery
 - Re-establishing normal operations, which entails:
 - Recovering of infrastructure necessary to resume normal operations
 - Notifying community authorities and the public that normal healthcare system operations are resuming and any changes (e.g., location, contact information for rescheduling, security procedures) that are pertinent
 - Rescheduling of cancelled or postponed activities
 - Addressing the backlog of urgent and elective cases in an expedited manner

- Evaluating the public's perception of the clinic's response, with public information interventions, as indicated
- Coordination with external systems: Recovery activities should be coordinated with other healthcare facilities and the community response system. This might include:
 - Notification when baseline operations have been achieved
 - Sharing particular hazard or vulnerability information that was developed during response recovery that may impact other healthcare facilities or the community
 - Coordinating the application for and allocation of financial resources as well as other resources (e.g., re-supply of medications from an arriving shipment, or resumption of the normal blood supply for the region) in an objective and fair manner
- Organizational learning/Systems improvement: The recovery plan should address the critical activities that initiate the organizational learning process.
 - Recovery efforts should include a thorough evaluation of how the response system performed under stress.
 - Specific strengths, weaknesses, and strategies to both lessen vulnerability and improve the system's ability to respond to future emergencies should be captured and tracked.
 - This information should be analyzed, formatted, and entered into the emergency management program process for organizational learning and should also be noted and considered during the Hazard Vulnerability Assessment revision process.
- After Action Reports/Corrective Action Plans: An After Action Report is used to provide feedback to a clinic after an event. The After Action Report summarizes response activities and analyzes performance so corrective actions for improvement can be identified, along with timelines for their implementation and assignment to responsible parties. Additional information on After Action Reports and templates can be found at: https://hseep.dhs.gov/support/AAR-IP_Template%202007.doc.
- Community recovery activities: Active participation in planning and implementing initiatives that return the community itself to normal or to the defined 'new normal.' Some of this may be done urgently through the community-wide Incident Command System structure, and some may be accomplished through more normal business routes of administration as the community undertakes reconstruction. Community care clinics should take an active role in recovery activities to help communities rebuild and redefine themselves following a healthcare surge.

6. Expanding the Workforce

The community care clinic workforce is often constrained during normal daily operations. The need to increase staff during a surge will be one of the greatest challenges for community care clinics and one that requires significant planning. Since workforce resources will be limited and clinic services will be in greater demand, determining the clinic's role during an emergency is imperative. This role determination should be coordinated with local government and other community providers such as other clinics, hospitals, and long-term care facilities. When planning for a healthcare surge, it is important to consider that a clinic's operating model may change based on the type of emergency and that the available staff will be expected to function at a faster pace than usual. Planning efforts should include other community stakeholders for they will be a key asset in expanding the workforce in the event of a healthcare surge.

In developing emergency plans, it is recommended that community care clinics consider the following issues when developing workforce expansion.

1. What type of emergency response scenario is being planned?
 - Natural disasters (e.g., fire, flood, earthquake)
 - Nuclear emergency
 - Bioterrorism
 - Pandemic infectious disease
2. What types of workforce skills are available during normal daily operations?
3. What types of specific skills would be needed during a surge and how can they be acquired?
4. From the community perspective, what is the expectation of the clinic's role during an emergency?
5. If our clinic is rendered inoperable, where should the staff resources go to aid in the overall emergency response?

Because of the complexity in expanding the clinic's workforce during an emergency, staffing issues have been divided into the following sections:

- **Chapter 7: Augmenting Clinical Staff and Other Staffing Strategies.** This section considers issues related to clinical staff (licensed and non-licensed) in terms of scope of practice, staffing strategies for registered nurses, and liability protections. In addition, streamlined credentialing and privileging processes for a healthcare surge are presented.

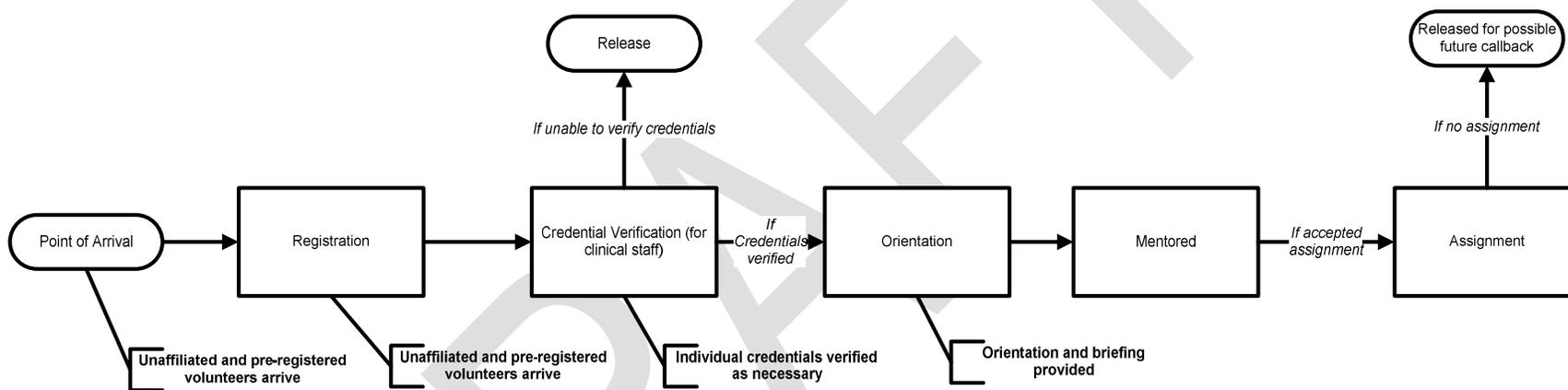
- **Chapter 8: Augmenting Non-Clinical Staff.** This section discusses the verification processes for non-clinical staff and provides a non-clinical staff support matrix.
- **Chapter 9: Maintaining the Workforce.** This section discusses staff support provisions for both existing and expanded long-term care health facility staff.

6.1. Process Flow for Acceptance and Assignment of Additional Staff during a Healthcare Surge

The following diagram has been produced to assist in staff planning and illustrates a process by which additional staff are accepted and deployed. Although acquiring staff for different functions may differ based on the staffing source, the acceptance and deployment process would essentially be consistent.

The Acceptance and Assignment of Augmented Staff during Healthcare Surge Flow Chart is shown on the next page. The complete chart can be found in the *Community Care Clinics Operational Tools Manual* on pages 54-55.

Acceptance and Assignment of Augmented Staff during Healthcare Surge Flow Chart



As summarized in the flowchart on the previous page, there are many steps to the acceptance and assignment of staff, and Chapters 6, 7, and 8 include standards, guidelines, and operational tools to assist long-term care health facilities complete the process. The following list links specific sections and operational tools to the steps in the acceptance and assignment process:

- **Overview**
 - Acceptance and Assignment of Augmented Staff during Healthcare Surge Process Flow (Section 6.1)
- **Registration**
 - Volunteer Application for Non-Clinical Staff (Section 8.1)
 - Volunteer Application for Clinical Staff (Section 7.3.3)
 - Skills and Abilities Assessment Tool (Section 7.1.2)
 - Skills and Abilities Assessment Tool (Section 7.1.2)
- **Credential Verification and Competency Assessment**
 - Credentialing Log for Licensed Healthcare Professionals (Section 7.3.4)
- **Assignment**
 - Staff Assignment Tracking Sheet (Section 6.4.1)
 - Non-Clinical Support Matrix (Section 8.2)

6.2. Staffing Component Considerations for Development of a Mutual Aid/Mutual Assistance Memoranda of Understanding with Neighboring Healthcare Facilities

In order to support the delivery of care at the onset of a healthcare surge, it may be necessary for community care clinics to invoke pre-established Memoranda of Understanding with neighboring healthcare facilities (e.g., other clinics, hospitals, long-term care health facilities, physician practices). Clinics should be aware that at the 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 Memorandum of Understanding.

Memoranda of Understanding between facilities and other organizations will contain provisions that can address, patient transfer; supplies, equipment, and pharmaceuticals; and staff, among other topics. The Staffing Component Considerations for Development of Mutual Aid/Mutual Assistance Memoranda of Understanding on the following page summarizes some of the staffing issues to consider when creating a Memorandum of Understanding.

The Staffing Component Considerations for Development of Mutual Aid/Mutual Assistance Memoranda of Understanding is shown below. The complete tool can be found in the *Community Care Clinics Operational Tools Manual* on pages 56-57.

Staffing Component Considerations for Development of Mutual Aid/Mutual Assistance Memoranda of Understanding

1. **Communication of Request:** The request for the transfer of staff initially can be made verbally. Any request, however, must be followed up with written documentation. Ideally, this should occur prior to the arrival of staff at the recipient healthcare facility. The recipient healthcare facility will identify to the donor healthcare facility the following:
 - a. The type and number of requested staff
 - b. An estimate of how quickly the request is needed
 - c. The location to which staff are to report
 - d. An estimate of how long the staff will be needed
2. **Documentation:** The arriving staff will be required to present their healthcare facility identification badge at the check-in site designated by the recipient healthcare facility's command center. The recipient healthcare facility will be responsible for the following:
 - a. Meeting the temporarily reassigned staff (usually performed by the recipient healthcare facility's security department or designated employee)
 - b. Providing adequate identification (e.g., "visiting staff" badge) to the arriving reassigned staff
3. **Staff Support:** The recipient clinic shall provide food, housing, and/or transportation for temporarily reassigned staff asked to work for extended periods and for multiple shifts. The costs associated with these forms of support will be borne by the recipient healthcare facility.
4. **Financial Liability:** The recipient healthcare facility will reimburse the donor healthcare facility for the salaries and benefits of the donated staff at the staff member's salary rate as established at the donor healthcare facility if the staff are employees being paid by the donor healthcare facility. The reimbursement will be made within 90 days following receipt of the invoice.
5. **Demobilization Procedures:** The recipient clinic will provide and coordinate any necessary demobilization procedures and post-event stress debriefing.
6. **Emergency Privileging Procedures:** The Medical Director or other designee of the recipient healthcare facility will be responsible for providing a mechanism for granting emergency privileges for physicians, nurses, and other licensed healthcare providers to provide services at the recipient healthcare facility.

6.3. Requesting Staff through the Standardized Emergency Management System

Even with extensive planning, staffing a community care clinic during a surge may require resources beyond local availability. In these cases, additional staffing resources should be requested through SEMS/NIMS to the Unified Command. The Unified Command will coordinate staffing requests across the Operational Area and shift resources as needed. During catastrophic events resulting in scarcity of resources, resource requests will be prioritized by policymakers within the SEMS/NIMS structure and some resource requests may be unfilled. Staffing requests should be as specific as possible to ensure resource needs are met. For example, when requesting a registered nurse, a clinic should identify the specific skill sets needed. For more information on the SEMS/NIMS structure, see section 3: "General Emergency Response Planning" and *Foundational Knowledge*, Section 3.9: "Standardized Emergency Management System."

Staffing resources that can be accessed through SEMS/NIMS are regional, state, and federal assets such as the California Medical Assistance Team (CalMAT), Community Emergency Response Teams (CERT)/Neighborhood Emergency Response Teams(NERT), the Disaster Medical Assistance Team (DMAT), Disaster Service Workers (DSW), California Disaster Healthcare Volunteers, the Los Angeles County Emergency System for the Advance Registration of Volunteer Health Professionals (ESAR VHP), the Medical Reserve Corps (MRC), and the American Red Cross (ARC). The Emergency Medical Services Authority is implementing the California Disaster Healthcare Volunteers, which will serve as a registry for all licensed local, regional, and state emergency response volunteer staff. Potential staffing resources are described in more detail in the table below.

The List of Potential Staffing Sources during Healthcare Surge is shown below. The complete list can be found in the *Community Care Clinics Operational Tools Manual* on pages 58-62.

Organization Brief Background & History	Additional Information May Be Found at:
<p>California Medical Assistance Team (CalMAT) Three 120-person California Medical Assistance Teams have been created under state control to respond to catastrophic disasters. Each California Medical Assistance Team consists of volunteers drawn from the private, not-for-profit, and state and local government healthcare delivery sector.</p> <p>The California Medical Assistance Teams will maintain caches that contain medical supplies, medical equipment, tents, pharmaceuticals, and interoperable (compatible) communications.</p> <p>The California Medical Assistance Team program will be supported on-site by an Emergency Medical Services Authority-led Mission Support Team for</p>	<p>http://www.emsa.ca.gov/disaster/files/DMAT_general_flyer.doc</p>

Organization Brief Background & History	Additional Information May Be Found at:
<p>administrative direction, logistical direction, and re-supply.</p> <p>Community Emergency Response Teams (CERT)/Neighborhood Emergency Response Teams (NERT)</p> <p>The Community Emergency Response Team program educates people about disaster preparedness for hazards that may impact their area and trains them in basic disaster response skills, such as fire safety, light search and rescue, team organization, and disaster medical operations. Using the training learned in the classroom and during exercises, Community Emergency Response Team members can assist others in their neighborhood or workplace following an event when professional responders are not immediately available to help. Community Emergency Response Team members also are encouraged to support emergency response agencies by taking a more active role in emergency preparedness projects in their community.</p> <p>The Community Emergency Response Team concept was developed and implemented by the Los Angeles Fire Department in 1985. The Whittier Narrows earthquake in 1987 underscored the area-wide threat of a major disaster in California and confirmed the need for training civilians to meet their immediate needs. As a result, the Los Angeles Fire Department created the Disaster Preparedness Division and the Community Emergency Response Team program to train citizens and private and government employees.</p>	<p>http://www.citizencorps.gov/cert</p> <p>Information is available for the national organization as well as links to the local chapters.</p>

DRAFT

Organization Brief Background & History	Additional Information May Be Found at:
<p>Disaster Medical Assistance Team (DMAT) Disaster Medical Assistance Team is a group of professional and para-professional medical staff (supported by a cadre of logistical and administrative staff) designed to provide medical care during a disaster or other event. Each team has a sponsoring organization, such as a major medical center, public health or safety agency, nonprofit, public, or private organization that signs a Memorandum of Agreement with the federal Department of Health and Human Services.</p> <p>Disaster Medical Assistance Teams are designed to be a rapid-response element to supplement local medical care until other federal or contract resources can be mobilized or the situation is resolved. Disaster Medical Assistance Teams deploy to disaster sites with sufficient supplies and equipment to sustain themselves for a period of 72 hours while providing medical care at a fixed or temporary medical care site. In catastrophic incidents, their responsibilities may include triaging patients, providing high-quality medical care despite the adverse and austere environment often found at a disaster site, and preparing patients for evacuation.</p> <p>Under the rare circumstance that disaster victims are evacuated to a different locale to receive definitive medical care, Disaster Medical Assistance Team may be activated to support patient reception and disposition of patients to clinics. Disaster Medical Assistance Teams are principally a community resource available to support local, regional, and state requirements. As a national resource, however, they can be federalized.</p>	<p>http://www.ndms.dhhs.gov/teams/dmat.html</p>
<p>Disaster Service Worker (DSW) Disaster Service Workers include public employees and can include any unregistered person pressed into service during a state of war emergency, a state of emergency, or a local emergency by a person having authority to command the aid of citizens in the execution of his or her duties.</p>	<p>http://www.oes.ca.gov/Operational/OESHome.nsf/PDF/Disaster%20Service%20Worker%20Volunteer%20Program%20(DSWVP)%20Guidance/\$file/DSWguide.pdf</p>
<p>California Disaster Healthcare Volunteers California Disaster Healthcare Volunteers is an electronic database of healthcare professionals who volunteer to provide aid in an emergency. The California Disaster Healthcare Volunteers system registers health volunteers, applies emergency credentialing standards to registered volunteers, and allows for the verification of the identity, credentials, and qualifications of registered volunteers in an emergency.</p>	<p>https://medicalvolunteer.ca.gov/</p>

Organization Brief Background & History	Additional Information May Be Found at:
<p>Los Angeles County Emergency System for the Advance Registration of Volunteer Health Professionals (ESAR VHP) Medical professionals who pre-register and are accepted as volunteers with the Los Angeles County Emergency System for the Advance Registration of Volunteer Health Professionals can be deployed rapidly and effectively to help following a disaster. The Volunteer Center of Los Angeles is working in partnership with the Los Angeles County Department of Health Services, Emergency Medical Services Agency, and Department of Public Health (including the Health Alert Network) to provide volunteer registration and assist in volunteer accreditation of health professionals.</p> <p>Physicians, dentists, podiatrists, clinical psychologists, physician assistants or advanced practice registered nurses who wish to be on the Surge Capacity Team or the Alternate Care Site Team will have their information forwarded to CheckPoint Credentials Management for further credentialing.</p> <p>Other medical and mental health professionals do not require additional credentialing.</p> <p>As required by the national Emergency System for the Advance Registration of Volunteer Health Professionals Program, all potential volunteers are screened using the Federal Exclusion List.</p>	<p>http://signup.esarvhp.net/</p>
<p>Medical Reserve Corps (MRC) The Medical Reserve Corps program was created after President Bush's 2002 State of the Union Address, in which he asked all Americans to volunteer in support of their country. The Medical Reserve Corps comprises organized medical and public health professionals who serve as volunteers to respond to natural disasters and emergencies. These volunteers assist communities nationwide during emergencies and with ongoing efforts in public health.</p> <p>There is no "typical" Medical Reserve Corps unit. Each unit organizes in response to an area's specific needs. At the local level, each Medical Reserve Corps unit is led by a Medical Reserve Corps Unit Coordinator who matches community needs for emergency medical response and public health initiatives with volunteer capabilities. Local coordinators are also responsible for building partnerships, ensuring the sustainability of the local unit, and managing the volunteer resources.</p>	<p>http://www.medicalreservecorps.gov/HomePage</p>
<p>American Red Cross (ARC) The most visible and well-known Red Cross disaster relief activities are sheltering and feeding. The mission of American Red Cross Disaster Services is to ensure nationwide disaster planning, preparedness, community education, mitigation and response that will provide the American people with quality services delivered in a uniform, consistent, and responsive manner. The American Red Cross responds to disasters such as hurricanes, floods, earthquakes, and fires, or other situations that cause human suffering or create human needs that those affected cannot alleviate without assistance. It is an independent, humanitarian, voluntary organization, not a government agency. All Red Cross assistance is given free of charge, made possible by the generous contribution of people's time, money, and skills.</p>	<p>http://www.redcross.org Information is available for the national organization with links to local chapters.</p>

6.4. Tracking Staff Providing Services in a Community Care Clinic³⁵

Once a staff member has been assigned a role during a healthcare surge, a process should be established to track that person while providing services in the clinic. This section provides sample tracking sheets for that purpose.

6.4.1. Staff Assignment Tracking Sheet

The Staff Assignment Tracking Sheet documents staffing assignments and designated roles and responsibilities during a healthcare surge. Clinic staff members can be pre-assigned to explicit roles during a healthcare surge. In addition, this tool will allow additional staff to be assigned roles during a healthcare surge.

The Staff Assignment Tracking Sheet is shown on the following page. The complete tool can be found in the *Community Care Clinics Operational Tools Manual* on pages 63-64.

7. Augmenting Clinical Staff and Other Staffing Strategies

This section addresses areas pertaining to increasing clinical staff, both licensed and non-licensed, during a healthcare surge. Issues addressed include scope of practice, staffing ratios, license verification (if applicable), and policies for surge capacity staffing.

7.1. Scope of Practice and Liability Protections

During a healthcare surge, when the demand for patient care is greater than the supply of providers required to deliver care, it may become necessary for healthcare professionals to practice outside of their licensed scope of practice in order to fulfill the overarching mission of ensuring the greatest good for the greatest number of people. Focus may shift from patient-based care to population-based care and the current standards that allow professional scope of practice to shift (in terms of waiving or flexing these standards) must be identified and addressed.

7.1.1. California Healing Arts Boards

The table below identifies current emergency statutory flexibility in scope of practice and liability protections for selected California Healing Arts Boards. The list below includes only those Boards that provided guidance on current statutory flexibility in scopes of practice and liability protections and is not a complete list of all California Healing Arts Boards.

Board	Current Scope of Practice	Scope of Practice/ Liability in an Emergency
Vocational Nursing	California Business and Professions Code Section 2860.5 outlines the normal scope of practice for licensed vocational nurses.	According to California's Board of Vocational Nursing and Psychiatric Technicians, a licensed vocational nurse may practice outside his/her scope of practice to save a life or limb if he/she can do so competently and safely. This determination would not apply to disaster or emergency situations in which an individual's life or limb was not in immediate danger.
Pharmacy	California Business and Professions Code Sections 4052.1 – 4052.5 outlines the normal scope of practice for pharmacists.	According to California's Business and Professions Code Section 4062(b), during a declared federal, state, or local emergency, the board may waive application of any provisions of this chapter or the regulations adopted pursuant to it if, in the board's opinion, the waiver will aid in the protection of public health or the provision of patient care.

Board	Current Scope of Practice	Scope of Practice/ Liability in an Emergency
Medical: Physician Assistants	California Business and Professions Code Section 3502 outlines the normal scope of practice for physician assistants.	In the event of an emergency (as defined by California Government Code Section 8558), the scope of practice for physician assistants is defined by California Business and Professions Code Section 3502.5, which states that they may perform permitted Medical services “regardless of whether the physician assistant’s approved supervising physician is available to supervise the physician assistant, so long as a licensed physician is available to render the appropriate supervision.”
Podiatric Medicine	California Business and Professions Code Section 2472 outlines the normal scope of practice for doctors of podiatric medicine.	According to California’s Business and Professions Code Section 2397(d), immunity from liability for civil damages for injury or death caused in an emergency situation occurring in the licensee’s office or in a clinic on account of a failure to inform a patient of the possible consequences of a Medical procedure is not applicable to doctors of podiatric medicine.
Respiratory Care	California Business and Professions Code Sections 3702 and 3702.7 outline the normal scope of practice for a professionals licensed by the Respiratory Care Board of California.	According to California’s Business and Professions Code Section 3703, “respiratory care may also be provided during the transportation of a patient and under any circumstances where an emergency necessitates respiratory care.” Per California Business and Professions Code Section 3765, the Respiratory Care Practice Act does not prohibit respiratory care services in case of an emergency. Additionally, per California’s Business and Professions Code Section 3706, “a person licensed under this chapter who in good faith renders emergency care at the scene of an emergency which occurs outside both the place and the course of employment shall not be liable for any civil damages as the result of acts or omissions by the person in rendering the emergency care. This section does not grant immunity from civil damages when the person is grossly negligent.”
Registered Nursing: Nurse Practitioners	California Business and Professions Code 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.	According to California’s Business and Professions Code Section 2725, nursing practice includes “implementation, based on observed abnormalities, of appropriate reporting, or referral, or standardized procedures, or changes in treatment regimen in accordance with standardized procedures, or the initiation of emergency procedures.” Additionally, per California’s Business and Professions Code Section 2727.5, “ A person licensed under this chapter who in good faith renders emergency care at the scene of an emergency which occurs outside both the place and the course of that person’s employment shall not be liable for any civil damages as the result of acts or omissions by that person in rendering the emergency care. This section shall not grant immunity from civil damages when the person is grossly negligent.”

Board	Current Scope of Practice	Scope of Practice/ Liability in an Emergency
Dental	California Business and Professions Code Sections 1625, 1646, and 1647 outline the normal scope of practice for dentists, including use of general anesthesia and conscious sedation.	The California Dental Association has suggested that "with very little additional training, dentists could be activated to prescribe and distribute medications and administer vaccinations" during an emergency. Additionally, the CDA proposes that dental offices "be activated to serve as 'mini-hospitals' when local hospital facilities become overwhelmed or when a concentration of patients at one site is to be avoided. Pre-designated dental offices may act as storage sites for materials and supplies to be distributed in the event of an emergency." ³⁶ At this time, no legislation or legislative amendments exist to codify these proposals.
Medical: Medical Assistants	As per the California Medical Board, Medical Assistants are not licensed, certified, or registered by the State of California. ³⁷ California Business and Professions Codes Sections 2069 and 2070 outline the normal scope of practice for a medical assistant.	

7.1.2. Flexed Scope of Practice

During a healthcare surge, the appropriate standard of care will vary based on the availability of resources, patient needs and environmental factors. As indicated in Section 2.2: Standard of Care Defined, the standard of care is also dependent on the scope of practice each available provider is licensed or authorized to provide. However, in some emergencies, healthcare professionals may need to function outside their specialties to meet the needs of the emergency and save the greatest possible number of lives.

Section 7.1.4, "Liability Protections during a Healthcare Surge" outlines state and federal laws that provide immunity from liability for community care clinics, healthcare professionals, and volunteers. Recognizing the need to provide additional liability protection to healthcare professionals during situations when they provide care outside their authorized scope of practice while responding to emergency healthcare needs, the Standby Order for Expanded Scope of Practice was drafted. 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. A standby order must be approved by the Emergency Council and then issued during a proclaimed state of emergency. In some cases, standby orders delegate the authority to suspend requirements to a specific state official, for example the Director of CalEMA, the Emergency Medical Services Authority, or CDPH. The proclamation of a state of emergency alone is not sufficient to effectuate a suspension of regulatory requirements, unless those

requirements have a provision enabling their automatic activation upon such a proclamation. The proclamation would need to include a standby order or the Governor would need to issue a separate executive order issuing the standby order.

The standby order below has been prepared for the use by the Governor and is intended to address the likelihood that an increasing number of paid healthcare professionals able to provide services will be needed during a state of emergency in California. Under the proposed order, the Governor, in collaboration with the State Health Officer, will decide which licensed healthcare professionals should have expanded scope of practice to mitigate the extent of the emergency. Local Health Officers responsible for alternate care sites or Chief Medical Officers of healthcare facilities will decide who is qualified to perform services outside the scope of practice authorized under their license. By creating a flow of authority from the Governor to the Local Health Officer or Chief Medical Officer to the healthcare provider, this order will link the action of providers to the protections provided in the Emergency Services Act.

The standby order addresses the following objectives:

- **Liability protection for healthcare professionals:** to provide to a broader class of healthcare professionals, to the extent possible under current law, the liability protections currently afforded under Government Code Section 8659, which provides liability protection to physicians, surgeons, hospitals, pharmacists, nurses, and dentists
- **Licensure protection for healthcare professionals:** to protect, to the extent prudent and reasonable under the circumstances, a healthcare professional's license if that individual renders emergency aid necessary to save lives, without willful misconduct
- **Patient protection:** to protect patients when receiving healthcare from healthcare professionals that is inconsistent with their training, experience, or abilities
- **The need to balance local decision making with State authority**

Text of the Standby Order for Expanded Scope of Practice:

It is hereby ordered that in the area proclaimed to be in a State of Emergency and/or that specific area(s) designated by the State Public Health Officer outside of the proclaimed area(s) but which is (are) essential to the relief and aid of the medical and health needs of the people within the proclaimed area, those rules that regulate the practice of licensed healthcare providers, including but not limited to _____*, _____*, shall be waived or amended as directed by the State Public Health Officer in order to increase the availability of acute medical care. Pursuant to the State Public Health Officer's actions, the Local Health Officer, or Chief Medical Officer at a healthcare facility, shall direct healthcare providers under their authority to mitigate the medical needs caused by the emergency.

***Instructions**

State Health Officer would fill in the blanks, based on the needs of the emergency, from a comprehensive list of healthcare professionals:

- Acupuncturists
- Associate Clinical Social Workers
- Audiologists
- Certified Nurse Midwives
- Chiropractors
- Clinical Nurse Specialists
- Dentists
- Home Health Aides
- Laboratory Technicians
- Laboratory Technologists
- Licensed Clinical Social Workers
- Licensed Educational Psychologists
- Marriage and Family Therapists
- Marriage and Family Therapist Interns
- Medical Assistants
- Occupational Therapists
- Optometrists
- Osteopaths
- Nurse Practitioners
- Pharmacists
- Pharmacist Interns and Pharmacy Technicians
- Physical Therapists
- Physician Assistants
- Physicians
- Podiatrists
- Psychiatric Technicians
- Psychologists
- Radiologic Technicians
- Registered Dental Assistants
- Registered Dental Assistant in Extended Functions
- Registered Dental Hygienists

- Registered Dental Hygienists in Alternative Practice
- Registered Dental Hygienists in Extended Functions
- Registered Dispensing Opticians
- Registered Nurse Anesthetists
- Registered Nurses
- Registered Veterinary Technicians
- Respiratory Care Therapists
- Speech-Language Pathologists
- Veterinarians
- Vocational Nurses

As the scope of practice for licensed professionals is subject to change, the Healing Arts Board's websites are a useful resource for understanding the current scope of practice for any particular licensed healthcare professional.

Healing Arts Board	Website
The Acupuncture Board	http://www.acupuncture.ca.gov/
Board of Behavioral Sciences	http://www.bbs.ca.gov/
Board of Occupational Therapy	http://www.bot.ca.gov/
Board of Optometry	http://www.optometry.ca.gov/
Board of Pharmacy	http://www.pharmacy.ca.gov/
Board of Podiatric Medicine	http://www.bpm.ca.gov/
Board of Psychology	http://www.psychboard.ca.gov/
Board of Registered Nursing	http://www.rn.ca.gov/
Board of Vocational Nurses and Psychiatric Technicians	http://www.bvnpt.ca.gov/
Dental Board of California	http://www.dbc.ca.gov/
Medical Board of California	http://www.medbd.ca.gov/
Osteopathic Medical Board of California	http://www.ombc.ca.gov/
Physical Therapy Board of California	http://www.ptb.ca.gov/

California Department of Consumer Affairs Physician Assistant Examining Committee	http://www.pac.ca.gov/
Medical Board of California Registered Dispensing Optician Program	http://www.medbd.ca.gov/allied/rdo_program.html
Respiratory Care Board of California	http://www.rcb.ca.gov/
Speech-Language Pathology and Audiology Board	http://www.slpab.ca.gov/
Veterinary Medical Board	http://www.vmb.ca.gov/
Medical Board of California: Medical Assistants	http://www.medbd.ca.gov/allied/medical_assistants.html

Although the standby order for flexing the scope of practice allows any included category of licensed healthcare provider to provide care beyond their current scope of practice, it is recommended that community care clinics maintain an inventory of skills/experiences beyond the normal licensing scope for each staff member. The Skills and Abilities Assessment Tool below is designed to facilitate that inventory and assist staffing coordinators at community care clinics in planning and allocating staff resources during a healthcare surge. As part of the clinic's Emergency Management Plan, clinic planners should complete a skills inventory of existing staff and pre-registered volunteers to identify staff with experiences, skills, or competencies beyond their licensed capacity that may be useful during a healthcare surge. This inventory can help the clinic's Medical Director to quickly make use of the standby order above and assign staff to particular patients or duties during an emergency by providing detailed information on staffing skills. Understanding the abilities of staff during an emergency will enable better decisions on what tasks should be performed by each staff member.

The Skills and Abilities Assessment Tool is shown below. The complete tool can be found in the *Community Care Clinics Operational Tools Manual* on pages 65-66.

Skills and Abilities Assessment Tool

Instructions

Clinic staffing coordinators or medical staff representatives should identify existing staff and pre-registered volunteers who may have useful skills, competencies, or experience beyond their license or credentials.

Identify staff members or pre-registered volunteer as either credentialed or non-credentialed. In the column marked 'Current Position Title,' indicate the staff member or pre-registered volunteer's current position. In the column marked 'Competencies/Skills beyond Licensing,' identify any known skills that may be relevant during a healthcare surge that are not part of the staff member's current scope of practice. Two examples are provided.

When complete, this plan should be included as part of the clinic emergency operations plan.

Skills and Abilities Assessment		
Name	Current Position Title	Competencies/Skill Sets beyond Licensing
Credentialed Staff		
<i>Ex: Staff Person #1</i>	<i>Respiratory Therapist</i>	<i>Military experience includes suturing</i>
<i>Ex: Staff Person #2</i>	<i>Certified Nursing Assistant</i>	<i>Advanced Life Support certification</i>
Non-credentialed Staff		
<i>Ex: Family Member #1</i>	<i>Volunteer</i>	<i>Volunteer experience includes grief counseling</i>
<i>Ex: Family Member #2</i>	<i>Volunteer</i>	<i>Experience as Home Health Aide</i>

7.1.3. Augmenting Staff Through Standby Orders

Standby orders may also assist community care clinics to expand or augment staff. This section provides a sample standby order that may be used to facilitate timely and appropriate regulatory assistance during a healthcare surge. The standby order below deems contractors working in a community care clinic as Disaster Service Workers. The decision to implement

this measure and other standby orders is a decision made by the Governor and the Director of the CalEMA following a declared State of Emergency by the Governor.

Clarification of Governmental Agents Providing Services within a Healthcare Facility as Disaster Service Workers Standby Order Text

In the event a local governmental jurisdiction is required to assist a healthcare facility in providing or arranging to provide treatment of disaster-related victims when existing facilities are overloaded and cannot accommodate the patient load, all persons providing services at the healthcare facility pursuant to an actual or implied request of the local governmental jurisdiction shall be agents of the local governmental jurisdiction, and as such, deemed Disaster Service Workers under the Emergency Services Act.

7.1.4. Liability Protections during a Healthcare Surge

Several California statutes provide qualified immunity to persons rendering aid and to those healthcare facilities providing health care services during an emergency. These immunity provisions instruct the courts not to impose liability in specified emergency circumstances. These existing regulations may reduce the need for a suspension of regulatory requirements because the immunity already contemplates that the standard of care is dependent upon available resources.

The table below highlights specific state and federal laws and other regulatory activities that govern healthcare operations and provide immunity from liability for healthcare facilities, healthcare professionals, and volunteers. This table should be used by community care clinics and their legal counsel to develop healthcare surge response plans. For further information on these topics, see *Reference Manual*, Section 3: "Surge Regulations and Compliance Legal Matrix."

Statute/Regulation	Description of Statute/Regulation and Waiver Requirements
Liability of Healthcare Facilities	
California Civil Code Section 1714.5	Provides immunity from liability for Disaster Service Workers as well as an owner or operator, including a public agency, that owns or maintains any building or premises which is used as a mass care center, first-aid station, temporary hospital annex, or other necessary facility for mitigating the effects of an emergency. The immunity protects against liability to any person who has entered to seek refuge, treatment, care, or assistance, while in or upon the premises, for injuries sustained as a result of the condition of the building or premises, as the result of any act or omission, or as a result of the use or designation of the premises as a mass care center, first-aid station, temporary hospital annex, or other necessary facility for emergency purposes. The only exclusions from immunity are the willful acts of the owner or occupant or their employees. ³⁸

<p>California Health and Safety Code Section 1317</p>	<p>By law, emergency services and care must be provided upon request to any person for any condition in which the person is in danger of loss of life, serious injury, or illness at any health facility licensed by the State that maintains and operates an emergency department to provide emergency services to the public when the health facility has appropriate facilities and qualified staff available to provide the services or care.³⁹ A medical screening examination and stabilization of an emergency medical condition is required.⁴⁰ The health facility and its employees, however, including any physician, surgeon, dentist, clinical psychologist and podiatrist, are immune from liability in any action arising out of a refusal to render emergency services or care if the refusal is based on the determination, exercising reasonable care, that the person is not suffering from an emergency medical condition or that the health facility does not have the appropriate facilities or qualified staff available to render those services.⁴¹</p>
<p>Liability of Healthcare Professionals</p>	
<p>California Emergency Services Act, Government Code Section 8659</p>	<p>Any physician or surgeon (whether licensed in this state or any other state), hospital, pharmacist, nurse, or dentist who renders services during a state of war emergency, a state of emergency, or local emergency at the express or implied request of any responsible state or local official or agency shall have no liability for any injury sustained by any person by reason of such services, regardless of how or under what circumstances or by what cause such injuries are sustained; provided, however, that the immunity herein granted shall not apply in the event of a willful act or omission.</p>
<p>California Business and Professions Code Section 1627.5</p>	<p>No licensed dentist, who in good faith renders emergency care at the scene of an emergency occurring outside the place of that person's practice, or who, upon the request of another person so licensed, renders emergency care to a person for a complication arising from prior care of another person so licensed, shall be liable for any civil damages as a result of any acts or omissions by that person in rendering the emergency care.</p>
<p>California Business and Professions Code Section 2395</p>	<p>No licensed physician or surgeon, who in good faith renders emergency care at the scene of an emergency or during a medical disaster, shall be liable for any civil damages as a result of any acts or omissions by such person in rendering the emergency care. "Medical disaster" means a duly proclaimed state of emergency or local emergency declared pursuant to the California Emergency Services Act (Government Code Section 8550, Title 2, Division 1, Chapter 7). Acts or omissions exempted from liability pursuant to this section shall include those acts or omissions which occur after the declaration of a medical disaster and those which occurred prior to such declaration but after the commencement of such medical disaster. The immunity granted in this section shall not apply in the event of a willful act or omission.</p>
<p>California Business and Professions Code Section 2727.5</p>	<p>A registered nurse who in good faith renders emergency care at the scene of an emergency which occurs outside both the place and the course of that person's employment shall not be liable for any civil damages as the result of acts or omissions by that person in rendering the emergency care. The immunity from civil damages granted in this section shall not apply when the person is grossly negligent.</p>

<p>California Business and Professions Code Section 2861.5</p>	<p>A licensed vocational nurse who in good faith renders emergency care at the scene of an emergency which occurs outside the place and during the course of employment shall not be liable for any civil damages as the result of acts or omissions in rendering the emergency care. This section shall not be construed to grant immunity from civil damage to any person whose conduct in rendering emergency care is grossly negligent.</p>
<p>California Business and Professions Code Section 3503.5</p>	<p>A physician assistant who in good faith renders emergency care at the scene of an emergency that occurs outside the place and during the course of that person's employment shall not be liable for any civil damage as a result of any acts or omissions by that person in rendering the emergency care. This section shall not be construed to grant immunity from civil damages to any person whose conduct in rendering emergency care is grossly negligent. In addition to the immunity specified in Business and Professions Code Section 3503.5 (a), the provisions of Business and Professions Code Section 2395, Chapter 5, Article 17 shall apply to a physician assistant when acting pursuant to delegated authority from an approved supervising physician.</p>
<p>Government Code Section 178 Article 5</p>	<p>This section addresses the liability of health professionals providing service outside the state by which they are licensed. This section indicates that no party, state, or its officers or employees rendering aid in another state pursuant to this compact shall be liable on account of any act or omission in good faith on the part of such forces while so engaged.</p>

Liability of Volunteers Providing Uncompensated Care	
Federal Volunteer Protection Act of 1997 Section 4(a)	<p>A volunteer of a nonprofit organization or government generally will be relieved of liability for harm if the volunteer was acting within the scope of his or her responsibilities and was properly licensed, certified, or authorized for the activities (whenever such licensing, certification, or authorization is appropriate or required). This statute is very broad and may apply in a variety of circumstances. If a volunteer is summoned by a proper authority and possesses the required first aid and emergency care training, immunity from liability appears to exist while providing any service that could fall within the definition of emergency services. For the purposes of this statute, emergency services include, but are not limited to, first aid and medical services, rescue procedures, and transportation or other related activities necessary to insure the safety of the individual who is the object of a search or rescue operation. The Act preempts state law, but allows a state to apply its own law exclusively in any case that does not involve out-of-state parties. It does not protect volunteer organizations. As it is a federal provision, it cannot be suspended or flexed by the Governor.</p> <p>The Act provides immunity from liability to Disaster Service Worker volunteers, protecting them from any civil litigation resulting from acts of good faith. The Disaster Service Worker volunteer also has protection while providing disaster service (e.g., damage or destruction of property, injury or death of an individual). Immunity from liability does not apply in cases of willful intent, unreasonable acts beyond the scope of Disaster Service Worker training, or a criminal act.</p>
Good Samaritan statutes under California Business and Professions Code Sections 2395, 2395.5, 2396, and 2398	<p>No licensee, who in good faith renders emergency care at the scene of an emergency, shall be liable for any civil damages as a result of any acts or omissions by such person in rendering the emergency care. "The scene of an emergency" as used in this section shall include, but not be limited to, the emergency rooms of hospitals in the event of a medical disaster. "Medical disaster" means a duly proclaimed state of emergency or local emergency declared pursuant to California Emergency Services Act. Volunteers who come forward to offer services and have not pre-registered or been impressed into service (known as convergent volunteers) and are not listed as Disaster Service Worker volunteers have some liability protection for disaster service under the Good Samaritan statutes.</p>
Disaster Service Worker Volunteer Program Guidance, ⁴² Emergency Services Act Government Code Section 8657	<p>Disaster Service Worker volunteers are provided limited immunity from liability while providing disaster service as it is defined in 19 CCR 2570.2 and 2572.2. The Disaster Service Worker Volunteer Program limits the ability of volunteers to be paid for any services provided, distinguishing a Disaster Service Worker from others who are compensated for their services.</p>

<p>California Civil Code Sections 1714.2 and 1714.21</p>	<p>If a person trained in basic cardiopulmonary resuscitation by the American Hospital Association or American Red Cross and renders cardiopulmonary resuscitation in good faith at the scene of an emergency, he or she is not liable for any civil damages unless grossly negligent. This provision is not applicable to those who expect to be compensated. A person is not liable for any civil damages if an automated external defibrillator is used at the scene of an emergency and the requirements for proper maintenance and use of the defibrillator defined in Health and Safety Code Section 1797.196 are followed.</p>
<p>Civil Code Section 1714.6</p>	<p>The violation of any statute or ordinance shall not establish negligence as a matter of law where the act or omission involved was required in order to comply with an order of the Governor promulgated under the California Emergency Services Act. No person shall be prosecuted for a violation of any statute or ordinance when violation of such statute or ordinance is required in order to comply with an order or proclamation of the Governor promulgated under the Emergency Services Act. The provisions of this section shall apply to such acts or omissions whether occurring prior to or after the effective date of this section. Therefore, to the extent an existing statute or ordinance delineates certain requirements (e.g., statutory scope of service), an order modifying that statute and authorizing altered scope of service could not, during the declared disaster, constitute a violation of law upon which to base a negligence cause of action against the licensed healthcare worker.</p>

7.1.5. Federal Tort Claims Act (FTCA) Coverage of Community Care Clinics during a Healthcare Surge

The Federally Supported Clinics Assistance Act of 1992 (FSHCAA) extends Federal Tort Claims Act (FTCA) coverage to eligible program grantees. The intent of FSHCAA is to increase the funds available for the provision of primary healthcare services by reducing the expenditure of clinic funds for medical malpractice insurance. This is accomplished by making eligible clinics federal employees for the purpose of medical malpractice protection. As federal employees, these organizations and individuals are immune from medical malpractice suits for actions within the scope of their clinic employment. In the event that a suit is filed, the clinic and covered employee will be dismissed from the case, and the case will continue against the United States as the sole defendant.

This policy applies to all clinics funded under the Health Center Program authorization in section 330 of the PHS Act (42 U.S.C. 245b), as amended, specifically: Community Health Center (CHC) Programs, funded under section 330(e); Migrant Health Center (MHC) Programs, funded under section 330(g); Health Care for the Homeless (HCH) Programs, funded under 330(h); and Public Housing Primary Care (PHPC) Programs, funded under section 330(i). Clinic employees and eligible contractors are eligible for FTCA coverage while providing services within the approved section 330-grant supported scope of the project.

During an emergency, FTCA-deemed clinics may be called upon to provide services at temporary locations. Temporary locations include any place that provides shelter to evacuees and victims of an emergency, as well as those locations where mass immunizations or medical care is provided as part of a coordinated effort to create a temporary medical infrastructure in areas of need. These temporary locations are considered part of a clinic's scope of project if all of the following conditions are met:

- Services are provided on a temporary basis.
- Temporary locations are within the clinic's service area or neighboring counties, parishes, or other political subdivisions adjacent to the clinic's service area.
- Services are provided by clinic staff and are within the approved scope of project.
- All activities of clinic staff are conducted on behalf of the clinic.

In situations where an emergency impacts an entire region or state, a clinic may be called upon to provide care to its target population which has been displaced to a distant part of the state or region. In these instances, the clinic may submit a request for prior approval to temporarily change its scope of project to include operation of a site outside the clinic's usual area of operation. The following conditions must be met in order for a temporary site outside the usual area of operation to be eligible for inclusion within the scope of project:

- The clinic must demonstrate that the purpose of the temporary site is to provide services primarily to its original target population, which has been displaced by the emergency, and to other Medically underserved populations that may have been displaced by the disaster.
- Services are provided on a temporary basis.
- Services are provided by clinic staff and are within the approved scope of project.
- All activities of clinic staff are conducted on behalf of the clinic.

7.2. Special Considerations for Pharmacists: The California State Board of Pharmacy Waiver of Pharmacy Practices

To respond to the potential of a healthcare surge and to ensure an effective response to a local, state, or national emergency, the California State Board of Pharmacy issued a Disaster Response Policy Statement in January 2007. The purpose of the Policy Statement and potential waivers is to encourage pharmacists to do everything possible to do the most good for the largest number of people during a healthcare surge.

In the event of a declared emergency, the Board expects to use its authority under the California Business and Professions Code, including Sections 4005(b) and 4062, to encourage and permit emergency provision of care to impacted patients and areas, including waiver of requirements that may be difficult to meet during surge events.⁴³ This policy considers normal operating procedures that may not be able to be performed during a healthcare surge, such as

recordkeeping requirements, labeling requirements, employee ratio requirements, consultation requirements, and other standard pharmacy practices and duties that may interfere with the most efficient response to those affected.

7.2.1. Communication of the California State Board of Pharmacy Waiver

In the event the pharmacy waiver is activated, the California State Board of Pharmacy will communicate this information to CalEMA for wide distribution. Information will also be posted on their website at <http://www.pharmacy.ca.gov> and communicated via phone at (916) 574-7900.

The Board expects licensed pharmacists to use judgment and training when providing medication to patients and do what is in the best interest of the patients. The board also expects that the highest standard of care possible will be provided and that once the emergency has dissipated, its pharmacists will return to practices conforming to state and federal requirements.⁴⁴

7.2.2. California State Board of Pharmacy Disaster Policy Statement

The California State Board of Pharmacy Disaster Policy Statement below should be used for reference to better understand the purpose of the California State Pharmacy Board waiver and how it will be used in the event of a healthcare surge:

The California State Board of Pharmacy wishes to ensure complete preparation for, and effective response to, any local, state, or national disaster, state of emergency, or other circumstance requiring expedited health system and/or public response. Skills, training, and capacities of Board licensees, including wholesalers, pharmacies, pharmacists, intern pharmacists, and pharmacy technicians, will be an invaluable resource to those affected and responding. The Board also wishes to encourage an adequate response to any such circumstance affecting residents of California by welcoming wholesalers, pharmacies, pharmacists, intern pharmacists, and pharmacy technicians licensed in other states to assist with health system and/or public response to residents of California.

The Board encourages its licensees to volunteer and become involved in local, state, and national emergency and disaster preparedness efforts. City or county health departments, fire departments, or other first responders can provide information on local opportunities. The Emergency Preparedness Office of the California Department of Public Health is a lead agency overseeing emergency preparedness and response in California, particularly regarding health system response, drug distribution and dispensing, and/or immunization and prophylaxis in the event of an emergency. At the federal level, lead contact agencies include the Department of Health and Human Services, the Centers for Disease Control,

and/or the Department of Homeland Security and its Federal Emergency Management Agency (FEMA). Potential volunteers are encouraged to register and get information at <http://www.medicalvolunteer.ca.gov> (California) and <http://www.medicalreservecorps.gov> (federal).

The Board also continues to be actively involved in such planning efforts, at every level. The Board further encourages its licensees to assist in any way they can in any emergency circumstance or disaster. Under such conditions, the priority must be protection of public health and provision of essential patient care by the most expeditious and efficient means. Where declared emergency conditions exist, the Board recognizes that it may be difficult or impossible for licensees in affected areas to fully comply with regulatory requirements governing pharmacy practice or the distribution or dispensing of lifesaving medications.

In the event of a declared disaster or emergency, the Board expects to utilize its authority under the California Business and Professions Code, including Section 4062, Subdivision (b), to encourage and permit emergency provision of care to affected patients and areas, including by waiver of requirements that it may be implausible to meet under these circumstances, such as prescription requirements, record-keeping requirements, labeling requirements, employee ratio requirements, consultation requirements, or other standard pharmacy practices and duties that may interfere with the most efficient response to those affected.¹ The Board encourages its licensees to assist, and follow directions from local, state, and federal health officials. The Board expects licensees to apply their judgment and training to providing medication to patients in the best interests of the patients, with circumstances on the ground dictating the extent to which regulatory requirements can be met in affected areas. The Board further expects that during such emergency, the highest standard of care possible will be provided, and that once the emergency has dissipated, its licensees will return to practices conforming to state and federal requirements.

Furthermore, during a declared disaster or emergency affecting residents of California, the Board hopes that persons outside of California will assist the residents of California. To facilitate such, in the event of a declared California disaster or emergency, the Board expects to use its powers under the California Business and Professions Code, including Section 900 and Section 4062(b), to allow any pharmacists, intern pharmacists, or pharmacy technicians, who are not licensed in California but who are licensed in good standing in another state, including those presently serving military or civilian duty, to provide emergency pharmacy services in California.² The Board also expects to allow nonresident pharmacies or wholesalers that are not licensed in California but that are licensed in good standing in another state to ship medications to pharmacies, health professionals or other wholesalers in California.

Finally, the Board also expects to allow use of temporary facilities to facilitate drug

distribution during a declared disaster or state of emergency. The Board expects that its licensees will similarly respond outside of the state to disasters or emergencies affecting populations outside California, and will pursue whatever steps may be necessary to encourage that sort of licensee response.

¹Expanded powers in the event of a disaster are also granted to the Governor and/or other chief executives or governing bodies within California by the California Emergency Services Act (California Government Code Sections 8550-8668) and the California Disaster Assistance Act (California Government Code, Section 8680-8690.7), among others. Section 8571 of the California Government Code, for instance, permits the Governor to suspend any regulatory statute during a state of war or emergency where strict compliance therewith would prevent, hinder, or delay mitigation.

²See also the Interstate Civil Defense and Disaster Compact (California Government Code, Section 177-178), the Emergency Management Assistance Compact (California Government Code, Sections 179-179.5), and the California Disaster and Civil Defense Master Mutual Aid Agreement (executed 1950), regarding cooperation among the states.

7.2.3. Distribution and/or Dispensing of Pharmaceuticals by Non-Licensed Pharmacists during a Healthcare Surge

During a healthcare surge, there is a possibility that there may not be a licensed pharmacist available on-site to dispense pharmaceuticals. California Business and Professions Code Section 4051 states that “it is unlawful for any person to manufacture, compound, furnish, sell, or dispense any dangerous device, or to dispense or compound any prescription pursuant to [Business and Professions Code] Section 4040 of a prescriber unless he or she is a pharmacist under this chapter.”⁴⁵

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, and
- Access to the information is secure from unauthorized access and use.

To expand the dispensing of pharmaceuticals during a surge, the California State Board of Pharmacy may opt to waive application of any provisions or regulations adopted if, in the Board of Pharmacy’s opinion, this waiver will aid in the protection of public health or the provision of patient care during a declared federal, state, or local emergency as noted in California Business and Professions Code Sections 4005(b) and 4062.

7.2.4. Out-of-State Licensed Pharmacists, Intern Pharmacists, and/or Pharmacy Technicians

The possibility of limited pharmacy staff during a catastrophic emergency may necessitate using volunteers from out-of-state to assist in providing services that a pharmacist, intern pharmacist, and/or pharmacy technician licensed in California would provide under normal operating conditions.

The California State Board of Pharmacy encourages persons outside of California to assist California residents during declared states of emergency. In the event of a declared emergency, the Board expects to use its powers under the California Business and Professions Code, including Section 900 and Sections 4005(b) and 4062, to allow pharmacists, intern pharmacists, or pharmacy technicians who are not licensed in California but who are licensed in good standing in another state, including those presently serving military or civilian duty, to provide emergency pharmacy services in California.⁴⁶

7.2.5. Furnishing Medications without a Prescription

During a healthcare surge, there may be limited opportunities to obtain a prescription for needed medication from a physician. Therefore, California's 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.⁴⁷ It further states that a record containing the date, name, and address of the person to whom the drug or device is furnished and the name, strength, and quantity of the drug or device furnished shall be maintained and the pharmacist shall communicate this information to the patient's attending physician as soon as possible.

7.3. Credential Verification

7.3.1. Credential Verification During a Healthcare Surge

Federal and state laws address credentialing and privileging responsibilities to ensure that healthcare professionals have the requisite education, training, and experience to provide care. State and federal credential requirements can be found in California Business and Professions Code Sections 2282, 2283; 22 CCR 75027; and 42 CFR 482.12 and 482.22. By law, these responsibilities are held by both the medical staff and the facility's governing body. Through prescribed processes and procedures, including primary source verification, healthcare professionals undergo an assessment and competency evaluation to credential and privilege. These same requirements are also addressed under Joint Commission accreditation standards. The Accreditation Association for Ambulatory Health Care (<http://www.aaahc.org>) can also offer guidance related to credentialing verification procedures.

The Joint Commission *Comprehensive Accreditation Manual for Ambulatory Care* (2009 edition, available for purchase at <http://www.jcrinc.com/Accreditation-Manuals/2009-PORTABLE-CAMAC/865/>) 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 of patient care services (e.g., clinical privileges) are authorized for a healthcare professional by a healthcare organization, based on evaluation of the individual’s credentials and performance.⁴⁸

Under normal operations, Joint Commission-accredited organizations are obligated to complete the credentialing process for each licensed independent health professional including, but not limited to, physicians and physician assistants. The Joint Commission does not suspend accreditation requirements during an emergency. Community care clinics continue to be required to verify competency and maintain oversight of the professionals and care delivered. If primary source verification cannot be obtained within 72 hours from the health professional presenting, the provider must keep records of the reasons for not completing the required verification check.

Although no existing authority has the power to waive Joint Commission requirements during a healthcare surge, it may be necessary to allow clinics to rely on healthcare professionals who are not currently credentialed staff members. These staff may be pre-registered volunteers, Disaster Service Workers, or out-of-state professionals and may be activated under the auspices of the SEMS/NIMS. Additional clinical staff may be walk-in volunteers.

In some instances, existing law automatically facilitates the use of these augmented staff. California Government Code Section 178, Article 4 (Interstate Civil Defense and Disaster Compact), recognizes the licensure, credentialing, or permit held by a healthcare professional in any state as evidence of qualifications to provide disaster assistance within the scope of service of the provider or health professional.

California Government Code Section 179.5, Article 5 (Emergency Management Assistance Compact), provides deemed recognition to healthcare professionals holding a current license, certificate, or other permit issued by another state that is part of the Mutual Aid Compact. By virtue of this deemed status as a licensed health professional, out-of-state professionals may assist during an emergency without the administrative delay required to verify qualifications of the healthcare professional. Business and Professions Code Section 900 authorizes the Director of the Emergency Medical Services Authority, during a state of emergency, to authorize healthcare professionals licensed in another state to practice in designated areas of California. This provision allows for the use of healthcare professionals who are not governed by a Mutual Aid Compact.

Business and Professions Code Section 921, as part of the Health Care Professional Disaster Response Act, permits the use of providers with lapsed or inactive licenses in disaster areas where shortage exists. However, the administrative requirements associated with this

permission (i.e., application submitted to the Medical Board, documentation of continuing education credits, fingerprinting) may be prohibitive if time is of the essence.

7.3.2. Streamlined Credentialing and Privileging during a Healthcare Surge

The credentialing process emphasizes verification of a healthcare professional's experience, abilities, and competencies – an act that should not be omitted even during (or especially during) a healthcare surge. As such, the recommendations contained in this section for streamlining the credential verification process are not centered on the flexing or suspension of this process but are meant to provide an expedited mechanism by which the pool of potential personnel may be increased more rapidly. This may be accomplished in two ways:

- Implementing a streamlined credentialing and/or competency assessment process
- Collecting the minimum amount of information necessary

The emergency credentialing and/or competency assessment processes referred to in this section are based on Joint Commission standards and current positive practices from various community care clinics. Tools to implement these recommendations have been developed and are featured in this section and in the *Community Care Clinics Operational Tools Manual*.

The requirements for credentialing of health professionals under normal operations do not allow a volunteer health professional to provide immediate care, treatment, and services in the event of an emergency due to the length of time it would take to complete the process. Community care clinics should consider their current processes for evaluating the credentials and competencies of staff and volunteers and identify aspects of that process that may be impossible or impractical to administer during a healthcare surge. Processes that rely on internet resources or phone systems, which may become unavailable in an emergency, deserve special attention. Based on this analysis, a clinic should develop a modified credentialing and/or competency assessment process to implement when an emergency operations plan has been activated and the immediate needs of patients cannot be met.

Even under a modified process, safeguards must remain in place to assure that volunteer health professionals are competent to provide safe and adequate care. Even in an emergency, the integrity of two parts of the usual credentialing and/or competency assessment process must be maintained. These are:

- Verification of licensure (if applicable)
- Oversight of the care, treatment, and services provided

The Joint Commission does not outline any formal procedure for carrying out this process, nor does it make any commitment to suspend accreditation requirements during an emergency. Community care clinics retain the obligation to verify competency and maintain oversight of

health professionals and care delivered. 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 reason for not completing the required verification check.

To comply with Joint Commission and best practice standards, clinics are held to the following criteria or performance expectations when streamlining the credentialing and privileging process:

- Emergency privileges are granted only when the following two conditions are present: (1) the clinic's emergency management plan has been activated, and (2) the clinic is unable to meet immediate patient needs.
- An individual(s) responsible for granting emergency privileges is identified.
- The Medical Director describes, in writing, a mechanism (e.g., direct observation, mentoring, clinical record review) to oversee the professional performance of volunteer health professionals who receive emergency privileges.
- The clinic has a mechanism to readily identify volunteer health professionals who have been granted emergency privileges.
- For volunteers to be considered eligible to act as licensed independent health professionals, the clinic must obtain for each volunteer practitioner, at a minimum, a valid photo identification issued by a state or federal agency (e.g., driver's license or passport), and at least one of the following.
 - A current healthcare facility photo identification card that clearly identifies professional designation
 - A current license to practice
 - Primary source verification of the license (if applicable)
 - Identification indicating that the individual is registered with the California Disaster Healthcare Volunteers or a member of a California Medical Assistance team, Disaster Medical Assistance Team, Medical Reserve Corps, or other recognized federal or state organization or group
 - Identification indicating that the individual has been granted authority to render patient care, treatment, and services in emergency circumstances (such authority having been granted by a federal, state, or municipal entity)
 - Identification by a current clinic or medical staff member who possess personal knowledge regarding a volunteer's ability to act as a licensed independent practitioner during an emergency
 - Primary source verification of licensure (if applicable) begins as soon as the immediate situation is under control and is to be completed within 72 hours after the volunteer practitioner presents to the clinic. If primary source verification cannot be completed in 72 hours (e.g., no means of communication or a lack of resources), it is expected that it

be done as soon as possible. In this extraordinary circumstance, there must be documentation of the following: why primary source verification could not be performed in the required time frame; evidence of a demonstrated ability to continue to provide adequate care, treatment, and services; and an attempt to rectify the situation as soon as possible.

- The clinic's Medical Director oversees the professional practice of volunteer independent health professionals (licensed and unlicensed).
- The organization makes a decision (based on information obtained regarding the professional practice of the volunteer) within 72 hours related to the continuation of the emergency privileges initially granted.

Community care clinics should review their current policies, procedures, bylaws, rules, and regulations for credentialing staff and granting temporary emergency privileges to determine their compliance with accreditation standards. Additionally, current policies and procedures should be updated to reflect that, under a declared state of 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).

7.3.3. Volunteer Application for Clinical Staff

Community care clinics may use the following application to register volunteer clinical staff (licensed and non-licensed) during an emergency.

The Volunteer Application for Clinical Staff is shown below. The complete tool can be found in the *Community Care Clinics Operational Tools Manual* on pages 67-71.

Volunteer Application for Clinical Staff

Instructions:

1. For clinical staff who present at a clinic, the Medical Director or representative will provide him/her with the following application form.
2. All clinical staff must present proper identification, including a valid photo identification issued by a state or federal agency (e.g., driver's license or passport) and at least one of the following:
 - a. A current healthcare facility photo identification card
 - b. A current license to practice (if applicable)
 - c. Identification indicating that the individual is a member of a California Medical Assistance Team or a Disaster Medical Assistance Team
 - d. Documentation indicating that the individual has been granted authority to render patient care in emergency circumstances by a federal, state, or municipal entity

- or
- e. Presentation by current clinic or medical staff member(s) with personal knowledge regarding the healthcare professional's identity
3. The completed application form should be given to the Medical Director or other designated individual for review and determination of the healthcare professional's duties and area of assignment.
 4. Concurrently, a clinic representative should initiate the primary source verification process. This process should be completed within 72 hours from the time the practitioner presented to the organization.

VOLUNTEER APPLICATION FOR CLINICAL STAFF		
APPLICATION DATE: / /	DATE YOU CAN START: / /	
PERSONAL INFORMATION		
Last Name:	First Name:	Middle Initial:
Is there any additional information about a change of your name, use of an assumed name, or use of a nickname that will assist us in checking your work and educational records? <input type="checkbox"/> No <input type="checkbox"/> Yes - If Yes, explain:		
<u>Current Address</u> Street: City: State: Zip:	<u>Alternate Address</u> Street: City: State: Zip:	
Phone number: ()	Pager/Cell Phone number: ()	
Other Phone: ()	Are you 18 years or older? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Birth Date (mm/dd/yyyy):	Birth Place (City, State):	
EMERGENCY CONTACTS		
Give name, telephone number, and relationship of two individuals whom we may contact in the event of an emergency.		
Name	Telephone Number	Relationship
1.	()	
2.	()	
DEPENDENTS		
List any dependents for whom you are responsible.		
Name	Place of Residence, Telephone Number	Relationship

1.				
2.				
3.				
LICENSURE/CERTIFICATION/REGISTRATION INFORMATION (If Applicable)				
Do you now have or have you previously had a healthcare-related license, certification, and/or registration? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, license, certification and/or registration type(s): Issuing State(s): Is your license/certification/registration currently in good standing? <input type="checkbox"/> No <input type="checkbox"/> Yes If No, explain why not: Has your license/certification/registration ever been revoked or suspended? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, explain reason(s), date of revocation(s) or suspension(s), and date of reinstatement(s):				
<u>Current Place of Practice</u> Street: City: State: Zip:		<u>Location of Internship/Residency</u> Street: City: State: Zip: Year/Month of Graduation:		
Medical License Number:	National Provider Identification number (NPI):	Drug Enforcement Administration (DEA) number:		
AVAILABILITY & AFFILIATION				
Indicate your availability: <input type="checkbox"/> Sunday <input type="checkbox"/> Monday <input type="checkbox"/> Tuesday <input type="checkbox"/> Wednesday <input type="checkbox"/> Thursday <input type="checkbox"/> Friday <input type="checkbox"/> Saturday Times of day you may be available: _____				
Are you registered with a volunteer organization? If Yes, select below: <input type="checkbox"/> California Disaster Healthcare Volunteers <input type="checkbox"/> Medical Reserve Corps (MRC) <input type="checkbox"/> California Medical Assistance Team (CalMAT) <input type="checkbox"/> Other: _____ <input type="checkbox"/> Disaster Medical Assistance Team (DMAT)				
EDUCATION & VOCATIONAL TRAINING				
	High School	College/University	Graduate/Professional	Vocational/Business
School Name, City & State				

No. Years/Last Grade Completed																													
Diploma/Degree																													
<p>Do you have any experience, training, qualifications, or skills which would assist labor pool coordinators in assigning an appropriate position? <input type="checkbox"/> No <input type="checkbox"/> Yes -If Yes, specify.</p> <p>Check the boxes below for each age group for which you have expertise in providing age-appropriate nursing care:</p> <p> <input type="checkbox"/> Newborn/Neonate <input type="checkbox"/> Infant (30 days - 1 yr) <input type="checkbox"/> Toddler (1 - 3 yrs) <input type="checkbox"/> Preschooler (3 - 5 yrs) <input type="checkbox"/> School age children (5 - 12 yrs) <input type="checkbox"/> Adolescents (12 - 18 yrs) <input type="checkbox"/> Young adults (18 - 39 yrs) <input type="checkbox"/> Middle adults (39 - 64 yrs) <input type="checkbox"/> Older adults (64+) </p> <p>My experience is primarily in: (Indicate number of years.)</p> <p> <input type="checkbox"/> Critical Care year(s): _____ <input type="checkbox"/> Emergency Medicine year(s): _____ <input type="checkbox"/> Home Care year(s): _____ <input type="checkbox"/> Med/Surg year(s): _____ <input type="checkbox"/> Pediatrics year(s): _____ <input type="checkbox"/> Outpatient year(s): _____ <input type="checkbox"/> Surgery year(s): _____ <input type="checkbox"/> Trauma year(s): _____ <input type="checkbox"/> Other (specify): _____ year(s): _____ </p>																													
<p>Do you speak, write, and/or read any languages other than English? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, identify which other language(s) and rate your proficiency in these languages:</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;">Language</th> <th style="text-align: center;">Fluent</th> <th style="text-align: center;">Speak</th> <th style="text-align: center;">Read</th> <th style="text-align: center;">Write</th> </tr> </thead> <tbody> <tr> <td>_____</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>_____</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>_____</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>_____</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </tbody> </table>					Language	Fluent	Speak	Read	Write	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Language	Fluent	Speak	Read	Write																									
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																									
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																									
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																									
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																									
VERIFICATION OF TRUTHFULNESS AND UNDERSTANDING REGARDING VOLUNTEER AGREEMENT																													
_____ Initials	I swear that the information I provide and the representations I make are truthful, complete, accurate, and free of any attempt to mislead.																												

_____ Initials	By completing this form, I attest that I am of sound physical and mental capacity and capable of performing in an emergency/disaster setting. I acknowledge that emergency/disaster settings can pose significant psychological and physical hardships and risks to those volunteering their services and the emergency/disaster settings often lack the normal amenities of daily life and accommodations for persons with disabilities. In agreeing to volunteer my services, I agree to accept such conditions and risks voluntarily.
_____ Initials	I understand that I am required to abide by all rules and practices of this facility and affiliated entities as well as all applicable state and federal laws and regulations.
_____ Initials	I agree to serve as a volunteer without compensation or payment for my services. I agree to hold the [Clinic Name] and any of its entities or subdivisions harmless from any claims of civil liability, including but not limited to claims of malpractice or negligence, criminal liability, injury, or death.
Signature of Volunteer: _____ Date: / /	
TO BE COMPLETED BY FACILITY REPRESENTATIVE	
_____	Proper identification was verified and copied. <input type="checkbox"/> Government issued photo identification (all applicants) <input type="checkbox"/> A current healthcare facility photo identification card <input type="checkbox"/> A current license to practice (if applicable) If applicant unable to present license, 2 witnesses from applicant's current place of practice may attest to applicant's qualifications to practice. <input type="checkbox"/> Identification indicating that the individual is a member of the California Medical Assistance Team (CaMAT) or a Disaster Medical Assistance Team (DMAT) <input type="checkbox"/> Documentation indicating that the individual has been granted authority to render patient care in emergency circumstances by a federal, state, or municipal entity. <input type="checkbox"/> Attestation by current staff member(s) with personal knowledge regarding the practitioner's identity. Witness 1 Signature _____ Date _____ Witness 2 Signature _____ Date _____
To be completed by Administrator or authorized designee. I authorize this individual to volunteer.	
Signature of Administrator: _____ Date: / /	

7.3.4. Credentialing Log for Licensed Healthcare Professionals

The following table provides a template to document that those health professionals who have been granted temporary emergency privileges have supplied the appropriate and required documentation.

The Credentialing Log for Licensed Healthcare Professionals is shown below and on the following page. The complete tool can be found in the *Community Care Clinics Operational Tools Manual* on pages 72-73.

Credentialing Log for Licensed Healthcare Professionals

Instructions for Use

For each licensed health care professional who presents at a clinic to apply for emergency credentials, a staff member will document the following information:

- Professional's full name
- Presence (by checking off the applicable box) of the identification requirements; a government-issued photo identification (e.g., a driver's license) is required in order to qualify for emergency credentials.
- Comparison of the government-issued photo identification to verify the other forms of identification indicating what authority the individual has to render patient care.
 - If the health professional submits other forms of identification, such as documentation indicating that the individual has been granted authority to render patient care in emergency circumstances (e.g., proof of volunteer participation in the California Disaster Healthcare Volunteers) or presentation by current clinic or medical staff member(s) with personal knowledge regarding the professional identity, these should be specified in the box labeled "Other."

Once the practitioner's identity has been verified and their ability to practice has been confirmed, the Medical Director will determine the duties and area of assignment for each healthcare professional. This information should be documented in the column labeled "Declared Competencies."

8. Augmenting Non-Clinical Staff

In addition to clinical staff, the operation of a clinic requires non-clinical staff to carry out functions such as administration, child care, security, pastoral care, transport services and maintenance. In developing its emergency operations plan, community care clinics should identify the functions that can be performed by community-based organizations, volunteer staff, and/or private contractors.

The clinic may have Memoranda of Understanding with local staffing agencies to provide this support; the Memoranda should include a process to verify employee's background. In the event that a volunteer not registered with a staffing agency presents at the clinic to provide non-clinical support, the Volunteer Application Form for Non-Clinical Staff can be used.

Acceptance of non-clinical staff may follow a process similar to that outlined for clinical staff in "Acceptance and Assignment of Augmented Staff during Healthcare Surge," in Section 6.1. Clinics may choose to adapt this flow-chart to ease augmentation of their non-clinical workforce.

8.1. Verification of Non-Clinical Staff

The Volunteer Application Form for Non-Clinical Staff should be used in registering all support staff volunteers. This form can serve as a tool to verify identification of volunteers, capture needed emergency information, and identify skills of volunteer staff.

The Volunteer Application for Non-Clinical Staff is shown below. The complete tool can be found in the *Community Care Clinics Operational Tools Manual* on pages 74-78.

Volunteer Application for Non-Clinical Staff

Instructions

1. For all non-clinical volunteers who present at a clinic to provide service, the Human Resources department representative should provide him/her with the following application form.
2. Each professional or volunteer must present to the Human Resources department representative with proper identification including a valid photo identification issued by a state or federal agency (i.e., driver's license or passport and at least one of the following below to grant temporary work during the emergency:
 - a. A current healthcare facility photo identification card that clearly identifies professional designation

Name	Place of Residence, Telephone Number	Relationship
1.		
2.		
3.		

AVAILABILITY, AFFILIATION, & EXPERIENCE

Indicate your availability:

- Sunday Monday Tuesday Wednesday Thursday Friday Saturday

Times of day you may be available: _____

Are you registered with a volunteer organization? If Yes, select below:

- California Disaster Healthcare Volunteers Medical Reserve Corps (MRC)
 California Medical Assistance Team (CalMAT) Other: _____
 Disaster Medical Assistance Team (DMAT)

Check the areas in which you are experienced and can provide services.

- Ability to supervise children Administrative/ clerical duties
 Computer skills Facilities management (e.g., electrical, plumbing, maintenance)
 First aid (e.g., wound care) Other – specify: _____

EDUCATION & VOCATIONAL TRAINING

	High School	College/University	Graduate/Professional	Vocational/Business
School Name, City & State				
No. Years/Last Grade Completed				
Diploma/Degree				

Do you speak, read, and/or write any languages other than English? No Yes

If Yes, identify which other languages and rate your proficiency in these languages:

Language	Fluent	Speak	Read	Write
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

VERIFICATION OF TRUTHFULNESS AND UNDERSTANDING REGARDING VOLUNTEER AGREEMENT

<u> </u> Initials	I swear that the information I provide and the representations I make will be truthful, complete, accurate, and free of any attempt to mislead.
<u> </u> Initials	I acknowledge by completing this form that I am of sound physical and mental capacity, and capable of performing in an emergency setting. I acknowledge that emergency settings can pose significant psychological and physical hardships and risks to those volunteering their services and the emergency settings often lack the normal amenities of daily life and accommodations for persons with disabilities. In agreeing to volunteer my services, I agree to accept such conditions and risks voluntarily.
<u> </u> Initials	I understand that I am required to abide by all rules and practices of this facility and affiliated entities as well as all applicable state and federal laws and regulations.
<u> </u> Initials	I agree to service as a volunteer, without compensation or payment for my services. I agree to hold the State of California and any of its entities or subdivisions harmless from any claims of civil liability, including but not limited to claims of malpractice or negligence, criminal liability, injury, or death.

Signature of Volunteer Applicant: _____ **Date:** / /

TO BE COMPLETED BY ASSIGNED DESIGNEE - STAFF VERIFICATION

Proper identification was verified and copied.

- Government-issued photo identification (All Applicants)
- Contractor License # (Human Resources - Unlicensed Staff only)
- Union or Trade Association identification (Human Resources - Unlicensed Staff only)
- Professional Certification (Human Resources - Unlicensed Staff only)

To be completed by Administrator or authorized designee.

I authorize this individual to volunteer.

Signature of Administrator: _____ **Date:** / /

8.2. Non-Clinical Support Matrix

The following sample staff utilization matrix, which has been adapted from the Wisconsin State Expert Panel⁴⁹, provides community care clinics with a template and guidelines for identifying non-clinical staffing needs during healthcare surge.

The Non-Clinical Support Matrix is shown below. The complete tool can be found in the *Community Care Clinics Operational Tools Manual* on pages 79-80.

Non-Clinical Support Matrix

Instructions

In planning for an emergency, facilities should consider the staff necessary to treat not only patients but also staff, patients' family members, and visitors who may come to the healthcare facility. The following non-clinical roles should be considered when planning for a non-clinical service function during a healthcare surge.

- Housekeeping
- Food Services
- Security
- Registration and Billing
- Medical Records
- Pastoral Care
- Transport Services
- Environmental Services (e.g., maintenance, housekeeping)
- Clerical Assistance
- Runners

Each clinic department or functional group should complete its own staff utilization matrix. It is recommended that functions collaborate to determine how to best allocate and assign staff among functions.

Non-Clinical Support Matrix				
Level	Number of Patients Expected	Complex/Critical Rooms	Basic and Supportive Rooms	Staff Support Functions
I	1-10			
II	11-25			
III	26-50			
IV	51-100			
V	>100			

9. Maintaining the Workforce

9.1. Workforce Health and Safety and Workers' Rights

Health and safety is an integral part of any emergency preparedness plan. Community care clinics must remain compliant with occupational safety and health requirements set forth in federal and state statutes and regulations, including Cal/OSHA and federal Occupational Safety and Health Administration (OSHA) regulations, and the California Labor Code. Together, these authorities dictate the overarching primary obligation of employers, including community care clinics, to provide for the health and safety of their staff.

One method by which a clinic can protect the health and safety of their workforce is in the provision of personal protective equipment. 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.

The U.S. Department of Labor’s *Worker Safety and Health Support Annex* provides guidelines for implementing worker safety and health support functions during potential or actual incidents of national significance. This Annex describes the actions needed to ensure that threats to responder safety and health are anticipated, recognized, evaluated and controlled consistently so that responders are properly protected during incident management operations. The Annex can be accessed at:

http://www.osha.gov/SLTC/emergencypreparedness/nrp_work_sh_annex.html.

Employers not only have an obligation to safeguard the health and safety of their workforce but also have responsibility to honor employees’ rights. A healthcare surge would affect the way in which community care clinics would be able to address workers’ rights (e.g., requiring staff and administrators to report to work or remain at work during an emergency). The California Industrial Welfare Commission Order Number 4-2001,3(B) (9)-(10) outlines the number of hours that healthcare professionals may work during a healthcare emergency. Healthcare emergency is defined in this order as “an unpredictable or unavoidable occurrence at unscheduled intervals relating to healthcare delivery, requiring immediate action.” Order Number 4-2001 3(B) (9)-(10) specifically states:

- No employee assigned to work a 12-hour shift established pursuant to this order shall be required to work more than 12 hours in any 24-hour period unless the Medical Director or authorized executive declares that:
 - A "healthcare emergency" exists;

- All reasonable steps have been taken to provide required staffing; and
- Considering overall operational status needs, continued overtime is necessary to provide required staffing.
- No employee shall be required to work more than 16 hours in a 24-hour period unless by voluntary mutual agreement of the employee and the employer, and no employee shall work more than 24 consecutive hours until said employee receives not less than eight consecutive hours off duty immediately following the 24 consecutive hours of work.

This order is subject to modification or waiver under the Governor's executive powers during a state of emergency.

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. This release can be obtained from the workers' compensation approved physician. In order to respond to a healthcare surge, this standard may be waived by authority of the Governor under the Emergency Services Act. Doing so potentially would allow facilities to return certain staff members willing and able to work in an expedited manner, thereby increasing the workforce pool.

9.2. Occupational Safety and Health Planning

Community care clinics are required to have a Health and Safety plan that addresses the following topics:

- Infection control
- Life safety
- Emergency action plan
- Control of hazardous substances
- Personal protective equipment
- Fatigue
- Heat stress
- Provision of sanitary facilities

For details related to the requirements for health and safety plans, see 29 CFR 1910.120; Joint Commission Standards on Safe Environment, Worker Safety, Waste Management; and 8 CCR 3203.

During a declared emergency, it is likely that the Cal/OSHA will work with the Safety Officer in the state, regional, or Operational Area Emergency Operations Centers to assist with achieving compliance with occupational safety standards and regulations. The following are additional occupational safety and health planning resources to assist in preparing for or responding to a healthcare surge:

- Community care clinics should develop an employee Health and Safety Checklist, which should be incorporated into the clinic emergency operations plans. Cal/OSHA's manual, "Guide to Developing Your Workplace Injury and Illness Prevention Program with Checklists for Self-Inspection" describes an employers' responsibilities in establishing, implementing, and maintaining an Injury and Illness Prevention Program. It also outlines steps that can be taken to develop an effective program that helps assure the safety and health of employees while on the job. The manual can be found at http://www.dir.ca.gov/dosh/dosh_publications/iipp.html.
- U.S. Department of Labor's Occupational Safety and Health Administration's *Worker Safety and Health Support Annex* provides guidelines for implementing worker safety and health support functions during potential or actual incidents of national significance. This annex describes the actions needed to ensure that threats to responder safety and health are anticipated, recognized, evaluated, and controlled consistently so that responders are properly protected during incident management operations. These can be adapted for use in the clinic emergency operations plans. The annex can be accessed at: http://www.osha.gov/SLTC/emergencypreparedness/nrp_work_sh_annex.html.

9.3. Support Provisions for Staff

In the Joint Commission emergency management standards revisions effective on January 1, 2008, Environment of Care 4.14 states that accredited healthcare facilities must establish strategies for managing resources and assets during emergencies. The Elements of Performance for Environment of Care 4.14 require that the organization plan for:

- Managing staff support activities (e.g., housing, transportation, incident stress debriefing)
- Managing staff family support needs (e.g., child care, elder care, communication)

Community care clinics that are recognized by the Accreditation Association for Ambulatory Health Care (AAHC) can reference the AAHC handbook to incorporate appropriate standards and tools. The AAHC handbook can be purchased from the AAHC website, <http://www.aaahc.org/>.

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. In order to meet the overarching obligation to support and safeguard the health and safety of their workforce and to increase the likelihood that staff will report to and remain at work during an emergency, it is recommended

that community care clinics develop a workforce resiliency policy including incident stress management and dependent care. The following tool outlines key elements of staff support provision.

The Considerations for Staff Support Provisions is shown below. The complete tool can be found in the *Community Care Clinics Operational Tools Manual* on pages 81-83.

Considerations for Staff Support Provisions

Purpose: The following information provides an outline for community care clinics when developing policies and provisions to support staff during a healthcare surge.

Staff Support Considerations

Clinics should consider the following issues in developing staffing plans and strategies:

- Some staff will not be able to report to work due to the fact that they, or their family and friends, may have been directly involved in the incident.
- Normal care providers may not be able to provide services during an incident so dependent care options (i.e., childcare, eldercare, care for family members with disabilities) should be offered to enable staff members to report to work.
- Some staff may have concerns about the shelter and care of their pets. Considerations should be made to plan for pet care during a healthcare surge. Designated kennel or housing provisions should be identified in the emergency operations plan. Service animals would not be subject to pet care provisions. Service animals must be allowed to accompany patients, visitors, and/or staff throughout the clinic.
- Clinics should designate areas for staff to rest or sleep. Clinics should make showers available to staff, and stock personal items (e.g., blankets, pillows, sheets, towels, soap, shampoo). In the case of a biological incident, there may be the need for work quarantine in addition to staff working longer shifts or otherwise unable to go home. Clinics may want to consider availability of sleeping accommodations and showers in local hotels, churches, and similar organizations.
- Clinics should designate areas for staff to eat and have refreshments and may want to consider working with neighboring restaurants for food preparation.
- Staff may be away from home for extended shifts and need to communicate with family members and other loved ones. Clinics should make telephones available to call home and computer access for email.
- For staff working extended shifts or unable to go home, there may be the need for laundry services or the provision of scrubs. Staff members should consider having an “emergency kit” readily available with personal items (e.g., underwear, socks, toiletries, a supply of

medications)

- Clinics should encourage staff to develop a family emergency plan so that family members are aware of what will happen and who is responsible for various duties if a family member, who works at the clinic, needs to work longer shifts or is quarantined at the clinic. Tools for staff family emergency plans are discussed in Section 9.4, "Staff Family Emergency Plan." Clinics may want to encourage staff to designate the clinic as their family meeting place in the event of an emergency.
- Clinics should consider back-up provisions for essential services (e.g., food services, laundry, and housekeeping) especially if these services are out-sourced, the incident affects the ability of the contractor to continue to provide these services, and/or if the surge of patients and visitors overwhelms the capacity of these contractors.

Based on these recommendations, the following staff support provisions should be considered by community care clinics when developing a surge plan:

- Behavioral/mental healthcare for staff
- Behavioral/mental healthcare for dependents
- Dependent care (i.e., childcare, eldercare, and care for family members with disabilities)
- Meal provisions for 3-7 days
- Water provisions for 3-7 days (1 gallon per person per day)
- Pet care
- Designated rooms for resting/sleeping
- Designated restrooms and showers
- Personal hygiene provisions (e.g., blankets, pillows, sheets, towels, soap, shampoo)
- Designated eating and food preparation areas
- Email/telephone access for communicating with family
- Clothing or laundry services for staff and dependents
- Emergency kits with personal items (e.g., underwear, socks, toiletries, a supply of medications) for staff to store at the place of work
- Family emergency plan

In regard to the provision of dependent care (i.e., child care, eldercare, care for family members with disabilities), it is recommended that clinics identify staff members who can provide care and supervision as needed during a healthcare surge. Using existing staff

increases the likelihood that these individuals have undergone background checks as part of the employment process. In addition, it may be beneficial to establish contracts with outside agencies or vendors who could be responsible for providing qualified and licensed professionals for dependent care. In the event such contracts are not feasible or agencies are not accessible, additional community resources should be identified as part of healthcare surge planning. Community resources may include schools, faith-based organizations, or other service organizations.

Community care clinics are encouraged to utilize the following tools to assist in addressing workforce resilience during an emergency and developing a policy for provision of dependent care.

The Policy for Workforce Resilience during an Emergency is shown below. The complete tool can be found in the *Community Care Clinics Operational Tools Manual* on pages 84-88.

Policy for Workforce Resilience during Emergencies

Purpose:

This policy offers guidelines for optimizing workforce resilience in the event of an emergency. It provides minimum standards for facilities to incorporate into current workforce resiliency policies. This policy applies to all clinic staff (paid employees or volunteers) during a time of healthcare surge.

Rationale:

The response to an emergency will pose substantial physical, personal, social, and emotional challenges to healthcare professionals. Clinic staff and their families will be at personal risk for as long as the emergency continues in their community. Special planning is therefore needed to ensure that clinics are prepared to help employees maximize personal resilience and professional performance.

Planning for workforce resilience will become especially important in the case of pandemic emergencies. During a pandemic, the occupational stresses experienced by healthcare workers are likely to differ from those faced in the aftermath of other emergencies. Globally and nationally, a pandemic might last for more than one year, and disease outbreaks in local communities may last for 5 to 10 weeks.

Staff Needs

Physical:

- Rest areas for staff members are located in (list departments and areas) .
- Provisions for showers are available in (list locations) .
- Food will be served or provided (list location, frequency, times) .

- Healthcare in case of illness or injury will be provided _____ (list location and schedule) _____.
- Transportation to and from work will be provided _____ (list schedule, vendor, etc.) _____.

For pandemic: _____ (describe what will happen if the employee is too sick to be at work) _____

Personal:

- Telephones for personal calls are located _____ (list locations and rules) _____.
- Televisions, radios, and internet access for keeping apprised of events are located _____ (list locations and rules) _____.
- Childcare is provided at _____ (list location, rules, providers, schedule, etc.) _____.
- Care for family members with disabilities or elderly family members is provided at _____ (list location, rules, providers, schedule, etc.) _____.
- Pet care is provided at _____ (list location, rules, providers, schedule, etc.) _____.

For pandemic: Guide sheets should be provided for staff to deal with sickness in their homes.

Emotional:

- Management will provide all staff members with regular updates of emergency status and response activities within the organization. Supervisors will brief staff at least once per shift.
- Managers and supervisors will be alert to recognize worker distress.
- Management will provide a stress control team to help staff members deal with stress.
- Management will arrange for a chaplain or other appropriate religious services.

For pandemic: Counseling will include techniques for addressing the stigma that staff members may face for working with vulnerable or infectious individuals. Stress control teams will be trained in infection control precautions.

Training

There are four main categories of training in preparation for staff support during an emergency: training for all staff members, department-specific training, training for ad hoc counselors, and information packets or other handouts.

1. All employees will receive training in the following areas:
 - Signs of distress
 - Traumatic grief
 - Psychosocial effects of management of mass fatalities
 - Stress management and coping strategies
 - Strategies for building and sustaining personal resilience
 - Behavioral and psychological support resources
 - Strategies for helping children and families in times of crisis
 - Strategies for working with highly agitated patients
 - Stressors related to pandemic influenza and other specific hazards

2. Department-specific training will be developed by department managers as appropriate based on the type of services provided.
3. If there are not enough behavioral health specialists available for response to staff needs in an emergency, (affiliate or contractor name) will provide basic counseling training to selected individuals to assist in meeting staff emotional needs.
4. (Affiliate or contractor name) has developed information regarding workforce resilience that will be available for distribution to staff members and their families.

Deployed Workers

In the event of a major emergency, especially one that lasts for multiple weeks, staff may be asked to work at other long-term care health facilities or other locations in the community. Within your own facility or at these other locations, staff members may be asked to use transferable skills to do work that is not in their current job description or scope of practice.

Deployment within the organization

- Pre-deployment, staff will be briefed on stress management, coping skills, and resilience.
- Supervisors will develop job description (just-in-time) training sheets that outline tasks for a borrowed worker or volunteer.
- Supervisors will ascertain competency of borrowed workers to do assigned tasks.
- Volunteers will be trained in the specific areas to which they are assigned until adequate education is provided.
- All deployed staff have a responsibility to advise their supervisor when they have been assigned a task for which they have no training or skills. Supervisors should train the employee to the task, if appropriate, or assign the task to someone else.
- A buddy system will be established to help employees support each other.
- Staff will be trained on self-help activities.

Deployment outside of the organization

Local, tribal, state, and/or federal government may require assistance and request that healthcare workers be deployed to other sites. (contact person) is responsible for coordinating all external deployment of employees.

- (Contact person) will coordinate with the Incident Commander to determine how many staff members can be spared and then will send a call for volunteers for deployment.
- Pre-deployment, staff will be briefed on:
 - Status of community or agency to which they are temporarily re-assigned
 - Work that is expected of them
 - Stress management, coping skills, and resilience
 - Self-help activities

- Approximate duration of temporary reassignment

Deployed Workers

In the event of a major emergency, especially one that lasts for multiple weeks, staff may be asked to work at other long-term care health facilities or other locations in the community. Within your own facility or at these other locations, staff members may be asked to use transferable skills to do work that is not in their current job description or scope of practice.

Deployment within the organization

- Pre-deployment, staff will be briefed on stress management, coping skills, and resilience.
- Supervisors will develop job description (just-in-time) training sheets that outline tasks for a borrowed worker or volunteer.
- Supervisors will ascertain competency of borrowed workers to do assigned tasks.
- Volunteers will be trained in the specific areas to which they are assigned until adequate education is provided.
- All deployed staff have a responsibility to advise their supervisor when they have been assigned a task for which they have no training or skills. Supervisors should train the employee to the task, if appropriate, or assign the task to someone else.
- A buddy system will be established to help employees support each other.
- Staff will be trained on self-help activities.

Deployment outside of the organization

Local, tribal, state, and/or federal government may require assistance and request that healthcare workers be deployed to other sites. (contact person) is responsible for coordinating all external deployment of employees.

- (Contact person) will coordinate with the Incident Commander to determine how many staff members can be spared and then will send a call for volunteers for deployment.
- Pre-deployment, staff will be briefed on:
 - Status of community or agency to which they are temporarily re-assigned
 - Work that is expected of them
 - Stress management, coping skills, and resilience
 - Self-help activities
 - Approximate duration of temporary reassignment

The Sample Policy for Dependent Care is shown below. The complete sample can be found in the *Community Care Clinics Operational Tools Manual* on pages 89-92.

Sample Policy for Dependent Care**Purpose:**

This procedure outlines the process by which a community care clinic can provide shelter and food for dependents of staff and volunteers during an emergency situation.

Definition:

Dependent care area is located in [facility-designated area].

Policy:

In the event of an extended emergency response or civil disturbance where staff will remain at [Clinic Name] for long periods, dependents (i.e., children, elderly, and persons with disabilities) may be brought with the staff member and housed in the designated dependent care area if a responsible person is not available at home to provide care.

Responsibilities:

A Dependent Care Unit Leader should be assigned and be responsible for coordinating the dependent care area activities.

Procedure:

- A. Mobilization: Upon request by the Operations Chief or the Incident Commander, the Dependent Care Unit Leader shall mobilize sufficient staff and resources to activate a dependent care area.
- B. Safety requirements: Prior to activation of the dependent care area, the Dependent Care Unit Leader, with assistance from the Safety and Security Officer, shall conduct a safety inspection of the dependent care area to remove any unsafe objects and to secure any equipment that could pose a safety hazard.
- C. Staff
 1. The Dependent Care Unit Leader will oversee other staff and volunteers.
 2. Staff and volunteers shall sign in and out when reporting to assist in the dependent care area.
 3. Staff shall monitor the area continuously for safety issues and respond to dependents' needs.
 4. If additional assistance is needed, (e.g., supplementary support for dependents from the American Red Cross) staff will communicate those needs through the command structure.
- D. Supplies: Dependent care area supplies shall be requested through the Materials Supply Unit Leader.
- E. Food: Meals and snacks for dependents shall be arranged by the Nutritional Supply Unit Leader.

F. Registration Procedures

1. Post signs indicating “Dependent Care Area – Responsible Adult Must Register Dependent.”
2. Assign each family a family number.
3. Assign all dependents a dependent number and register using a dependent care registration form (e.g., Sample Tracking Form for Dependent Care). Establish the dependent number by adding a letter (A, B, C, D, etc.) to the family number for each dependent in a given family.
4. Apply armbands/wristbands to each dependent upon arrival with staff member name and department number.
5. Take a picture of each dependent with staff member responsible for them and attach to dependent care registration form.
6. Provide special sign-in and sign-out procedures for minor or incompetent dependents.
 - i. Implement a positive identification system for all children younger than 10.
 - ii. Provide matching identification for retrieving guardian to show upon release of child.
7. Tag medications, bottles, food and other belongings with dependent's name and dependent number and store appropriately.
8. Assign each dependent to a dependent care provider and record on form (See Sample Tracking Form for Dependent Care for an example of a tool that could be used to register dependents).

G. Medications

1. Ensure that dependents taking medications have a supply to last during the estimated length of stay.
2. Arrange for a licensed nurse to dispense medications as appropriate.

H. Psychological Support: Arrange for the Psychological Support Unit Leader (social services) to make routine contact with dependents in the shelter, as well as respond to specific incidents or individual needs.**I. Documentation**

1. Document all care (e.g., medications, psychological services, toileting, or dressing) provided to individual dependents.
2. Document all other actions and decisions and report routinely to the Dependent Care Unit Leader.

J. Checking Out of Dependent Care Area

1. When dependent leaves area, compare picture with dependent and responsible staff member.
2. Check identification, verify name, and obtain signature of responsible staff member

- picking up dependent.
- 3. Retrieve and send all medications and personal items with dependent.
- 4. Collect armbands/wristbands.

The Sample Tracking Form for Dependent Care is shown below. The complete form can be found in the *Community Care Clinics Operational Tools Manual* on pages 93-95.

Sample Tracking Form for Dependent Care

Instructions
 Use the Sample Tracking Form for Dependent Care to track the individuals for whom the clinic provides dependent care during a healthcare surge and to monitor the healthcare services provided to individuals while they are under dependent care. Complete all applicable fields in the form.

Sample Tracking Form For Dependent Care		
Check In Date	Time	
Check Out Date	Time	
Staff Name	Relationship to Dependent	Family Number
Dependent Name	Age	Dependent Number
Staff's Department	Extension	
Other Family, Relative, etc. we can call in an emergency		
Name	Phone Number	
Name	Phone Number	
<u>Special Needs</u>		
Allergies		
Food		
Toileting		
Medical Conditions		
Medications you brought		
Name	Dose	Times to be given
Name	Dose	Times to be given

People who may pick up Dependent		
Name	Relationship	
Name	Relationship	
Name	Relationship	
For Dependent Care Area Staff Only		
<u>Dependent Care Staff:</u>		
<ul style="list-style-type: none"> • Apply armband/wristband with name and registration number on each dependent. • Tag all medications, bottles, food and other belongings and store appropriately. • Photograph dependent with person responsible and attach photo to this form. • Use reverse side of this form to document care provided to this dependent. • Retain forms in dependent care area until "All Clear" is announced, then route to the Command Center. 		
Dependent Care Providers Assigned		
Name of Person Picking up Dependent		
Signature of Person Picking up Dependent		
Check In Date		Time
Check Out Date		Time
Staff Name	Relationship to Dependent	Family Number
Dependent Name	Age	Dependent Number
Staff's Department		Extension
Other Family, Relative, etc we can call in an emergency		
Name		Phone Number
Name		Phone Number
Special Needs		
Allergies		
Food		
Toileting		
Medical Conditions		
Medications you brought		
Name	Dose	Times to be given
Name	Dose	Times to be given
People who may pick up dependent		
Name	Relationship	

Name	Relationship
Name	Relationship
For Dependent Care Area Staff Only	
Dependent Care Staff: <ul style="list-style-type: none"> • Apply armband with name and registration number on each dependent. • Tag all medications, bottles, food and other belongings and store appropriately. • Photograph dependent with person responsible and attach photo to this form. • Use reverse side of this form to document care provided to this dependent. • Retain forms in dependent care area until "All Clear" is announced, then route to the Command Center. 	
Dependent Care Providers Assigned	
Name of Person Picking up Dependent	
Signature of Person picking up dependent	

9.4. Staff Family Emergency Plan

As mentioned above, 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. Therefore, community care clinics should encourage staff to establish a plan with their families for what could happen in an emergency. Family emergency plan templates can be found at <http://www.ready.gov> ("Ready America" tab, then "Make a Plan" tab), <http://www.pandemicflu.gov> (in the "Resources" section), <http://www.redcross.org> ("Preparing and Getting Trained" tab), and <http://bepreparedcalifornia.ca.gov/epo>. These websites provide detailed information about how families can prepare for emergencies. For samples of these templates see:

- **Community Care Clinics Operational Tools Manual pages 96-98: Sample Family Emergency Plan**
- **Community Care Clinics Operational Tools Manual pages 99-101: Sample Family Emergency Supply List**
- **Community Care Clinics Operational Tools Manual pages 102-104: Pandemic Flu Planning Checklist for Individuals and Families**
- **Community Care Clinics Operational Tools Manual pages 105-107: Family Emergency Health Information Sheet**

A family emergency plan should address the following items:

- Discuss the types of emergencies that are most likely to happen and what to do in each case.

- Establish an out-of-town emergency contact so that all family members can call this contact in an emergency to check in.
- Arrange pet care as many emergency shelters will not accept pets other than service animals.
- Make an emergency supply kit (e.g., food, water, prescription medications) to last at least three days for each member of the household).
- For more information visit: <http://bepreparedcalifornia.ca.gov/EPO/>.

DRAFT

10. Pharmaceuticals, Supplies, and Equipment

Managing a clinic supply chain involves getting the right product to the right place at the right time through collaboration and information sharing with supply partners. Under normal operating conditions, the management of supplies, pharmaceuticals, and equipment is often dictated by clinic size. Small clinics may store supplies in a variety of locations based on access to space and may look to outside resources for storage options. On the other hand, larger multi-site clinics that use centralized storage facilities, may need to find the capability to store "just in time" supplies on site.

Michael Osterholm, Director of the Center for Infectious Disease Research and Policy at the University of Minnesota, has said, "Most if not all of the medical products or protective-device companies in this country are operating almost at full capacity. That's the reality of today's economy -- just-in-time delivery with no surge capacity."⁵⁰ During the surge planning process, clinics should move away from the "just in time" supply chain management as it may result in the clinic's inability to respond adequately to a healthcare emergency; the first step in preparing for a healthcare surge is ensuring the clinic can function independently for 72-96 hours at surge levels.

As described in Section 3.3: "How Clinics Connect to the Emergency Response Structure," 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 healthcare clinics that the Unified Command has been established and provide contact information.¹ 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; community care clinics can go through this command structure to obtain additional supplies to support the provisions of services during surge conditions.

10.1. Maximizing Sustainability

Effective planning for clinic sustainability will help mitigate the effects of limited resource availability during a healthcare surge. Community care clinics should use the recommendations provided in this section to identify the types and quantities of pharmaceuticals, supplies, and equipment they will acquire prior to a catastrophic event. Individual clinic decisions should be based on affordability, space, and proximity of the clinic to alternate locations.

In order for community care clinics to maximize sustainability:

¹ It is likely that this notification will be provided through California Health Alert Network alert. Clinics can obtain more information about California Health Alert Network from their public health departments or Regional Hospital Preparedness Coordinator.

- The supplies required and the quantity of those supplies should be based on the type of event that occurs. Clinics should have enough pharmaceuticals, supplies, and equipment at their clinic to be self-sufficient to operate at 20% to 40% above their average daily number of visits for at least 72 hours, and ideally for 96 hours.
- When determining the type of inventory to stockpile, should take into consideration specific, likely risks, (e.g., earthquake zones). This planning can be based on a Hazard Vulnerability Analysis. See Section 3.7, "Developing a Hazard Vulnerability Analysis" for more guidance on conducting this analysis.
- Because community care clinics may need to rely on the available market supply (e.g., through Memoranda of Understanding, retailers, or wholesalers) and state and federal stockpiles for specific resources, clinics should work with vendors and government agencies in advance to develop a plan for acquisition of supplies, pharmaceuticals, and equipment during a healthcare surge.
- Clinics should be aware of their operational and storage limitations and communicate their capabilities and limitations to their communities. Clinics should engage with government agencies and other healthcare providers during the community surge planning process.

10.2. Acquiring Pharmaceuticals

One of the most challenging aspects of acquiring pharmaceuticals for a healthcare surge stockpile is determining which pharmaceuticals are needed and in what quantity. Clinics have adopted different models for dispensing pharmaceuticals, each of which might require different approaches to surge planning. In general the four models for dispensing pharmaceuticals at community care clinics include:

- **Dispensing License:** Clinic utilizes consulting pharmacists; Pharmaceuticals are prepackaged and may only be dispensed as packaged. This operating model usually relies on Memoranda of Understanding with local pharmacies.
- **Pharmacy License:** Clinic has a pharmacist on-site to dispense pharmaceuticals.
- **Physician Dispensing:** Clinic has physician on-site to dispense pharmaceuticals.
- **No Pharmaceutical Dispensing:** Clinic does not distribute pharmaceuticals. Patients leave the clinic with a prescription.

Pharmacy inventory levels are closely monitored by all community care clinics in order to meet financial performance requirements. It is therefore difficult to increase inventory. Information to guide community care clinics in determining the quantity and type of pharmaceuticals needed can be gathered from wholesalers, who can provide historical purchase data and software tools to easily establish par levels, reorder points, and reorder quantities. Par levels are the maximum amount of each type of pharmaceutical that the facility maintains in inventory for

adequate supply and the reorder quantity equals the difference between the par level and the quantity on hand.⁵¹ Generally, pharmacy wholesalers can provide deliveries to clinics every two weeks or as needed in order to have critical stock on-site.

The decision regarding specific pharmaceuticals 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. Because of the increased cost to the clinic, the decision to increase existing pharmaceutical inventories to accommodate a healthcare surge should be made on a case-by-case basis with clinic management. Consideration should be given to the specific risks the clinic has identified in its Hazard Vulnerability Assessment.

When resources allow, strong consideration should be given to involving clinic Administrators, Disaster Coordinators, and other staff in the planning for which pharmaceuticals to have available during a healthcare surge.

10.2.1. Inventory-Based Pharmaceuticals by General Classifications

The Inventory-Based Pharmaceuticals by General Classifications List, in conjunction with a Hazard Vulnerability Assessment, can assist community care clinics in determining the specific types and quantities of pharmaceuticals that a clinic should have on hand during a healthcare surge. The tool identifies potential pharmaceuticals needed in response to biological, chemical, and nuclear catastrophic emergencies.

The Inventory-Based Pharmaceuticals by General Classifications List is shown on the following pages. The complete tool can be found in the *Community Care Clinics Operational Tools Manual* on pages 108-114.

Inventory-Based Pharmaceuticals by General Classifications List

Description

The Inventory-Based Pharmaceuticals by General Classifications List, in conjunction with a Hazard Vulnerability Assessment, can assist community care clinics in determining the specific types and quantities of pharmaceuticals that a clinic should have on hand during a healthcare surge. The tool identifies potential pharmaceuticals needed in response to biological, chemical, and nuclear catastrophic emergencies.

Instructions

Use this tool as a guide in conjunction with the clinic's Hazard Vulnerability Assessment. Pharmaceutical needs are site-dependent based on the complexity of services offered and the

potential needs of the community.

1. The columns within the tool need to be populated and are explained below:
 - a. Sample Pharmaceuticals Suggested during a Surge
 - i. This list is not comprehensive and considers various surge scenarios including antidotes and vaccines for:
 - 1) Biological events
 - 2) Chemical events
 - 3) Radiological/nuclear events
 - ii. Add/delete specific pharmaceuticals that may or may not be needed at a specific clinic.
 - b. Package Size: Identify the number of items in the package.
 - c. Wholesaler Item #: Identify the number assigned to the item by the wholesaler the facility uses for ease of use in identifying and re-ordering.
 - d. Average Number of Visits/Procedures: Quantify the average number of visits/procedures at clinic to provide guidance in understanding quantity needs in a healthcare surge.
 - e. Potential Surge Patients: Estimate how many healthcare surge patients may be expected. This will vary considerably from type of event, location of clinic, and number and type of other facilities with the potential to provide care. The recommendation is that community care clinics should have enough pharmaceuticals, supplies, and equipment at their facilities to operate at 20% to 40% above their average daily census to be self-sufficient for 72 hours, at a minimum, with a goal of 96 hours.
 - f. Employees: Identify the number of employees. This may be important in understanding the total count of those that require treatment.
 - g. Doses Needed per Patient per Day: Calculate how many doses are needed per day to guide the amount that should be ordered.
 - h. Days of Therapy Required: Calculate how many days of therapy are required to guide the amount of pharmaceuticals that should be ordered.
 - i. Total Doses Required: Calculate the Total Doses Required
Total doses = Doses needed per patient per day X days of therapy required.
 - j. No. of Packages to Stock: Determine the number of packages to stock by considering the Total Doses Required.
 - k. Alternate Sources: Identify other sources (e.g., nearby clinic) that may have the specific pharmaceuticals.

Complete fields as needed to estimate a clinic's pharmaceutical needs during a healthcare surge.

Inventory-Based Pharmaceuticals by General Classifications List

Critical Pharmaceuticals That May Be Needed During a Surge													
Sample Pharmaceutical Suggested during a Surge	Strength	Route of Administration	Package Size	Wholesaler Item #	Average Daily Census	Potential Surge Patients	Employees	Total Potential Requiring Treatment	Doses Needed per Patient per Day	Days of Therapy Required (Max of 3 Days)	Total Doses Required	# Packages to Stock	Alternate Sources
Antidotes for Biological Agents													
Activated charcoal 50g slurry	N/A	Oral											
Cidofovir	75mg / ml	Injectable											
Ciprofloxacin	400mg	Injectable											
Ciprofloxacin	500mg	Oral											
Clindamycin	600mg	Injectable											
Doxycycline Hyclate	100mg	Injectable											
Doxycycline Hyclate	100mg	Oral											
Gentamicin Sulfate	10mg / ml	Injectable											
Gentamicin Sulfate	40mg / ml	Injectable											
Penicillin GK	20MU	Injectable											
Rifampin	300mg	Oral											
Streptomycin Sulfate	400mg / ml	Injectable											
Antidotes for Chemical Agents													
Amyl Nitrite 0.3ml. Crushable ampul	N/A	Inhaled											
Atropine Sulfate prefilled syringe	1mg / 10ml	Injectable											
Atropine Sulfate multidose vial	8mg / 20ml	Injectable											
Calcium Chloride	10mg / 10ml	Injectable											

Critical Pharmaceuticals That May Be Needed During a Surge													
Sample Pharmaceutical Suggested during a Surge	Strength	Route of Administration	Package Size	Wholesaler Item #	Average Daily Census	Potential Surge Patients	Employees	Total Potential Requiring Treatment	Doses Needed per Patient per Day	Days of Therapy Required (Max of 3 Days)	Total Doses Required	# Packages to Stock	Alternate Sources
Calcium Gluconate 10%	10mg / 100ml	Injectable											
Diazepam	5mg / ml	Injectable											
Dimeracaprol	100mg / ml	Injectable											
Diphenhydramine HCL	50mg / ml	Injectable											
Methylene Blue 1%	10mg / ml	Injectable											
Pralidoxime Chloride	1gm / 20ml	Injectable											
Pyridostigmine Bromide	30 Or 60mg	Oral											
Pyridoxine HCL	3g / 30ml	Injectable											
Sodium Nitrite	30mg/ml	Injectable											
Sodium Thiosulfate	12.5mg / 50ml	Injectable											
Antidotes for Radiological & Nuclear Agents													
Aluminum Hydroxide Suspension 240ml	N/A	Oral											
Calcium Carbonate	1g	Oral											
Chlorthalidone	100mg	Oral											
Deferoxamine Mesylate	1g	Injectable											
Edetic Acid	200mg / ml	Injectable											
Furosemide	100mg / 10ml	Injectable											

Critical Pharmaceuticals That May Be Needed During a Surge													
Sample Pharmaceutical Suggested during a Surge	Strength	Route of Administration	Package Size	Wholesaler Item #	Average Daily Census	Potential Surge Patients	Employees	Total Potential Requiring Treatment	Doses Needed per Patient per Day	Days of Therapy Required (Max of 3 Days)	Total Doses Required	# Packages to Stock	Alternate Sources
Magnesium Sulfate	N/A	Oral											
Magnesium Oxide	N/A	Oral											
Penicillamine	125 mg/250 mg	Oral											
Potassium Iodide	130mg	Oral											
Prussian Blue	500 mg	Oral											
Sodium Iodide	130mg	Oral											
Trisodium Calcium Diethylenetriami nepentaacetate	1g	Injectable											
Trisodium Zinc Diethylenetriami nepentaacetate	1g	Injectable											
Drugs for Treating Acute Radiation Syndrome													
Acyclovir Sodium	25mg/ml	Injectable											
Acyclovir	400mg	Oral											
Antidiarrheal	N/A	Oral											
Cefepime HCL	1g	Injectable											
Filgrastim	300ug / ml	Injectable											
Fluconazole	200mg / ml	Oral											
Ganciclovir	250-500mg	Oral											
Ganciclovir Sodium	500mg / ml	Injectable											
Granisetron HCL	1mg / ml	Injectable											
Granisetron HCL	1mg	Oral											

Critical Pharmaceuticals That May Be Needed During a Surge													
Sample Pharmaceutical Suggested during a Surge	Strength	Route of Administration	Package Size	Wholesaler Item #	Average Daily Census	Potential Surge Patients	Employees	Total Potential Requiring Treatment	Doses Needed per Patient per Day	Days of Therapy Required (Max of 3 Days)	Total Doses Required	# Packages to Stock	Alternate Sources
Ondansetron HCL	2mg / ml	Injectable											
Pegfilgrastim	6mg	Injectable											
Trimethoprim/ Sulfamethoxazole	160mg / 800mg	Oral											
Trimethoprim/ Sulfamethoxazole	16mg/ml /80mg/ml	Injectable											
Vaccines													
Tetanus Toxoid	N/A	Injectable											

Sources:

- Guidelines for Managing Inpatient and Outpatient Surge Capacity - State of Wisconsin, 2005*
- Emergency Preparedness Resource Inventory (EPRI), A Tool for Local, Regional, and State Planners AHRQ Publication, 2005*
- State of California Mass Prophylaxis Planning Guide, EMSA, June 2003.*
- Organization of a health-system pharmacy team to respond to episodes of terrorism, Am J Health-Syst Pharm-Vol 60 Jun 15,2003*

There are pharmaceuticals that are unique to the pediatric population. In the specific tools for this section, the pediatric population is not segmented. To find specific information on the emergency care of the pediatric population, refer to <http://www.emsa.ca.gov>.

10.2.2. Storage and Inventory Management of Pharmaceuticals

Pharmaceutical inventory must be managed efficiently to ensure that the proper amounts and types of pharmaceuticals will be available when needed. Therefore, there must be a process to reduce the likelihood of expired pharmaceuticals by monitoring expiration dates and storage dates, and rotating of stock from a cache into the general inventory. The Pharmaceutical Storage Checklist can assist community care clinics in developing processes to properly store pharmaceuticals at a clinic or in a cache/warehouse. Individual clinic storage checklists will differ and may be dependent on clinic type.

The Pharmaceutical Storage Checklist is shown below. The complete tool can be found in the *Community Care Clinics Operational Tools Manual* on pages 115-117.

Pharmaceutical Storage Checklist
<p>The Pharmaceutical Storage Checklist addresses the issues and processes that community care clinics are strongly encouraged to consider for storing and accessing pharmaceuticals at the facility during a healthcare surge, including:</p> <ul style="list-style-type: none">• Inventory Management• Environmental Management• Security• Caches External to a Facility• Ease of Access
<p>Inventory Management</p> <ul style="list-style-type: none"><input type="checkbox"/> Process for monitoring expiration dates<input type="checkbox"/> Process for rotating stock from the cache into the general inventory to minimize expiration, if applicable<input type="checkbox"/> Process for returning unused stock to vendors for replacement or credit, if applicable<input type="checkbox"/> Process for repackaging pharmaceuticals if they come in bulk containers<input type="checkbox"/> Process for properly labeling repackaged pharmaceuticals
<p>Environmental Management</p> <ul style="list-style-type: none"><input type="checkbox"/> Process for monitoring the environment (e.g., temperature, humidity, pests) to meet United States Pharmacopeia (USP) standards<input type="checkbox"/> Process for ensuring access to generators<input type="checkbox"/> Process for monitoring the environment (e.g., temperature, humidity, pests) to

<p>meet United States Pharmacopeia (USP) standards</p> <ul style="list-style-type: none"><input type="checkbox"/> Process for ensuring access to generators <p>Security</p> <ul style="list-style-type: none"><input type="checkbox"/> Process for ensuring the security of the pharmaceuticals (e.g., locks, security staff)<input type="checkbox"/> Process for controlling access into the building or area<input type="checkbox"/> Process for controlling access within the building<input type="checkbox"/> Process for identifying and tracking patients, staff, and visitors<input type="checkbox"/> Process for monitoring facilities with security cameras<input type="checkbox"/> Process for ensuring security locks on pharmaceuticals are in place<input type="checkbox"/> Process for working with local authorities prior to a healthcare surge to address heightened security needs<input type="checkbox"/> Process for working with private security entities prior to a healthcare surge to address heightened security needs <p>Caches External to a Facility</p> <ul style="list-style-type: none"><input type="checkbox"/> Process for ensuring the security of the caches<input type="checkbox"/> Process for controlling access into the area<input type="checkbox"/> Process for controlling access within the area<input type="checkbox"/> Process for working with local authorities prior to a healthcare surge to address heightened security needs<input type="checkbox"/> Process for working with private security entities prior to a healthcare surge to address heightened security needs <p>Licensing</p> <ul style="list-style-type: none"><input type="checkbox"/> Process for meeting licensing requirements, which depend on the location of the cache<input type="checkbox"/> Process for documenting the location of the cache and if it is licensed to receive a delivery of pharmaceuticals <p>Ease of Access</p> <ul style="list-style-type: none"><input type="checkbox"/> Process for staging the layout of pharmaceuticals needed during the first 24 hours to ensure ease of access
--

10.2.3. Off-Label Drug Use

During a healthcare surge, there is the possibility that the indicated medication for a diagnosis is not available. There may be other medications that have demonstrated effectiveness in the primary literature but have not yet been granted federal Food and Drug Administration (FDA) approval for a particular diagnosis. For example, many medications that are FDA-approved for anti-arrhythmic use are also effective for treating hypertension; some of the agents that are FDA-approved for depression also demonstrate effectiveness in treating pain.

There is no known statutory or regulatory prohibition against off-label use of a drug by a physician. Consequently, clinic pharmacists or physicians who can dispense pharmaceuticals may do so for off-label purposes without being out of compliance. Proclamation of an emergency could include a provision that shifts the goal of medical care to focus on prevention of the greatest loss of life, which could allow some off-label uses not generally accepted by the medical community but consistent with the goal of saving a life.

The Local Health Officer and/or the State Public Health Officer will be the prescribing authority for certain medications dispensed or vaccines administered during an emergency (e.g., mass prophylaxis or mass vaccination). Pharmaceuticals may have to be dispensed or administered under Investigational New Drug (IND) or Emergency Use Authorization (EUA) protocols. The FDA will make this determination. Clinics should coordinate with their public health departments for guidance regarding IND and EUA requirements during an emergency.

10.3. Supplies and Equipment

10.3.1. Determining Supply and Equipment Needs

Having supplies and medical equipment on hand will be critical to the clinic's ability to function in an emergency. Similar to pharmaceuticals, the decision regarding what supplies and equipment to maintain at the clinic is dependent upon the complexity of services offered and the volume of patients expected during a healthcare surge. Information from the Hazard Vulnerability Assessment should be utilized to assist in determining a clinic's needs.

When resources allow, strong consideration should be given to involving clinic Administrators, Disaster Coordinators, and other staff in the planning for supplies and equipment.

10.3.2. Inventory-Based Detailed Supplies and Equipment List

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 community care 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. For example, saline solution and other supplies may be in high demand during a healthcare surge because ensuring adequate hydration is vital to patients both during and after an emergency. Many of these intravenous supplies are not currently stocked in the clinic departments (e.g., lactated ringers and normal saline) and planning should consider the potential volume of patients that may require intravenous hydration for a 72-hour period. Community care clinics should also consider the potential volume of patients that may require oral hydration for the post-emergency period. Dehydration may result during and after an emergency due to diarrhea because of a lack of clean drinking water and sanitary facilities.

The Detailed Supplies and Equipment List on the following page provides planners with a guide for the ordering of 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; community care clinics should modify their supplies and equipment list based on individual clinic profiles. In addition, there are supplies and equipment that are unique to the pediatric population. For more detailed information on the emergency care of the pediatric population, refer to <http://www.emsa.ca.gov> (go to "EMS Systems" tab then, "EMS for Children" link)."

The Detailed Supplies and Equipment List is shown below. The complete tool can be found in the *Community Care Clinics Operational Tools Manual* on pages 118-126.

Detailed Supplies and Equipment List

Instructions

The Detailed Supplies and Equipment List has five columns which represent the following:

- **Current Supply:** Stock on hand.
- **Total Potential Requiring Treatment:** Estimate clinic's surge capacity.
- **Package Size** (e.g., 100/box, or simply 100.)
- **Quantity/Cache:** Additional quantities that may be available in clinic off-site storage or community caches.

The clinic should consider the following when determining which supplies and equipment to stock:

- What types of patients would a clinic expect given the results of their Hazard Vulnerability Analysis?
- What supplies and equipment has the clinic pledged through Memoranda of Understanding and/or community surge plans?
- What supplies and equipment should be considered for an all-hazards catastrophic emergency?
- What supplies and equipment would the clinic specifically choose to stock?
- What supplies and equipment are also a part of the clinic's supply inventory?

Complete fields as needed to estimate a clinic's supply and equipment needs during a healthcare surge. Supply and equipment needs are site-dependent based on the complexity of services offered and the potential needs of the community.

Detailed Supplies and Equipment List				
BANDAGES AND DRESSINGS	Current Supply	Total Potential Requiring Treatment	Package Size (if applicable)	Quantity / Cache
Adhesive strip, 1" X 3"				
Alcohol pads				
Bandage elastic (Ace wrap) 2"				
Bandage elastic (Ace wrap) 4"				
Bandage elastic (Ace wrap) 6"				
Bandage, gauze non sterile (kerlix) 4" X 10'				
Bandage, gauze non sterile 4X4				
Bandage 4X4 sterile				
Bandage 2X2 sterile				
Eye pad, oval sterile				
Eye Shields				
Morgan Lens				
Petroleum Gauze 5" X 9" (Xeroform)				
Vaseline gauze				
Gauze Pad 5" X 9" sterile				
Tape 1" transparent				
SURGICAL SUPPLIES	Current Supply	Total Potential Requiring Treatment	Package Size (if applicable)	Quantity / Cache
Scalpel with blade, disposable #10				
Scalpel with blade, disposable #15				
Sterile gloves, sizes 6.5, 7.0, 7.5, and 8.0				
Surgical scrub brushes with betadine				
Suture set (disposable)				
Suture removal kit				
Suture (Nylon sutures various sizes)				
ORTHOPEDIC SUPPLIES	Current Supply	Total Potential Requiring Treatment	Package Size (if applicable)	Quantity / Cache
Splint, cardboard 12"				
Splint, cardboard 18"				
Splint, cardboard 24"				
Splint, cardboard 34"				
Splint, fiberglass 3"				
Splint, fiberglass 4"				

Detailed Supplies and Equipment List				
Splint, fiberglass 5"				
IV SETS, NEEDLES AND SYRINGES	Current Supply	Total Potential Requiring Treatment	Package Size (if applicable)	Quantity / Cache
IV Start Kits				
IV catheter, 18 gauge				
IV catheter, 20 gauge				
IV catheter, 22 gauge				
IV catheter, 24 gauge				
IV administration set, adult				
IV administration set, pediatric				
IV piggyback tubing				
Needle disposable, 18 gauge				
Needle disposable, 22 gauge				
Needle disposable, 25 gauge				
Syringe, 1ml				
Syringe, 3 ml				
Syringe, 5 ml				
Syringe, 10 ml				
Syringe, 20 ml				
Syringe, 35cc, for wound irrigation				
Syringe/needle, 3 ml, 22gauge X 1 ½"				
Syringe/needle, 1 ml, 25 gauge X 5/8"				
Syringe/needle 1 ml, 29 gauge X ½"				
Sharps container				
AIRWAY MANAGEMENT SUPPLIES	Current Supply	Total Potential Requiring Treatment	Package Size (if applicable)	Quantity / Cache
Bag-valve-mask, adult				
Bag-valve-mask, pediatric				
Airway adjunct, OP Airway				
Airway adjunct, NP Airway				
Cricothyrotomy / Shiley 4				
Endotracheal tube, cuffed 8mm				
Endotracheal tube, cuffed, 7.5mm				
Endotracheal tube, cuffed 7mm				
Endotracheal tube, cuffed, 6mm				
Endotracheal tube, cuffed 2.5mm				

Detailed Supplies and Equipment List				
Endotracheal tube, cuffed 3mm				
Endotracheal tube, cuffed, 4mm				
Endotracheal tube, cuffed, 4.5mm				
Endotracheal tube, cuffed, 5mm				
Endotracheal tube, cuffed, 5.5mm				
Endotracheal tube, non-cuffed, 2.5mm				
Endotracheal tube, non-cuffed, 3mm				
Endotracheal tube, non-cuffed, 4mm				
Endotracheal tube, non-cuffed, 5mm				
ETT Holders				
Intubation kit, incl. Blades, medium handle, stylet and case – including magill forceps				
Intubation kit (Pediatrics) , incl. Blades, medium handle, stylet and case – including magill forceps				
Nasal cannula, adult				
Nasal cannula, pediatric				
O2 mask with tubing, pediatric				
O2 mask with tubing, adult				
O2 mask - non-rebreather, adult				
Nebulizers – hand held				
Nebulizers – masks				
Ventilator circuits				
Suction machine, portable				
Suction catheters 10 french				
Suction catheters 12 french				
Suction catheters 14 french				
Yankauer suction				
Suction tubing				
Suction Canisters				
NG Tubes				
Thoracostomy Tubes, assorted sizes				
Pleurivac & Heimlich valves				
INFECTION CONTROL SUPPLIES	Current Supply	Total Potential Requiring Treatment	Package Size (if applicable)	Quantity / Cache
Cover/Isolation gowns				
Splash guard for wound irrigation				
Masks surgical				
Face shield with eye shield				

Detailed Supplies and Equipment List				
Masks N-95				
Patient exam gloves, small				
Patient exam gloves, medium				
Patient exam gloves, large				
Shoe covers				
Surgical caps				
Wipes, disposable				
MISCELLANEOUS SUPPLIES	Current Supply	Total Potential Requiring Treatment	Package Size (if applicable)	Quantity / Cache
Bags, plastic 30 gallon, 8 mil				
Batteries, C for laryngoscope handle				
Batteries, D for flashlights				
Blankets lightweight				
Clipboards				
Diapers, disposable large				
Diapers, disposable medium				
Diapers, disposable small				
Diapers, disposable, large, peds				
Diapers, disposable, medium, peds				
Diapers, disposable, small, peds				
Emesis basins, plastic				
Facial tissues				
Flashlights				
Gloves work type leather/canvas				
OB kits, disposable				
Paper towels				
Patient ID bands				
Styrofoam cups				
Tongue depressors, non sterile				
NON-DISPOSABLE MEDICAL SUPPLIES	Current Supply	Total Potential Requiring Treatment	Package Size (if applicable)	Quantity / Cache
Blood Pressure multi-cuff kit with adult, pediatric, infant and thigh cuff				
Glucometer kit with lancets, test strips and battery				
Portable Otoscope/Ophthalmoscope set with batteries				
Pulse Oximetry, portable				

Detailed Supplies and Equipment List				
Stethoscope				
Tourniquets 1"				
Trauma/paramedic scissors				
MISCELLANEOUS Equipment	Current Supply	Total Potential Requiring Treatment	Package Size (if applicable)	Quantity / Cache
Ventilators - dual use Adult/Pediatric				
Portable/disposable vents				
Equipment Trailer				
18 X 24 Tent				
10 X 10 Tent				
Temps Beds				
Simpler Life Cots				
Junkin Cots				
Blankets/Sleeping Bags/Linen				
Tables				
Chairs				
Lights				
Portable Generator				
Heating System/Fan				
HEPA Filtration System				
Staff Notification/Recall System				
HAM Radio Equipment				
Communication Equipment (radios, walkie talkie)				
Evacusleds				
Evacuation Chairs				
CBRNE Detection/Monitoring Equipment				
Emergency Food/Water Supply Cache				
Portable Toilets				
Portable hand washing				
Outdoor Lighting				
EZ Up Shades				
Security Upgrades and hardening				
Post Decontamination clothing sets				
Pharmacy Cache				
CHEMPACK location site				
Medical/Surgical Supply Cache				
Prime Mover (tow vehicle)				

Sources: 1) Disaster Resource Center Supplies List -Revised 2006, 2) State of Research in High - Consequence Hospital Surge Capacity, Carl H. Schultz, MD, Kristi L. Koenig, MD

10.3.3. Use of Supplies and Equipment beyond the Manufacturer's Recommended Use

In a healthcare surge, medical supplies and equipment may be used in a different manner than their normal use, potentially impacting liability and reimbursement. An example is the use of an adult intubation kit on a pediatric patient. 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" states that the U.S. 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 (referred to in this section as an "emergency use") into interstate commerce during the effective period of a declaration under the Federal Food, Drug, and Cosmetic Act Chapter V, Subchapter E, Section 564(b). 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
- Approved, licensed, or cleared, but the use is not an approved, licensed, or cleared use of the product (i.e., an unapproved use of an approved product).

This authorization would require a request from the Governor or CDPH to the United States Secretary of Health and Human Services. In the event that the U.S. Secretary of Health and Human Services issues this authorization, community care clinics will have greater flexibility to utilize supplies and equipment in the manner that best meets the demands of the healthcare surge.

10.4. Personal Protective Equipment

Employers are required by Cal/OSHA to use personal protective equipment to limit employee exposure to hazards. Under California Labor Code Section 6401, every employer must furnish protective equipment, use safety devices and safeguards, and provide training. Detailed Cal/OSHA guidelines are available at http://www.dir.ca.gov/occupational_safety.html. For additional guidance on state and federal requirements for personal protective equipment, see Section 9.1, "Workforce Health and Safety and Workers' Rights."

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

In a report by the Agency for Healthcare Research and Quality (AHRQ) on personal protective equipment, OSHA levels of protection and related personal protective equipment ensemble were defined as follows:⁵²

Occupational Safety and Health Administration				
PPE Level	Level A	Level B	Level C	Level D
				
Definition/ Indicators	<ul style="list-style-type: none"> <input type="checkbox"/> The hazardous substance has been identified or is an unknown, and requires the highest level of protection for skin, eyes, and the respiratory system based on either the measured (or potential for) high concentration of atmospheric vapors, gases, or particulates; or the site operations and work functions involve a high potential for splash, immersion, or exposure to unexpected vapors, gases, or particulates of materials that are harmful to skin or capable of being absorbed through the skin, <input type="checkbox"/> Substances with a high degree of hazard to the skin are known or suspected to be present, and skin contact is possible; or 	<ul style="list-style-type: none"> <input type="checkbox"/> The type and atmospheric concentration of substances have been identified and require a high level of respiratory protection, but less skin protection. <input type="checkbox"/> The atmosphere contains less than 19.5% oxygen; or <input type="checkbox"/> The presence of incompletely identified vapors or gases is indicated by a direct-reading organic vapor detection instrument, but vapors and gases are not suspected of containing high levels of chemicals harmful to skin or capable of being absorbed through the skin. 	<ul style="list-style-type: none"> <input type="checkbox"/> The atmospheric contaminants, liquid splashes, or other direct contact may adversely affect or be absorbed through any exposed skin; <input type="checkbox"/> The types of air contaminants have been identified, concentrations measured, and an air-purifying respirator is available that can remove the contaminants; and <input type="checkbox"/> All criteria for the use of air-purifying respirators are met. <input type="checkbox"/> Clinics: Ideal and recommended 	<ul style="list-style-type: none"> <input type="checkbox"/> Selected when the atmosphere contains no known hazards <input type="checkbox"/> Work functions preclude splashes, immersion, or the potential for unexpected inhalation of or contact with hazardous levels of any chemicals <input type="checkbox"/> All clinics

Occupational Safety and Health Administration				
PPE Level	Level A	Level B	Level C	Level D
Ensemble/ Component	<p><input type="checkbox"/> Operations must be conducted in confined, poorly ventilated areas, and the absence of conditions requiring Level A have not yet been determined.</p> <p><input type="checkbox"/> When an event is uncontrolled or information is unknown about: the type of airborne agent, the dissemination method, if dissemination is still occurring or it has stopped.</p>	<p><input type="checkbox"/> A liquid-splash-resistant ensemble used with the highest level of respiratory protection</p> <p><input type="checkbox"/> The suspected aerosol is not longer being generated, but other conditions may present a splash hazard</p>		
	<p><input type="checkbox"/> A fully encapsulated, liquid and vapor protective ensemble selected when the highest level of skin, respiratory and eye protection is required</p> <p><input type="checkbox"/> Positive pressure, full face-piece self-contained breathing apparatus, or positive pressure supplied air respirator with escape self-contained breathing apparatus, approved by the National Institute for Occupational Safety and Health. Closed-circuit Re-breather/ open circuit self-contained breathing apparatus.</p> <p><input type="checkbox"/> Totally-encapsulating chemical-protective suit.</p> <p><input type="checkbox"/> Gloves, outer, chemical-resistant.</p> <p><input type="checkbox"/> Gloves, inner, chemical-resistant.</p> <p><input type="checkbox"/> Boots, chemical-resistant, steel toe and shank, outer booties.</p> <p><input type="checkbox"/> Disposable protective suit, gloves and boots (depending on suit construction, may be worn over totally-encapsulating suit).</p> <p><input type="checkbox"/> Coveralls*</p> <p><input type="checkbox"/> Long underwear*</p> <p><input type="checkbox"/> Hard hat (under suit), personal cooling system, chemical resistant tape*</p> <p>* optional/as needed</p>	<p><input type="checkbox"/> A liquid-splash-resistant ensemble used with the highest level of respiratory protection</p> <p><input type="checkbox"/> Positive pressure, full-face piece self-contained breathing apparatus self-contained breathing apparatus, or positive pressure supplied air respirator with escape self-contained breathing apparatus (National Institute for Occupational Safety and Health approved).</p> <p><input type="checkbox"/> Hooded chemical-resistant clothing (overalls and long-sleeved jacket; coveralls; one or two-piece chemical-splash suit; disposable chemical-resistant overalls).</p> <p><input type="checkbox"/> Gloves, outer, chemical-resistant.</p> <p><input type="checkbox"/> Gloves, inner, chemical-resistant.</p> <p><input type="checkbox"/> Boots, outer, chemical-resistant steel toe and shank.</p> <p><input type="checkbox"/> Boot-covers, outer, chemical-resistant</p> <p><input type="checkbox"/> Hard hat, personal cooling system, chemical resistant tape*</p> <p><input type="checkbox"/> Coveralls*</p> <p><input type="checkbox"/> Face shield*</p> <p>* optional/as needed</p>	<p><input type="checkbox"/> A liquid-splash-resistant ensemble, with the same level of skin protection as Level B, used when the concentration(s) and type(s) of airborne substances(s) are known and the criteria for using air-purifying respirators are met.</p> <p><input type="checkbox"/> Full-face or half-mask, air purifying respirators (National Institute for Occupational Safety and Health approved).</p> <p><input type="checkbox"/> Hooded chemical-resistant clothing (overalls; two-piece chemical-splash suit; disposable chemical-resistant overalls).</p> <p><input type="checkbox"/> Gloves, outer, chemical-resistant.</p> <p><input type="checkbox"/> Gloves, inner, chemical-resistant.</p> <p><input type="checkbox"/> Boots (outer), chemical-resistant steel toe and shank</p> <p><input type="checkbox"/> Boot-covers, outer, chemical-resistant</p> <p><input type="checkbox"/> Coveralls*</p> <p><input type="checkbox"/> Hard hat, face shield, personal cooling system*</p> <p><input type="checkbox"/> Escape mask*</p> <p><input type="checkbox"/> Face shield*</p> <p>* optional/as needed</p>	<p><input type="checkbox"/> A work uniform affording minimal protection: used for nuisance contamination only</p> <p><input type="checkbox"/> Coveralls.</p> <p><input type="checkbox"/> Boots/shoes, chemical-resistant steel toe and shank.</p> <p><input type="checkbox"/> Boots, outer, chemical-resistant (disposable)*</p> <p><input type="checkbox"/> Gloves*</p> <p><input type="checkbox"/> Safety glasses or chemical splash goggles*</p> <p><input type="checkbox"/> Hard hat*</p> <p><input type="checkbox"/> Escape mask*</p> <p><input type="checkbox"/> Face shield*</p> <p>* optional/as needed</p>

10.4.1. Guidance on Selecting and Obtaining Personal Protective Equipment

Community care clinics may face challenges in selecting, acquiring, managing, and storing personal protective equipment because of uncertainty in the amount of personal protective equipment needed, questions about who should use personal protective equipment, the reusability of such equipment during a healthcare surge, and storage limitations. Guidance on these and other challenges is provided below.

Occupational Safety and Health Administration (OSHA) guidelines stress that emergency response planning should include selection of personal protective equipment based on worst-case employee exposure scenarios. The clinic staff's personal protective equipment must be sufficient for the type and exposure levels an employee can reasonably anticipate from such incidents. Personal protective equipment selection should also be based on an evaluation of the clinic's role in community emergency response.

Various models have been developed to predict personal protective equipment needs, including models by the CDC and the World Health Organization.

- The CDC 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.
- For the World Health Organization model, see http://whqlibdoc.who.int/hq/2006/WHO_CDS_NTD_DCE_2006.2_eng.pdf

For greater detail on personal protective equipment and OSHA guidelines, see <http://www.osha.gov/SLTC/personalprotectiveequipment/index.html>.

Additional guidelines for community care clinics to consider in selecting and acquiring personal protective equipment for a healthcare surge include:

- Clinics should use a Hazard Vulnerability Analysis to assess the hazards that may impact a clinic and the specific potential hazard to employees, such as skin, ingestion, inhalation, and mucous membrane contact (e.g., eyes, nose, mouth). This will guide the clinic in determining the types of personal protective equipment needed. See Section 3.7, "Developing a Hazard Vulnerability Analysis" for additional information.
- Clinics should, at a minimum, be prepared for Occupational Safety and Health Administration (OSHA) Level D and, based on circumstances, consider Level C. Level C preparation will be dependent on funding and clinic location. Equipment selection should be clinic-specific.

- Clinics should consider adopting standard personal protective equipment guidelines. For interoperability, using the same type of equipment utilized by local emergency responders will standardize personal protective equipment within a community or region.
- Periodic training classes should be conducted to keep staff current on new protective equipment and proper application.

Clinics should conduct training for personal protective equipment quarterly so appropriate staff will have demonstrable competency for OSHA Level D, described above in Section 10.4, "Personal Protective Equipment". Clinics may wish to contact local field representatives from vendors and suppliers to discuss formalized training.

Suppliers can also provide guidance in determining the appropriate amount of supplies and equipment required during a healthcare surge, including personal protective equipment. Suppliers and manufacturers use tools designed to facilitate critical decisions, using specific inputs about the type and quantity of supplies needed at specific care sites. It will be vital to work with suppliers to consider each community care clinic's unique characteristics, such as patient population, surge capacity, and the probability of the various types of catastrophic emergencies that may occur due to location (e.g., proximity to a nuclear power plant).

Personal protective equipment is likely to be in short supply during a healthcare surge, especially a pandemic influenza. Still, community care clinics must provide respiratory protection, particularly for use during aerosol-generating procedures and for use with coughing/sneezing patients. 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.

10.5. Storage and Inventory Management of Supplies and Equipment

This section addresses storage and inventory management for supplies, pharmaceuticals, and equipment, including environmental, security, and access issues. These considerations should be addressed during pre-surge planning and healthcare surge responses.

10.5.1. Supplies and Equipment

During surge planning, clinics should be aware of items that require ongoing maintenance (e.g., portable monitoring equipment, ventilators, and other items that use batteries) and ensure they continue to be in working order. Obsolescence must be considered as supplies and equipment may become outdated due to technological advances or changes in ordering patterns.

Space is also a very important consideration. Some community care clinics may have inadequate storage to house equipment and supplies. There needs to be prioritization of what will be included in on-site storage space. Other storage options include storing supplies and equipment at other facilities within the healthcare system or using warehouse space either on-or-off site. The Supplies and Equipment Storage Checklist below addresses the vital areas that community care clinics are strongly encouraged to consider when developing plans to store supplies and equipment on-site at a clinic or off-site in a warehouse.

The Supplies and Equipment Storage Checklist is shown below. The complete tool can be found in the *Community Care Clinics Operational Tools Manual* on pages 127-129.

Supplies and Equipment Storage Checklist

Whether in preparation for a healthcare surge or during a surge, there are many planning considerations to ensure that supplies and equipment can be accessed and used immediately. The Supplies and Equipment Storage Checklist lists considerations for supplies and equipment storage across six major categories:

- Inventory Management
- Environmental Management
- Security
- Caches
- Transport

- Ease of Access

Inventory Management

- A process for monitoring and maintaining preventive maintenance requirements:
 - Batteries
 - Ventilator seals
 - Electrical equipment
- A process for returning stock to the vendors for replacement or credit, if applicable
- A process for monitoring the obsolescence of equipment (out-of date) (e.g., automated external defibrillators)
- Considerations for storing large amounts of supplies and equipment:
 - Is storage space limited on-site?
 - Can supplies and equipment be stored at other off-site locations (e.g., warehouses, other facilities in health system)?

Environmental Management (e.g., temperature)

- A process for monitoring personal protective equipment

Security

- A process for ensuring the security of the supply and equipment caches
- A process for controlling access into the building or area
- A process for controlling access within the building
- A process for identifying and tracking patients, staff, and visitors
- A process for monitoring facilities with security cameras
- A process for working with local authorities prior to a healthcare surge to address heightened security needs
- A process for working with private security entities prior to a healthcare surge to address heightened security needs

Caches External to a Facility

- A process for ensuring the security of the supply and equipment caches
- A process for controlling access into the area
- A process for controlling access within the area
- A process for working with local authorities prior to a healthcare surge to address heightened security needs
- A process for working with private security entities prior to a healthcare surge

to address heightened security needs

Transport

- A process for obtaining the caches and transporting them to the desired locations
- A process for loading supplies and equipment in an efficient manner (e.g., loading docks)

Ease of Access

- A process for staging the layout of supplies and equipment to ensure ease of access, (e.g., what is needed in the first 24 hours)

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

Many community care clinics rely on vendors to acquire pharmaceuticals, supplies and equipment. Some clinics may be dependent on community donations to supplement pharmaceuticals, supplies, and equipment. Below is a list of factors a community care clinic should consider during vendor selection to ensure proper acquisition and maintenance of pharmaceuticals, supplies, and equipment:

- “Disaster clauses” within the vendor contract to establish their responsibilities 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

10.6.1. Memoranda of Understanding with Vendors/Suppliers

Prior to a declared emergency and the establishment of a resource prioritization process through SEMS/NIMS, 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

The benefits of developing Memoranda of Understanding include developing an increased level of awareness and understanding of community needs and capabilities and building an environment of trust and collaboration in the event of an emergency. The process of developing a Memorandum of Understanding may be more beneficial than the Memorandum of Understanding itself.

10.6.2. Donations of Supplies and Equipment

Donations received from non-governmental organizations, manufacturers, wholesalers, and retailers are an additional way to increase the pool of supplies and equipment available during a healthcare surge. Potential donation sources may include corporations and faith-based organizations that have stockpiles of supplies and equipment. In recent emergencies, some community care clinics have accepted donations from these organizations directly. This is recommended only if the clinic has adequate infrastructure, staff, and processes in place to manage the receipt, storage, maintenance, security, and deployment of the donated pharmaceuticals, supplies, and equipment. It is recommended that the donations be coordinated at the Operational Area Emergency Operations Center. This will enable the entry of additional resources at the community, county, or regional level so supplies can be made available for communities and organizations most in need. This will also avoid burdening the long-term care health facility staff with the logistics of receiving, storing, securing, maintaining, and supplying donated supplies and equipment.

10.7. Acquiring Additional Pharmaceuticals, Supplies, and Equipment through the Standardized Emergency Management System

Even with extensive planning, community care clinics may still require pharmaceuticals, supplies, and equipment beyond local availability. Additional resources must be requested through the SEMS/NIMS structure. Requests for resources should be made through the appropriate Clinic Incident Command staff to the Unified Command. Resource requests should be as specific as possible to ensure resource needs are adequately met. See Section 3.2,

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

The following are examples of federal and state resources that may be accessed to fill resource requests received through the SEMS/NIMS process. Planners should be aware that during statewide disaster events, resources will be used to fill multiple requests and some requests may be delayed, or unfulfilled.

10.7.1. State Resources

During a healthcare surge community care clinics should use the Standardized Emergency Management System (SEMS) to request resources that CDPH has purchased, such as N-95 respirators and ventilators. Although CDPH has 50.9 million N-95 respirators and 2400 ventilators to help healthcare providers respond to an emergency in California, they may be insufficient to meet demand in a pandemic. These resources will be distributed based on event-specific priorities and may not be available to all long-term care health facilities in all events. Clinics should consider these resources one source but not the only source of necessary resources.

Additional information on SEMS can be found in Section 3.3 "Standardized Emergency Management System (SEMS)" and *Foundational Knowledge* Section 3.9 "Standardized Emergency Management System."

10.7.2. Federal and State Resources

As a standard operating procedure, federal and state antiviral caches have been allocated by population and will be distributed to each public health department per the California Pandemic Influenza Antiviral Allocation and Distribution Plan. Other pharmaceuticals are also available through the federal Strategic National Stockpile. Through state and federal partnerships, the following resources can 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 of 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 public health departments

10.8. Staging Considerations

Many community care clinics have limited or no storage capacity and are likely to have insufficient emergency supply storage in close proximity to their designated treatment areas. Furthermore, because emergency supplies are not routinely used, they are often stored in the least convenient space, sometimes in off-site warehouses. This can result in delays in care as clinics try to retrieve their supplies from various storage locations during a surge situation.

Clinics often organize their emergency supplies similar to other clinic materials – each item is stored with like items in the same location. While this is an efficient means of monitoring and replenishing inventory under routine operating procedures, it may not be optimal in an emergency response.

Clinics may wish to identify a small storage area near their designated emergency triage and treatment site. This area can be used for the “first push” of the supplies that are likely needed in the first moments of a crisis. For example, a small collection of medical supplies, linens, protective equipment, gowns, and medical supplies could be gathered here. If space allows, a casualty shelter (tent), lights, and generator could be added. If environmental conditions allow, pharmaceutical supplies might be included. As the catastrophic emergency evolves and additional supplies are needed, the more remote storage areas can be accessed to replenish or supplement the first push of supplies. Plans to retrieve the additional supplies should be activated as the first set is deployed.

If space is sufficient, the “first push” supplies may be packaged in a cart 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. Further, a detailed inventory should accompany the first push of supplies to indicate “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.⁵³

The Staging Recommendations Checklist on the following page serves as a tool to identify considerations that community care clinics should assess when staging their resources.

The Staging Recommendations Checklist is shown below. The complete tool can be found in the *Community Care Clinics Operational Tools Manual* on pages 130-131.

Staging Recommendations Checklist

- Develop a process for determining what items will be needed first. Use the concept of last in, first out.
- Develop a staging plan that does not place one type of material all in one place (e.g., cots all in one area).
- Develop a plan for how the materials will be moved (e.g., deployable cart).
- Develop a plan for how items will be set up once they are taken out of storage (e.g., tents, tables, carts, and provisions for temperature control, such as ice, ice chests, etc.).
- Develop a plan that considers that space is often a limiting factor.
- Develop a plan that considers alternate sites to stage pharmaceuticals, supplies, and equipment (e.g., offsite warehouses).
- Develop a plan that considers using pushcarts for moving materials efficiently and incorporate into staging plan.
- Label pushcarts with all materials and expiration dates.
- Identify ownership of staging areas (state vs. local) and who is responsible for identifying points of distribution.
- Store pharmaceutical caches in secure containers that can be easily transported (e.g., plastic totes with tear-away locks).
- Keep non-expired medical supplies separate from medical supplies that have expiration dates.
- Cover pharmaceuticals, supplies, and equipment for protection from the elements for purposes of reducing spoilage and the need to repackage materials.

11. Administration

It is essential that community care clinics plan for administrative functions and possible necessary modifications during a healthcare surge. This section discusses key administrative tasks including patient tracking, patient registration, medical records documentation, document storage, disease reporting, and workers' compensation obligations and how these tasks can be planned for and managed during a healthcare surge.

11.1. Patient Tracking

While some clinics have implemented electronic health records systems, a large majority of community care clinics continue to use practice management software and paper-based patient health recordkeeping systems. For those clinics currently using electronic health record systems, this section provides recommendations for an interim paper-based system during a health care surge. For those clinics using a paper-based patient record system, this section provides a recommended approach for patient tracking during surge conditions.

The recommendations in this section are based on the following major concepts:

- **Collect minimum necessary data:** Given that an unanticipated emergency may severely limit the ability 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.
- **Assign patients a unique identifier:** A fundamental component of an effective tracking system will be to establish a unique patient identifier (e.g., triage tag code number). For information on triage tag code numbers and other patient identifiers, see *Volume I: Hospitals*, "Section 11.1.1 Disaster Incident Number."
- **Patient tracking is a priority:** Tracking persons seeking treatment at healthcare system entry points (e.g., hospitals, community care clinics, alternate care sites, and emergency medical system) during a healthcare surge is a high priority for healthcare facilities, alternate care sites, and the community.
- **Paper-based tracking is an essential contingency:** Although significant efforts are under way to develop electronic patient tracking systems for emergency purposes, manual backup 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.

Pediatric Care: Children necessitate specific care during an emergency. In addition to considering the child's medical and psychological condition, clinics must have a procedure to identify the child's guardian prior to discharge.

11.1.1. Patient Tracking Form⁵⁴

The following form is an example of the type of tool that could be instituted at a community care clinic for the purpose of tracking patients as they are transferred to or from other clinics, hospitals, or an alternate location.

The Patient Tracking Form is shown below. The complete tool can be found in the *Community Care Clinics Operational Tools Manual* on pages 132-134.

Patient Tracking Form

Instructions

Print legibly and enter complete information for each of the following fields.

1. **INCIDENT NAME:** If the incident is internal to the clinic, the name may be given by the treating clinic's Incident Commander. If the incident affects the larger community, the name may be given by a local authority (e.g., fire department, local Emergency Operations Center, etc.).
2. **DATE/TIME PREPARED:** Use the international standard date notation YYYY-MM-DD, where YYYY is the year, MM is the month of the year between 01 (January) and 12 (December), and DD is the day of the month between 01 and 31. For example, the fourteenth day of February in the year 2006 is written as 2006-02-14. Use the international standard notation hh:mm, where hh is the number of complete hours that have passed since midnight (00-24), and mm is the number of complete minutes that have passed since the start of the hour (00-59). For example, 5:04 pm is written as 17:04. Use local time.
3. **OPERATIONAL PERIOD DATE/TIME:** Identify the operational period during which this information applies. This is the time period established by the treating clinic's Incident Commander, during which current objectives are to be accomplished and at the end of which they are evaluated. For example, a 12-hour operational period might be 2006-08-16 18:00 to 2006-08-17 06:00.
4. **PATIENT DATA:** For each patient, record as much identifying information as available: medical record number, triage tag number, name, sex, date of birth and age. Identify area to which patient was triaged. Record disposition of patient and time of disposition.
 - **LAST NAME:** Patient's last name
 - **FIRST NAME:** Patient's first name

- **SEX:** “M” for male and “F” for female
 - **DOB/AGE:** Patient's date of birth as YYYY-MM-DD; If time permits, record age as well.
 - **MR #/Triage #:** Medical record number and/or triage number assigned to at the clinic
 - **TIME IN:** Time the patient was received at the clinic. Use the international standard date notation YYYY-MM-DD. Use the international standard notation hh:mm. Use local time.
 - **LOCATION:** The area or zone to which a patient is triaged
 - **DISPOSITION:** The specific area, facility, or location to which the patient is transferred or discharged
 - **TIME OUT:** Time of patient transfer or discharge. Use the international standard date notation YYYY-MM-DD. Use the international standard notation hh:mm. Use local time.
 - **FAMILY NOTIFICATION:** As soon as time allows, family members should be notified of their loved one's location and condition. Note the date and time of the notification and the name of the staff member placing the call.
5. **AUTHORIZATION SIGN OFF:**
 6. **CLINICAL PROVIDER:**
 7. **SUBMITTED BY:** Full name of person verifying the information and submitting the form
 8. **AREA ASSIGNED TO:** Triage area where these patients were first seen
 9. **DATE/TIME SUBMITTED:** Indicate date and time that the form is submitted to the situation unit leader.
 10. **CLINIC NAME:** Clinic name; use when transmitting the form outside of the treating clinic.
 11. **PHONE:** Clinic phone number.
 12. **FAX:** Clinic fax number.
- WHEN TO COMPLETE:** Hourly and at end of each operational period or the length of time specified in the incident action plan, upon arrival of the first patient and until the disposition of the last.

PATIENT TRACKING FORM

1. INCIDENT NAME: _____		2. DATE/TIME PREPARED: _____			3. OPERATIONAL PERIOD DATE/TIME: _____				
4. PATIENT TRACKING DATA:									
Last Name	First Name	Sex	DOB/Age	MR #/ Triage #	Time in	Location	Disposition	Time Out	Notification of Family
5. AUTHORIZATION SIGN OFF: _____					6. CLINICAL PROVIDER: _____				
7. SUBMITTED BY: _____					8. AREA ASSIGNED TO: _____			9. DATE/TIME SUBMITTED: _____	
10. CLINIC NAME: _____					11. PHONE: _____			12. FAX: _____	

11.1.2. Paper-Based Intra-Clinic Patient Tracking Process

A manual method for tracking patients as they move through the clinic may be required during a healthcare surge when computer systems are unavailable. The following procedure is an example of a process that could be implemented at a community care clinic for the purpose of tracking patients as they move through a clinic when electronic systems are unavailable.

The Paper-Based Intra-Clinic Patient Tracking Process is shown below. The complete text including the accompanying policy can be found in the *Community Care Clinics Operational Tools Manual* on pages 135-136.

Paper-Based Intra-Clinic Patient Tracking Process

Procedure:

Prior to the healthcare surge, a clinic will maintain a supply of index cards and determine a method for housing those cards (e.g., "bed board," index card box)

1. At the point of a healthcare surge, a designated person will be responsible for completing a card for each patient currently in-house. The following information will be recorded on the card:
 - a. Patient name
 - b. Date of birth/Age
 - c. Major medical conditions
 - d. Physical location of the patient (e.g., Room 20, Bed 2)
 - e. Condition (e.g., critical, stable)
 - f. Presence and/or location of care plan
 - g. Need for and location of any special equipment or supplies
 - h. List of current medications and location of drugs
 - i. Name and contact information for family member, durable healthcare power of attorney, legal representative, or other responsible party
2. A card will also be initiated at the point of registration for every patient that is treated, triaged, admitted, or discharged once the healthcare surge begins.
3. At midnight each night, a designated staff person(s) will make rounds in the patient care areas to collect newly created cards and ensure that the current location of the patient is documented on the card. At the same time, the location of each patient who already had a card will be verified.
4. The updated and newly collected cards will be filed back into the index card box or other collection device in the patient care area so updates can easily be made the following day.

11.2. Downtime Procedures for Registration and Medical Record Numbers

During an emergency, methods for completing registration and obtaining medical record numbers within community care clinics may be unavailable. Although many clinics have established paper-based registration and medical records process, streamlined procedures may be required to sustain operations during a healthcare surge.

11.2.1. Sample Registration Downtime Procedures

Many community care clinics have existing procedures that can be used during daily system downtime situations. For additional guidance, the following Sample Registration Downtime Procedures can be adapted by clinics to prepare for downtime during a healthcare surge.

Clinic registration staff should manually complete pre-numbered face sheets (if available), 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. Sample registration logs, face sheets, and insurance verification forms follow the procedures below.

The Sample Registration Downtime Procedures are shown below. The complete tool can be found in the *Community Care Clinics Operational Tools Manual* on pages 137-138.

Sample Registration Downtime Procedures

PURPOSE: To provide registration services to patients in the event of a healthcare surge capacity. Also, to enable registration staff to complete registration processes during healthcare surge capacity downtimes.

PROCEDURE: During healthcare surge capacity and computer downtime, the following guidelines for minimum data collection are recommended:

- Create an emergency packet that includes paper copies of the following:
 - Paper-Based Face Sheets
 - Charge Ticket/Billing Form
 - Order Sheets
 - Blank Labels
 - Consent to Treat Forms
- Include a field for a unique patient identifier on all emergency packet materials.
- Maintain a reasonable supply of emergency packets to use in the event of a healthcare surge (at least 25 packets at each clinic).
- Create the packets with pre-numbered documents, labels, and armbands/wristbands.
- Maintain a block of downtime-specific medical record numbers and account numbers to be used in the event of a healthcare surge.
- Maintain a log of all patients registered with their medical record number. This might

require multiple logs at each registration/access point.

- All registration staff may need to complete a paper-based face sheet (see Sample Paper-Based Face Sheet for example).
- If multiple copies of the patient face sheet are required in the clinic, consider maintaining a supply of carbon paper with the emergency packet supply.
- Collect a minimum data set to facilitate the ability to complete claim forms in the event of an emergency. This will depend upon governmental and private payer approval. Clinics should initiate discussion with their payer representatives to discuss minimum data sets.

Requested data might include:

- Name/Guardian
- Sex
- Date of birth
- Name of payer
- Primary care provider
- National Provider Identifier

The Sample Registration Log is shown below. The complete tool along with the accompanying policy can be found in the *Community Care Clinics Operational Tools Manual* on pages 139-140.

Sample Registration Log

Instructions

Complete log for all registered patients. Multiple logs at each registration/access point may be needed.

- **Medical Record Number:** Enter patient medical record number if available.
- **Triage or Other Tracking Number:** Enter patient triage number, or other applicable tracking number.
- **Last Name:** Enter patient’s last name.
- **First Name:** Enter patient’s first name.

#	Medical Record #	Last Name	First Name
1			
2			
3			
4			
5			

The Sample Paper-Based Face Sheet is shown below. The complete tool along with the accompanying policy can be found in the *Community Care Clinics Operational Tools Manual* on pages 141-142.⁵⁵

Sample Paper-Based Face Sheet

Registration personnel should fill-out the form as completely as possible upon patient registration during a healthcare surge.

Paper-Based Face Sheet

Patient Information

Name: _____
 MRN: _____ DOB: _____ Sex: Male Female
 Mailing Address: _____
 Zip: _____ City: _____ County: _____
 Marital Status: Single Married Widowed Divorced Separated
 Name of Spouse: _____ Maiden Name: _____
 Race/Ethnicity: _____ Primary Language: _____ Translator Requested? Y N
 Employer Name: _____ Employer's Phone Number: _____
 Employer Address if Work Comp related: _____
 Occupation: _____

Emergency Contact

Name: _____ Relationship: _____ Phone #: _____
(Last Name, First Name)

Insurance Information

Name of insurance coverage: _____ Policy # _____ Group #: _____
 MediCal? Y N
 Name of Insurance Carrier: _____ Policy #: _____
 Is this an HMO Plan Y N If yes, name of Medical Group: _____
 Primary Care Physician: _____ Co-pay \$ _____

Subscriber Information

Name _____ Relation: _____ Insurance ID # _____
(Last Name, First Name)
 Employer Name: _____ Employer's Phone Number: _____
Transferring Facility: _____ **Referring Physician:** _____

Notes:

11.2.2. Minimum Requirements for Medical Record Documentation

During an emergency, electronic medical record information may be unavailable. Therefore, for those community care clinics who electronically document medical records, paper-based methods for capturing medical record information may be required. Furthermore, 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. This section recommends minimum requirements for medical record documentation during healthcare surge.

The sample Short Form Medical Record is an example of the type of patient medical record that could be initiated during a healthcare surge when electronic systems for documenting the provision of care are unavailable. The Short Form Medical Record should be utilized to capture pertinent assessment, diagnosis, and treatment information. This form is not expected to meet existing medical records documentation requirements, rather it should serve as a recommended set of elements that can be considered accepted documentation during a healthcare surge.

The Short Form Medical Record is shown on the following page. The complete tool can be found in the *Community Care Clinics Operational Tools Manual* on pages 143-144.

Short Form Medical Record

Instructions

The Short Form Medical Record should be completed for all individuals seeking medical attention at a community care clinic during a healthcare surge.

Short Form Medical Record											
Means of Arrival	<input type="checkbox"/> AMB	<input type="checkbox"/> Other	Allergies NKDA	Latex Sensitive	Last TD	LMP	Room #	Time			
	<input type="checkbox"/> W/C		Y <input type="checkbox"/> N <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>							
Street Address: _____					Current Meds						
City: _____ State: _____ Zip: _____ Phone: _____					Past Medical History						
CHIEF COMPLAINT _____					T/BP/P/R _____			Pain Asses. _____ /10			
_____, RN											
HISTORY/ PHYSICAL FINDINGS:											
CLINICIAN ORDERS					NURSE NOTES						
IMPRESSION / DIAGNOSIS											
Clinicians Signature					(Print Name)						
Disposition <input type="checkbox"/> Home <input type="checkbox"/> Left without being seen @ (time):					Time of Discharge:						
Transferred to: _____ Transfer Form completed <input type="checkbox"/> Referred to :					Follow-Up in Clinic _____ Days/Weeks						
					Number Name						
					DOB						

Source: University of California, Berkeley - University Health Services

11.2.3. Community Care Clinic Reporting Requirements

During a declared healthcare surge, it may be difficult for community care clinics to adhere to all reporting requirements. However, 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 of Elder and Child Abuse
- 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. To the extent clinics are able, they would be expected to make reasonable efforts to report information during the declared emergency time period or as soon as practical. In cases where information is destroyed and the reporting of information is not practical, no penalty exists.

The table below provides a description of community care clinic reporting requirements, corresponding time requirements, penalties under normal operating conditions, and entity responsible for receiving reporting information. Column titles are defined as follows:

- **Clinic Reporting Requirements:** Lists community care clinic reporting requirements under normal conditions
- **Time Requirement:** Defines time period by which reporting requirement must be met
- **Penalty:** Describes penalty(ies) associated with not meeting the corresponding clinic reporting requirement
- **Receiving Entity:** Organization/agency/governing body to receive required reporting information

Clinic Reporting Requirement	Time Requirement	Penalty	Receiving Entity
Health Response Reporting			
Disease Reporting/Notification			
Epidemic outbreaks, poisonings, fires, major accidents, deaths from unnatural causes, or other catastrophes and unusual occurrences	1 Day	22 CCR 75053 requires that clinics report occurrences such as epidemic outbreaks, poisonings, fires, major accidents, deaths from unnatural causes, or other catastrophes and unusual occurrences which threaten the welfare, safety, or health of patients, personnel, or visitors within 24 hours either by phone (and confirmed in writing) or by telegraph to the Local Health Officer and CDPH.	Local Health Officer
Chancroid, Chlamydial Infections, Coccidioidomycosis, Cysticercosis, Echinococcosis (Hydatid Disease), Ehrlichiosis, Giardiasis, Gonococcal Infections, Hepatitis, Viral, Hepatitis B (specify acute or chronic), Hepatitis C (specify acute or chronic), Hepatitis D (Delta), Hepatitis (other, acute), Kawasaki Syndrome, Legionellosis, Leprosy (Hansen Disease), Leptospirosis, Lyme Disease, Mumps, Non-Gonococcal Urethritis (excluding lab confirmed Chlamydial infections), Pelvic Inflammatory Disease, Reye Syndrome, Rheumatic Fever, Acute, Rocky Mountain Spotted Fever, Rubella (German Measles) Rubella Syndrome, Congenital, Tetanus, Toxic Shock Syndrome, Toxoplasmosis, Typhus Fever.	7 Days	Per California Health and Safety Code Section 120275, failure to report a disease listed in statute or regulation is a misdemeanor, and for licensed facilities, is a condition of licensure under 22 CCR 75027. Failure to report may result in suspension or revocation of license. Note that a Local Health Officer may take any action required to control the spread of disease.	Local Health Officer

Clinic Reporting Requirement	Time Requirement	Penalty	Receiving Entity
Birth and Death Reporting			
a) Birth Reporting (California Health and Safety Code Section 102400 <i>et seq.</i>)	10 days from birth	Misdemeanor (California Health and Safety Code Section 103775)	Local registrar
b) Death Reporting (California Health and Safety Code Section 102775 <i>et seq.</i>)	8 calendar days after death and prior to disposition of human remains	Misdemeanor (California Health and Safety Code Section 103775)	Local registrar
c) Mass Fatalities (California Health and Safety Code 103450)	None identified	Misdemeanor (California Health and Safety Code Section 103775)	County Superior Court
Inventories of Medical Supplies (Health and Safety Code Section 120176)	Report upon request of the Local Health Officer	It is a misdemeanor to violate an order of the Local Health Officer related to or respecting quarantine or disinfection.	Local Health Officer
Law Enforcement Reporting			
Suspicious Injury Reports (California Penal Code Section 11160 <i>et seq.</i>)	Immediately or as soon as practicably possible	A misdemeanor subject to up to six months jail and/or \$1000 fine	Local law enforcement
Crime Scene/Evidence Collection Requirements (45 CFR 164.512 (f)(3),(5),(6) describes permitted disclosures under HIPAA, in accordance with certain requirements)	Covered entities <i>may</i> disclose certain protected health information, but no timeframe for making a permitted disclosure is required.	Permissible disclosures; no penalty identified for failure to report.	Local law enforcement
Crime Reporting/Law Enforcement			
Violence against a community healthcare worker (California Labor Code Section 6332)	None identified	Subject to surprise inspection, complaint-based investigation, and fines	Department of Industrial Relations, Division of Labor Statistics and Research

Clinic Reporting Requirement	Time Requirement	Penalty	Receiving Entity
Child abuse and neglect (California Penal Code Section 11164 et seq.)	Immediately or as soon as practicably possible. Written report filed within 36 hours	Misdemeanor punishable by up to six months confinement in a county jail or by a fine of \$1,000, or both	Police department, sheriff's department, county designated probation department, or county welfare department.
Elder and dependent adult abuse (California Welfare and Institutions Code Section 15600 et seq.)	By phone immediately or as soon as practicably possible, and by written report sent within two working days	A misdemeanor, punishable by not more than six months in the county jail, by a fine of not more than \$1,000, or both	local law enforcement agency
Facility neglect or abuse (California Penal Code Section 11161.8)	Immediately	Confinement in a county jail or a fine of \$1,000, or both	Local law enforcement
Administrative Reporting			
Office of Statewide Health Planning and Development Reporting Requirements (California Health and Safety Code Section 128675 et seq.)	Reasonable time	Civil penalty of \$100 per day (California Health and Safety Code Section 128770)	California Office of Statewide Health Planning and Development
Office of Statewide Health Planning and Development Reporting Requirements (California Health & Safety Code Section 1216) requires every specialty clinic to file with OSHPD an Annualized Utilization Report that contains utilization data for its licensed services.	Every clinic holding a license shall, on or before the 15th day of February each year	Suspended license by the Department of Health & Human Services	California Office of Statewide Health Planning and Development
Office of Statewide Health Planning and Development Reporting Requirements (California Health & Safety Code Section 1226.1)	None Identified	None Identified	California Office of Statewide Health Planning and Development

Clinic Reporting Requirement	Time Requirement	Penalty	Receiving Entity
California Health & Safety Code Section, 1217, 1226, 1226.3, 1226.5	None Identified	Failure to complete the plan of modernization as approved and within the time allowed shall constitute a basis for revocation or nonrenewal of the applicant's license	California Office of Statewide Health Planning and Development
Cancer Registry (California Health and Safety Code Section 103875 <i>et seq.</i>)	None identified	No penalty identified for failure to report; subject to recoupment of all costs expended by the California Department of Health Care Services to obtain the information if the clinic fails to report	CDPH or the authorized representative of CDPH
Reporting Adverse Reactions to Vaccinations (42 USC Section 300aa-14, 42 USC Section 300aa-25)	None identified	No penalty was identified for failing to report	Director appointed by United States Secretary of Health and Human Services.
Reports under the Safe Medical Device Act of 1990 (21 USC 360(i)(b), 21 CFR 803.10, 803.22, 803.19, 803.33)	As soon as practicable but not later than 10 working days after known death, serious injury, or other significant adverse device experiences	No penalty was identified for failing to report	United States Secretary of Health and Human Services or designee
Medication Errors (16 CCR 1711(a)(b); California Business and Professions Code Section 4125)	Medication errors must be recorded on an ongoing basis, as part of the pharmacy's quality assurance program	Requirement of the pharmacy; subject to loss of permit or license to operate	Board of Pharmacy

Clinic Reporting Requirement	Time Requirement	Penalty	Receiving Entity
Occupational Injuries and Illnesses (California Labor Code Section 6409, 8 CCR 14003)	Within five days after the employer obtains knowledge of the injury or illness; in every case involving a serious injury or illness or death, an additional report shall be made immediately by the employer to the Division of Occupational Safety	A civil penalty of not less than five thousand dollars (\$5,000) applies; other penalties are codified at Labor Code Section 6423 <i>et seq.</i>	Department of Industrial Relations, Division of Labor Statistics and Research
Joint Commission Sentinel Event Reporting (Joint Commission Manual, SE-2, IV - Reviewable Sentinel Events; SE-5 - Required Response to a Reviewable Sentinel Event, PI.1.10, PI.2.20, PI.2.30, PI.3.10)	45 days	Subject to loss of accreditation	Joint Commission
Medicare Claims Submission Medicare Claims Processing Manual, Chapter 1 – General Billing Requirements, Exhibit 1 – Data Element Requirements Matrix (FI) (Rev. 145, 04-23-04) A3-3600, Addendum L	Within 1 year of the service date (Social Security Act Section 1848(g)(4))	Assigned claims submitted more than 1 year after the service date will be subject to a 10 percent payment reduction. (Social Security Act Section 1848(g)(4))	Federal Centers for Medicare and Medicaid Services
Medi-Cal Claims Submission Medi-Cal Inpatient/Outpatient Provider Manual, Part 2 – Inpatient Services (IPS), UB-92 Completion: Inpatient Services, UB-92 Submission and Timeliness Instructions.	Original (or initial) Medi-Cal claims must be received by Electronic Data Systems (EDS) within six months following the month in which services were rendered	Reduced rate or denial of payment; delay reason codes may be entered in cases of late submission to avoid penalty	Electronic Data Systems (EDS)

Clinic Reporting Requirement	Time Requirement	Penalty	Receiving Entity
Work-Connected Fatalities and Serious Fatalities (8 CCR 342)	Immediately means as soon as practically possible but not longer than 8 hours after the employer knows or with diligent inquiry would have known of the death or serious injury or illness. If the employer can demonstrate that exigent circumstances exist, the time frame for the report may be made no longer than 24 hours after the incident.	Minimum penalty of \$5,000 (8 CCR 337 (a)(6))	District Office of the Division of Occupational Safety and Health

For more information on state and federal requirements, see Foundational Knowledge, "Tool 3: Tables of Specific State and Federal Regulations and their Emergency Provisions during a Healthcare Surge."

11.2.4. Waived, Flexed, Amended, or Suspended Licensing Regulations for Community Care Clinics during a Healthcare Surge

During a declared healthcare surge it may be difficult for community care clinics to remain compliant to all current licensing regulation. The table below provides a brief description of specific licensing regulations that may be waived, flexed, amended, or suspended during a healthcare surge. For a complete description of the regulations listed in the table please refer to the link below.

<http://government.westlaw.com/linkedslice/search/default.asp?tempinfo=find&RS=GVT1.0&VR=2.0&SP=CCR-1000>

From this link, the California Code of Regulations can be searched by Title or Section. Licensing regulations appear in Title 22, Division 5.

CCR Title & Section	California Code of Regulation for Primary Care Clinics
Title 22 CCR Sections 7500 - 75083	
Report of Changes CCR Section 75025	a) Any change in the principal officer such as chairperson, president, or general manager of the governing board shall be reported to the Department in writing immediately.
Basic Services General Requirements CCR Section 75026	<p>a) Diagnostic, therapeutic, radiological, laboratory and other services for the care and treatment of patients for whom the clinic accepts responsibility shall be provided in the clinic, or arranged for by the clinic with other licensed, certified or registered providers.</p> <p>b) All advice, diagnosis, treatment, drugs and appliances shall be provided only by persons authorized by law to provide such services.</p> <p>c) A clinic shall only provide those services for which it is organized, staffed, and equipped. A primary care clinic shall provide at least the following:</p>
Basic Services - Medical Staff CCR Section 7502-75028	a) Every medical clinic shall have a licensed physician designated as the professional director.
Basic Services Other Health Personnel CCR Section 75029	<p>a) Health personnel shall be employed to furnish the preventive, diagnostic and therapeutic services prescribed for patients accepted for care by the clinic. Such health personnel shall be qualified in accordance with current legal, professional and technical standards and shall be appropriately licensed, registered or certified where required.</p> <p>b) The professional director shall ensure that, in addition to meeting the licensing, certification or other legal requirements, all health personnel are qualified by training and experience to perform those services they are assigned to provide.</p>
Basic Services Policies and Procedures CCR Section 75030	a) Written policies and procedures which the clinic has implement to include, but not be limited to: patient care, follow-up care, provision to handling emergencies, infection control policies and procedures, may be potentially flexed or waived during a healthcare surge
Basic Services Equipment and Supplies CCR Section 75031	<p>a) Each clinic shall have equipment and supplies available to provide for the medical, dental or podiatric services offered and to meet the needs of the particular patients served.</p> <p>b) The clinic shall have equipment available for emergency treatment of patients. Such equipment shall be determined by the professional director and licensed nurse in accordance with the scope of services provided by the clinic. A list of such equipment and its location shall be posted</p>

CCR Title & Section	California Code of Regulation for Primary Care Clinics
Drug Distribution Services CCR Section 75032-75039	a) A clinic which provides drug distribution service shall provide such service in conformance with state, federal and local laws. b) All dangerous drugs not owned by and stored in a licensed pharmacy shall be owned by a licensed physician, dentist or podiatrist. c) A list of drugs available for use in the clinic shall be maintained. d) If a pharmacy is located on the premises, the pharmacy shall be licensed by the California State Board of Pharmacy.
Transfer Agreements CCR Section 75047	a) The clinic shall maintain written transfer agreements, which include provisions for communication and transportation, with one or more nearby hospitals and other inpatient health facilities as appropriate to meet medical emergencies.
Service Agreements CCR Section 75048	a) Written arrangements shall be made for obtaining all necessary diagnostic radiological, laboratory, therapeutic and other services which are prescribed by a person lawfully authorized to give such an order if such services are not provided in the clinic.
Employee Orientation and Training CCR Section 75050	a) The clinic shall recruit qualified staff and provide initial orientation of new employees, a continuing in-service training program, and supervision designed to improve patient services and employee efficiency. Staff shall be given training in infection control and emergency procedures consistent with the type of clinic and the services provided.
Unusual Occurrences Reporting CCR Section 75053	a) Unusual Occurrences. Occurrences such as epidemic outbreaks, poisonings, fires, major accidents, deaths from unnatural causes or other catastrophes and unusual occurrences which threaten the welfare, safety or health of patients, staff or visitors shall be reported by the facility within 24 hours either by phone (and confirmed in writing) or by telegraph to the Local Health Officer and the Department.
Patient Health Records Service CCR Section 75054	a) Each clinic shall establish and maintain a patient health record service b) Staff, space, equipment and supplies in the health record service shall be located to facilitate immediate retrieval of health information
Unit Patient Health Records CCR Section 75055	a) Records shall be permanent, either typewritten or legibly written in ink and shall be kept on all patients accepted for treatment. All health records of discharged patients shall be completed and filed within 30 days after termination of each episode of treatment.
Admission Records CCR Section 75056	a) The clinic shall complete an admission record for each patient
Written Disaster Program CCR Section 75057	a) Each clinic shall adopt a written disaster program and all personnel shall be instructed in its requirements. The program shall provide plans for disasters occurring within the facility. (may be flexed, amended, or suspended if services actually provided in the event of a healthcare surge vary from the clinic's planned program)

CCR Title & Section	California Code of Regulation for Primary Care Clinics
Physical Plant CCR Section 75060-75072	a) Alterations to existing buildings, or new construction, shall be in conformance with the applicable provisions of Chapter 1, Division T17, Title 24, California Administrative Code and approved by the Office of Statewide Health Planning and Development unless the Department approves waivers in accordance with Section 1217 of the Health and Safety Code.
Birth Services - General Requirements CCR Section 75075-75083	a) Primary care clinics providing a birth service shall provide care for patients during pregnancy, labor, delivery and the immediate postpartum period, and refer patients in need for specialized or tertiary care at any stage of pregnancy. For those clinics that don't already have a special permit to provide birth services, they would be required to provide emergency birth services
Specialty Clinic Licensing Regulations	
Title 22 CCR Sections 75172 - 75208	
Psychology Clinic Licensing Regulations	
Title 22 CCR Sections 75301 - 75371	
California Office of Statewide Health Planning and Development	
Building Standards Code	
<ul style="list-style-type: none"> Title 24, CCR; Part 1, Chapter 7 Title 24, CCR: Part 2, Chapter 4A, Division III Section 422A.1 et. seq. 	

11.3. Health Insurance Portability and Accountability Act of 1996 (HIPAA) Compliance during Healthcare Surge

During a healthcare surge, community care clinics may need to share patient information in order to provide urgent care to an increased number of patients. The Health Insurance Portability and Accountability Act of 1996 (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 impose HIPAA compliance fines on providers during a healthcare surge. This protection is in alignment with HIPAA regulations that indicate covered entities may use or disclose protected health information without facing HIPAA sanctions under the following instances:

- 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 emergency 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]
- The requirements in 45 CFR 164.510 (b)(2) and (3) apply to such uses and disclosures to the extent that the covered entity, in the exercise of professional judgment, determines that the requirements do not interfere with the ability to respond to the emergency circumstances.

Additionally, the federal Department of Health and Human Services issued the following guidelines on HIPAA emergency provisions. This guidance can be found at <http://www.hhs.gov/ocr/privacy/hipaa/understanding/special/emergency/katrinahipaa.pdf> and is excerpted below:

Providers and health plans covered by the HIPAA Privacy Rule can share patient information in the following ways:

- **TREATMENT.** Healthcare providers can share patient information as necessary to provide treatment.
 - Treatment includes:
 - sharing information with other providers (including clinics)
 - referring patients for treatment (including linking patients with available providers in areas where the patients have relocated)
 - coordinating patient care with others (such as emergency relief workers or others that can help in finding appropriate health services)
 - providers can also share patient information to the extent necessary to seek payment for these healthcare services
- **NOTIFICATION.** Under the following conditions, healthcare providers can share patient information as necessary to identify, locate, and notify family members, guardians, or anyone else responsible for the individual's care of the individual's location, general condition, or death:
 - The healthcare provider should obtain verbal permission from individuals, when possible. If the individual is incapacitated or not available, providers may share information for these purposes if, in their professional judgment, doing so is in the patient's best interest.
 - When necessary, the healthcare provider may notify the police, the press, or the public at large to the extent necessary to help locate, identify, or otherwise notify family members and others as to the location and general condition of their loved ones.
 - When a healthcare provider is sharing information with disaster relief organizations that, like the American Red Cross, are authorized by law or by their charters to assist in disaster relief efforts, it is unnecessary to obtain a patient's permission to share the information if doing so would interfere with the organization's ability to respond to the emergency.
- **IMMINENT DANGER.** Consistent with applicable law and the provider's standards of ethical conduct, healthcare providers can share patient information with anyone as necessary to prevent or lessen a serious and imminent threat to the health and safety of a person or the public.

- **FACILITY DIRECTORY.** Healthcare providers maintaining a directory of patients can tell people who call or ask about individuals whether the individual is at the facility, their location in the facility, and their general condition.

The United States Department of Health and Human Services has developed a Decision Making Tool depicting when protected health information can be disclosed during an emergency. For additional guidance on using this tool, see the federal Health and Human Services website at

<http://www.hhs.gov/ocr/privacy/hipaa/understanding/special/emergency/decisiontool.html>.

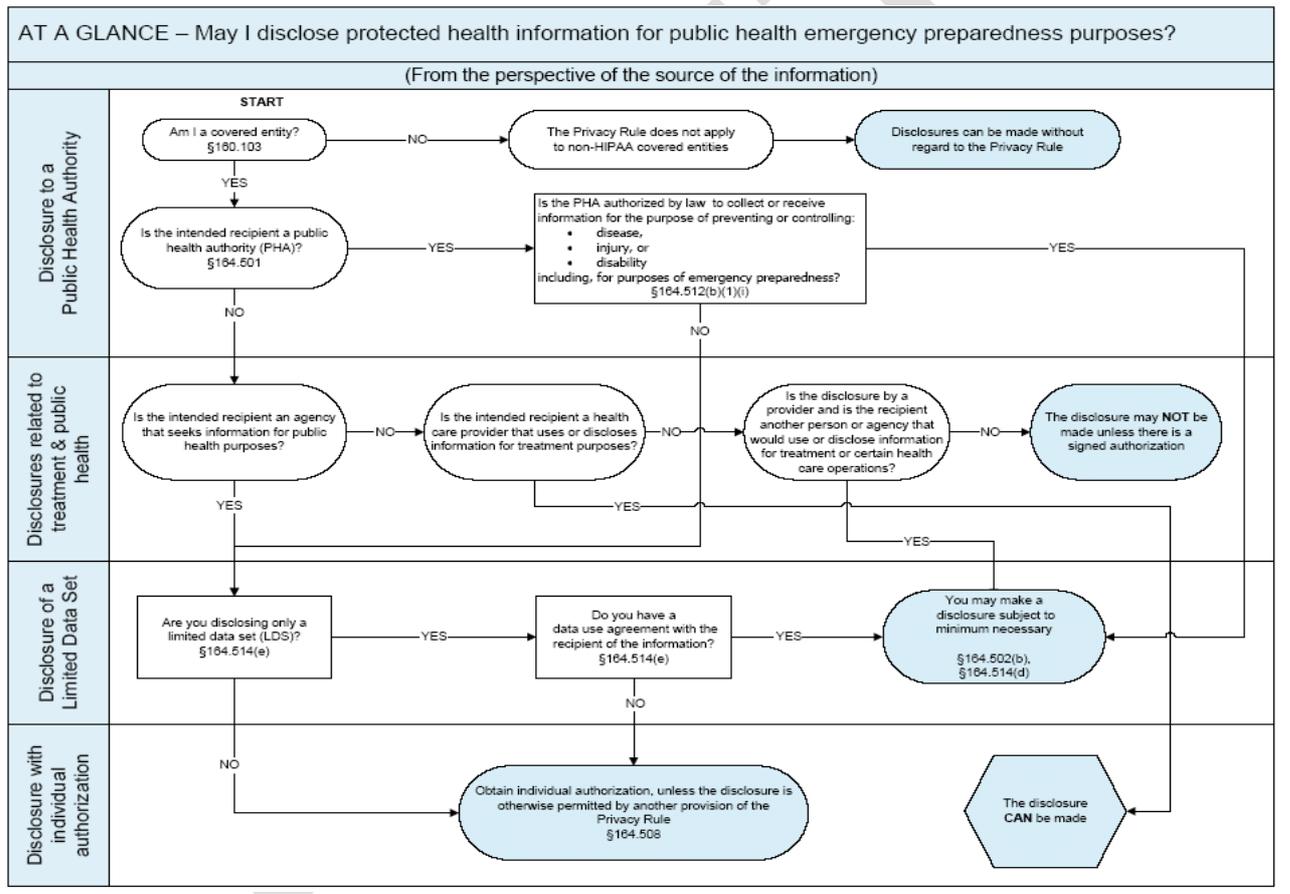
DRAFT

The Decision-Making Tool for Disclosure of Protected Health Information (PHI) is shown below. The complete tool can be found in the *Community Care Clinics Operational Tools Manual* on pages 145-146.

Decision-Making Tool for Disclosure of Protected Health Information

Instructions

Answer questions beginning at “Start.” Continue answering questions until resolution is provided regarding disclosure of Protected Health Information.



The federal Indian Health Service outlines a policy for the use and disclosure of private health information by Indian Healthcare Clinics during an emergency, which can be accessed from the following link:
<http://www.ihs.gov/PublicInfo/Publications/IHSMannual/Part2/part2chapter%207/meh.htm>.

Information from the Privacy Act Office of the Indian Health Service is available at
<http://www.ihs.gov/AdminMngrResources/PrivacyAct/>.

These materials, as well as forms available to adapt HIPAA, United States Health and Human Services regulations, and other national requirements to the specific administration of Indian Health Service clinics can be accessed from the following link:

http://www.ihs.gov/AdminMngrResources/HIPAA/index.cfm?module=training_forms.

11.4. Patient Valuables Tracking

Most community care clinics do not have a formal procedure in place to collect and track patient valuables. During a surge event, it may become necessary to collect and store patient valuables during the intake process. Clinics should consider developing procedures related to patient valuables tracking or evaluate current procedures to determine how they can be streamlined for use in a surge event.

11.4.1. Sample Procedure for Patient Valuables Tracking⁵⁶

This policy provides an example of the type of process and subsequent documentation that could be implemented by a community care clinic to track patient valuables during a healthcare surge.

PURPOSE:	To establish a uniform and secure procedure for the collection, storage, safeguarding, and release of patient valuables.
POLICY LIABILITY LIMITS:	A. The clinic shall not assume responsibility for damage to or loss of a patient’s personal valuables or property unless negligence or willful wrongdoing on the part of the facility or its employees can be shown. B. Patients or patient representatives shall be advised to send personal valuables or property home or make independent arrangements for off-site storage. If this is not possible, patients will be advised that the facility accepts no responsibility for the loss or damage of any personal valuables and property retained by the patient except where a negligent act contributed to a loss or damage.
DEFINITIONS:	A. Personal valuables include but are not limited to cash, checks, wallet contents, coin purses, keys, pocket knives, watches, hearing aids, miscellaneous papers, jewelry, and personal electronic devices. B. Property includes dentures or other dental appliances, glasses and other optical aids, clothing, footwear, purses, suitcases, walkers, wheelchairs, canes and other articles of unusual value and small size.

11.4.2. Inventorying Valuables

During the registration process, a designated staff member will advise the patient that valuables such as jewelry, credit cards, and cash will not be properly secured in the clinic. Patients should be strongly encouraged to arrange with family members or others to secure their valuables.

11.4.3. Patient Valuables Control Log

The Patient Valuables Control Log is used to document, track, and audit valuables deposited or removed from the secured locations. This log should indicate the date and time the deposits or releases occurred, the staff person releasing the valuables, the patient’s name, and the witnessing staff member’s initials.

The Patient Valuables Control Log is shown below. The complete tool can be found in the *Community Care Clinics Operational Tools Manual* on pages 147-148.

Patient Valuables Control Log

The Patient Valuables Control Log can be used to document, track, and audit valuables deposited or removed from secured locations. This log should indicate the date and time the deposits or releases occurred, the staff person releasing the valuables, the patient’s name, and the witnessing clinic staff member’s initials.

Patient Valuables Control Log						
Date Received	Patient Name	INITIALS		Date Released to Patient	INITIALS	
		Employee Witness	Employee Depositing Valuables		Employee Witness	Employee Releasing

12. Reimbursement

12.1. Funding Sources for California Community Care Clinics

California community care clinics rely on a diverse array of funding sources to maintain operations under normal conditions. The following sections outline some of these funding sources or funding programs. When developing surge plans, clinics should consider how their cash-flow and revenue may be impacted if the administrative processes associated with these funding programs are affected or altered during a healthcare surge. Some of these funding sources are discussed in further detail later in this chapter.

Federally Qualified Health Center (FQHC)	
Medicare	
<p><i>Under normal conditions</i></p> <ul style="list-style-type: none"> Enhanced reimbursement for Medicare-eligible patients 	<p><i>During surge:</i></p> <ul style="list-style-type: none"> Section 1135 Waivers Administrative Simplification Compliance Act Waiver Application
Medi-Cal/Healthy Families	
<p><i>Under normal conditions</i></p> <ul style="list-style-type: none"> Enhanced reimbursement for Medi-Cal eligible patients Payments through Child Health and Disability Prevention Program Payments through the Healthy Families Program Payments through the Family Planning Access Care and Treatment Program 	<p><i>During surge:</i></p> <ul style="list-style-type: none"> Section 1135 Waivers Section 1115 Demonstration Waivers Administrative Simplification Compliance Act Waiver Application
Managed Care	
<p><i>Under normal Conditions</i></p> <ul style="list-style-type: none"> Capitated or per visit payments for patients enrolled in managed care 	<p><i>During surge</i></p> <ul style="list-style-type: none"> Disaster code modifiers Possible suspension of managed care regulations through Government Code 8550 & 8557 Possible action by the Department of Managed Health Care
Other Funding Sources	
<p><i>Under normal conditions</i></p> <ul style="list-style-type: none"> Payments through the Breast and Cervical Cancer Control Program Payments through the Expanded Access to Primary Care Program Payments from various grand funding sources Payments through Workers' Compensation Insurance 	<p><i>During surge</i></p> <ul style="list-style-type: none"> Payments through Workers' Compensation Insurance Payments through FEMA Public Assistance Grand Program Payments through the United States Small Business Administration Disaster Loan Assistance Program

FQHC Look-Alikes	
Medicare	
<p><i>Under normal conditions:</i></p> <ul style="list-style-type: none"> Enhanced reimbursement for Medicare-eligible patients 	<p><i>During surge:</i></p> <ul style="list-style-type: none"> Section 1135 Waivers Administrative Simplification Compliance Act Waiver Application
Medi-Cal/Healthy Families	
<p><i>Under normal conditions:</i></p> <ul style="list-style-type: none"> Enhanced reimbursement Payments through the Child Health and Disability Prevention Program Payments through the Healthy Families Program Payments through the Family Planning Access Care and Treatment Program 	<p><i>During surge:</i></p> <ul style="list-style-type: none"> Section 1135 Waivers Section 1115 Demonstration Waivers Administrative Simplification Compliance Act Waiver Application
Managed Care	
<p><i>Under normal conditions:</i></p> <ul style="list-style-type: none"> Capitated or per visit payments for patients enrolled in managed care 	<p><i>During surge:</i></p> <ul style="list-style-type: none"> Disaster code modifiers Possible suspension of managed care regulations through Government Code 8550 & 8557 Possible action by Department of Managed Healthcare
Other Funding Sources	
<p><i>Under normal conditions:</i></p> <ul style="list-style-type: none"> Payments through the Breast and Cervical Cancer Control Program Payments through the Expanded Access to Primary Care Program Payments from various grant funding sources Discounts through a reduced cost drug purchasing program Funding through 330 New Access Point Grants (if criteria met) Payments through Workers' Compensation Insurance 	<p><i>During surge:</i></p> <ul style="list-style-type: none"> Payments through Workers Compensation Insurance Payments through the FEMA Public Assistance Grant Program Payments through the United States Small Business Administration Disaster Loan Assistance Program

Community Care Health Centers (CCHC)	
Medicare	
<p><i>Under normal conditions:</i></p> <ul style="list-style-type: none"> • Payments for Medicare-eligible patients 	<p><i>During surge:</i></p> <ul style="list-style-type: none"> • Section 1135 Waivers • Administrative Simplification Compliance Act Waiver Application
Medi-Cal/Healthy Families	
<p><i>Under normal conditions:</i></p> <ul style="list-style-type: none"> • Payments for Medi-Cal eligible patients • Payments through the Child Health and Disability Prevention Program • Payments through the Healthy Families Program • Payments through the Family Planning Access Care and Treatment Program 	<p><i>During surge:</i></p> <ul style="list-style-type: none"> • Section 1135 Waivers • Section 1115 Demonstration Waivers • Administrative Simplification Compliance Act Waiver Application
Managed Care	
<p><i>Under normal conditions:</i></p> <ul style="list-style-type: none"> • Capitated or per visit payments for patients enrolled in managed care 	<p><i>During surge:</i></p> <ul style="list-style-type: none"> • Disaster code modifiers • Possible suspension of managed care regulations through Government Code 8550 & 8557 • Possible action by Department of Managed Healthcare
Other Funding Sources	
<p><i>Under normal conditions:</i></p> <ul style="list-style-type: none"> • Payments through the Breast and Cervical Cancer Control Program • Payments through the Expanded Access to Primary Care Program • Payments from various grant funding sources • Payments through the Workers' Compensation Insurance 	<p><i>During surge:</i></p> <ul style="list-style-type: none"> • Payments through Workers' Compensation Insurance • Payments through the FEMA Public Assistance Grant Program • Payments through the United States Small Business Administration Disaster Loan Assistance Program

Indian Health Services	
Medicare	
<p><i>Under normal conditions:</i></p> <ul style="list-style-type: none"> Enhanced reimbursement for Medicare-eligible patients 	<p><i>During surge:</i></p> <ul style="list-style-type: none"> Section 1135 Waivers Administrative Simplification Compliance Act Waiver Application
Medi-Cal/Healthy Families	
<p><i>Under normal conditions:</i></p> <ul style="list-style-type: none"> Enhanced reimbursement for Medi-Cal eligible patients Payments through the Child Health and Disability Prevention Program Payments through the Healthy Families Program Payments through the Family Planning Access Care and Treatment Program 	<p><i>During surge:</i></p> <ul style="list-style-type: none"> Section 1135 Waivers Section 1115 Demonstration Waivers Administrative Simplification Compliance Act Waiver Application
Managed Care	
<p><i>Under normal conditions:</i></p> <ul style="list-style-type: none"> Capitated or per visit payments for patients enrolled in managed care 	<p><i>During surge:</i></p> <ul style="list-style-type: none"> Disaster code modifiers Possible suspension of managed care regulations through Government Code 8550 & 8557
Other Funding Sources	
<p><i>Under normal conditions:</i></p> <ul style="list-style-type: none"> Indian Health Services Memoranda of Agreement (638) payments Payments through the Breast and Cervical Cancer Control Program Payments through the Expanded Access to Primary Care Program Payments from various grant funding sources Payments through Workers' Compensation Insurance 	<p><i>During surge:</i></p> <ul style="list-style-type: none"> Payments through Workers' Compensation Insurance Payments through the FEMA Public Assistance Grant Program Payments through the United States Small Business Administration Disaster Loan Assistance Program

12.1.1. Federally Qualified Health Center (FQHC)

The Federally Qualified Health Center (FQHC) benefit under Medicare was added effective October 1, 1991 when Section 1861(aa) of the Social Security Act was amended by Section 4161 of the Omnibus Budget Reconciliation Act of 1990. FQHCs are "safety net" providers such as community health centers, Public Housing Primary Care (PHPC) Centers, outpatient health programs funded by the Indian Health Services, and programs serving migrants and the homeless. The purpose of the FQHC Program is to enhance the provision of primary care services in underserved urban and rural communities.

Funding Mechanism:

Medicare reimburses FQHCs an all-inclusive per visit payment amount based on reasonable costs as reported on its annual cost report. The beneficiary pays no Part B deductible for FQHC services but is responsible for paying the coinsurance with the exception of FQHC-supplied influenza and pneumococcal vaccines, which are paid at 100%. The FQHC all-inclusive visit rate is calculated by dividing the FQHC's total allowable cost by the total number of visits for all FQHC patients. The FQHC payment methodology includes two national per visit upper payment limits—one for urban FQHCs and one for rural FQHCs. Freestanding FQHCs must complete Form CMS-222-92, Independent Rural Health Clinic and Freestanding Federally Qualified Health Center Cost Report, in order to identify all incurred costs applicable to furnishing covered FQHC services.

Reference:

- For payment rules applicable to FQHCs see California Welfare & Institutions Code 14087.325
- Form CMS-222-92 can be found in the *Provider Reimbursement Manual Part 2* (Pub. 15-2), Chapter 29, available on the CMS website at <http://www.cms.hhs.gov/manuals/PBM/list.asp>
- FQHC Fact Sheet, available on the CMS website at <http://www.cms.hhs.gov/MLNProducts/downloads/fqhcfactsheet.pdf>.

12.1.2. FQHC Look-Alike

An FQHC Look-Alike is an organization that meets all of the eligibility requirements for Section 330 grant but does not receive grant funding. In its place, the organization is designated as an FQHC Look-Alike and receives financial and organizational support not extended to non-FQHC clinics. Not all FQHC benefits are extended to FQHC Look-Alikes. However, FQHC Look-Alikes are eligible to receive many of the same benefits, which include:

- Enhanced Medicare and Medi-Cal reimbursement
- Eligibility to purchase prescription and non-prescription medications for outpatients at reduced cost through the 340B Drug Pricing Program, described at <http://www.hrsa.gov/opa/introduction.htm>.

Funding Mechanism:

To qualify for Section 330 New Access Point Grant opportunities, an applicant must serve a defined geographic area federally designated as a Medically Underserved Area (MUA) or Medically Underserved Population (MUP). This is applicable to Community Health Center (CHC) applicants only; Migrant Health Centers (MHC), Healthcare for the Homeless (HCH) and Public Housing Primary Care (PHPC) organizations are not required to meet these criteria to apply. It is important that organizations review the program expectations and eligibility requirements developed by the Bureau of Primary Health Care prior to preparing a Section 330 FQHC Look-Alike application.

Reference:

For those organizations interested in submitting an FQHC Look Alike application, please visit <http://www.cpc.org/govaffairs/fedissues/presinitiative.cfm#AppGuidelines>.

12.1.3. Rural Health Clinics

The Rural Health Clinic program extends Medicare and Medi-Cal benefits to cover health care services provided by clinics operating in rural areas. Specifically trained primary care practitioners administer the health care services needed by the community when access to traditional physician care is difficult.

Funding Mechanism:

Medicare reimburses Rural Health Clinics on a cost basis, similar to FQHCs. In an RHC/FQHC, revenue is estimated on an average cost per visit (up to a cap, if applicable) for each Medicare visit.

Reference:

Please see http://files.medi-cal.ca.gov/pubsdoco/manuals_menu.asp, for more information. (Navigate to "Clinics and Hospitals (CAH), then to "Rural Health Clinics (RHCs) and Federally Qualified Health Centers.")

12.1.4. Medicare

Medicare is a health insurance program for the following:

- People 65 or older;
- People under age 65 with certain disabilities; and
- People of all ages with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

Medicare's coverage is divided into 'parts'. Each part provides a different type of insurance coverage to these beneficiaries:

- **Part A Hospital Insurance:** Most people do not pay a premium for Part A because they or their spouse already paid through their payroll taxes during employment. Medicare Part A (Hospital Insurance) helps to cover inpatient care in hospitals, including critical access hospitals and skilled nursing facilities but not custodial or long-term care. It also helps reimburse hospice care services and some home health care. Beneficiaries must meet certain conditions to receive these benefits.
- **Part B Medical Insurance:** Most people pay a monthly premium for Part B. Medicare Part B (Medical Insurance) helps to reimburse for physicians' services and outpatient care. It also covers some other medical services that Part A does not cover, such as

services provided by physical and occupational therapists and some home health care services. Part B helps pay for these covered services and supplies when they are medically necessary.

- **Part C Medicare Advantage:** Under Part C people with Medicare Parts A and B can choose to receive all of their health care services through a commercial health plan provider. Medicare Advantage plans may vary in service offered and monthly premiums charged.
- **Part D Prescription Drug Coverage:** Medicare Prescription Drug Coverage is a voluntary supplement to Medicare coverage which beneficiaries can elect to receive and which is provided through private insurance companies. Most people will pay a monthly premium for this coverage. Since January 1, 2006, Medicare prescription drug coverage has been available to every Medicare beneficiary. Beneficiaries receive this coverage to help lower prescription drug costs and protect against higher costs in the future. Beneficiaries choose a drug plan and pay a monthly premium. Like other insurance, if a beneficiary decides not to enroll in a drug plan when they are first eligible, they may pay a penalty if they choose to join later.

Funding Mechanism:

Medicare is partially funded through payroll taxes, specifically Federal Insurance Contributions Act (FICA) taxes. The Federal Insurance Contributions Act comprises Social Security tax and Medicare tax. High-income Social Security beneficiaries also pay income tax on their Social Security income, some of which goes toward Medicare. This money is deposited into a trust fund used to pay physicians, hospitals, and private insurance companies when Medicare beneficiaries use their services. This trust fund has been more difficult to manage than the Social Security trust fund because health care expenditures are harder to track and can change quickly. Medicare Parts B and D are partially funded by premiums and co-pays.

Reference: For more information on Medicare, please see <http://www.cms.hhs.gov/home/medicare.asp>.

12.1.5. Medi-Cal

Medi-Cal is California's Medicaid program; Medicaid is a means-tested entitlement program that has been in existence for over 35 years. It provides primary and acute care as well as long-term care to over 50 million Americans at a cost to federal and state government.

Funding Mechanism:

Medicaid is jointly financed by the federal and state governments, but each state designs and administers its own version of the program under broad federal guidelines. The complexity of Medicaid presents an enormous challenge for anyone attempting to generalize the program. State variability in eligibility, covered services, and how those services are reimbursed and delivered is the rule rather than the exception. California's Medicaid is targeted at individuals with low income, but not all of the poor are eligible, and not all of those covered are poor.

Reference:

- For payment rules and scope of services change rules applying to FQHCs see California Welfare & Institutions Code § 14132.100 and *Standards and Guidelines for Healthcare Surge during Emergencies Reference Manual*, page 6.
- For Medi-Cal Presumptive Eligibility rules, see Section 14148.7 of the Welfare and Institutions Code.

12.1. 6. Other Funding and Reimbursement Considerations

Indian Health Services Memorandum of Agreement (638)

On April 21, 1998, the California Department of Health Care Services implemented an Indian Health Services Memorandum of Agreement (IHS/MOA) between the federal Indian Health Services and the federal Centers for Medicare and Medicaid Services. The IHS/MOA changed the reimbursement policy for services provided to Medi-Cal recipients within 638 identified American Indian or Alaskan native health care facilities (outpatient health programs or tribal facilities operated by a tribe or tribal facility under the Indian Self-Determination Act or by an urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act for the provision of primary health services.) Rural Health Clinics (RHCs), Federally Qualified Health Centers (FQHCs), and certain Primary Care Clinics (PCCs) designated by the federal IHS as eligible in the IHS/MOA may enroll as IHS clinic providers. Clinics cannot be designated as both an IHS and an RHC/FQHC/PCC provider.

Funding Mechanism

Medi-Cal reimburses IHS/MOA clinics an all-inclusive per visit payment amount determined by the federal Department of Health and Human Resources, Indian Health Services.

Reference:

Inpatient-Outpatient Medi-Cal Provider Manual, Indian Health Services Memorandum of Agreement (pages IHS MOA 1-6 and IHS MOA cd 1-4) available at http://files.medi-cal.ca.gov/pubsdoco/manuals_menu.asp.

Breast and Cervical Cancer Control Program (BCCCP)

The federal Department of Health Care Services (DHCS) implemented the new Breast and Cervical Cancer Control Program (BCCCP) on January 1, 2002, as authorized by Assembly Bill 430 (Chapter 171, Statutes of 2001). The BCCCP provides urgently needed cancer treatment coverage to individuals diagnosed with breast and/or cervical cancer who require treatment and have met the Centers for Disease Control (CDC) screening criteria or were screened by a CDC provider.

Funding Mechanism:

The Department of Health and Human Services has provided funding for a Breast and Cervical Cancer Screening Program since 1985. In 1990, the US Congress passed the Breast and Cervical Cancer Mortality Prevention Act that mandated and provided funding for the National Breast and Cervical Cancer Early Detection Program.

State funding has combined its resources with federal funding since 1993 to provide a statewide BCCCP. Most women with no health insurance who are found to have breast or cervical cancer through the BCCCP will be enrolled in Medi-Cal. Medi-Cal health insurance will cover the costs of treatment.

Reference:

- For more information on the coverage, billing, delivery, and promotion of screening mammography please see <http://www.cms.hhs.gov/Mammography/>.
- For more information on pelvic exam and Pap test coverage, please see <http://www.medicare.gov/health/cervical.asp>.

Family Planning Access Care and Treatment Program (PACT)

The Family Planning Access Care and Treatment (PACT) Program provides free family planning services to low-income California residents. Eligible individuals have increased access to services due to an expanded provider network.

Funding Mechanism

Family PACT providers are reimbursed for the following services to eligible participants:

- Family planning methods
- Emergency Contraception
- Sexually transmitted infection testing and treatment
- Pregnancy testing and counseling
- Sterilization
- HIV testing
- Some types of female and male cancer screening

- Education and Counseling

Reference

For more information on Family PACT, please see <http://www.familypact.org/en/providers/provider-enrollment/how-do-i-enroll.aspx>.

Expanded Access to Primary Care Program (EAPC)

The mission of the Expanded Access to Primary Care (EAPC) Program is to improve the quality of health care and to expand access to primary and preventive health care to medically underserved areas and populations. Beneficiaries are those persons at or below 200% of the federal poverty level who do not have any third-party health or dental coverage.

Funding Mechanism

Current law provides for reimbursement at certain primary care clinics for the delivery of expanded outpatient medical services. These services include preventive health care, smoking prevention and cessation, health education, health assessments, and treatment and referral services for children that qualify for Child Health and Disability Prevention (CHDP) services. New provider applicants are considered for funding at the beginning of a three-year funding cycle.

Reference

For more information on EAPCP please see <http://www.dhcs.ca.gov/services/rural/Pages/EAPCPPage.aspx>.

Child Health and Disability Prevention Program (CHDP)

The Child Health and Disability Prevention (CHDP) Program provides complete health assessments for the early detection and prevention of disease and disabilities for low-income children and youth. In July 2003, the CHDP Program began using the "CHDP Gateway," an automated pre-enrollment process for non Medi-Cal, uninsured children. The CHDP Gateway serves as the entry point for these children to enroll in ongoing health care coverage through Medi-Cal or the Healthy Families

Funding Mechanism

The CHDP Gateway is based on federal law; Titles XIX and XXI of the Social Security Act allow states to establish presumptive eligibility programs for children and youth. Children eligible for these services are in families whose income is at or below 200% federal poverty level.

References

- California Child Health and Disability Prevention Program (CHDP) Child Health and Disability Prevention Program provided for pursuant to Article 6 (commencing with Section 124025) of Chapter 3 of Part 2 of Division 106.
- Medi-Cal regulations pertaining to the availability and reimbursement of EPSDT services through the CHDP program: CCR, Title 22, Sections 51340 and 51532.

Healthy Families

Healthy Families is low-cost insurance program for children and teens. It provides health, dental, and vision coverage to children who do not have insurance and do not qualify for free Medi-Cal. Accepted applicants can choose their plan and provider. Healthy Families provides coverage of children from ages 1 through 19 with family incomes from 100% to 200% of the federal poverty level.

Funding Mechanism

California has assigned the Managed Risk Medical Insurance Board (MRMIB) as the oversight agency for the Healthy Families Program. Administrative duties for this program are contracted through Maximus, a private vendor. Delivery of health services to Healthy Families members is administered by managed care organizations. MRIB has arranged the administration of Healthy Families in order to ensure that health care providers currently serving low-income families are given the opportunity to participate in the program: MRMIB encourages private managed care plans to subcontract with safety net providers by allowing the health plan (known as the Community Provider Plan) in each county that has the highest percentage of traditional and safety net providers in its provider network to charge a discounted premium, by allowing County Organized Health Systems and local initiatives to participate, and by giving priority in awarding contracts to plans with significant numbers of providers who serve uninsured children. The Healthy Families program receives an enhanced federal matching rate of 65%.

Reference

Title XXI State Program Fact Sheet is available at <http://www.cms.hhs.gov/NationalCHIPPolicy/downloads/CACurrentFactsheet508.pdf>.

Uninsured Services

For the uninsured population, certain statewide coverage exists. The extent and reimbursement levels of the coverage vary depending on the program.

Funding Mechanism

Reimbursement methods are program dependent. In most instances, claims must be filed to be properly reimbursed. Additional information can be found on the website below.

Reference

Additional information on uninsured services is available at http://www.hmohelp.ca.gov/dmhc_consumer/hp/hp_uninsured.aspx.

Grant Funding

In California, many foundations exist that provide grant funding for the improvement of health care. In most cases, funds are granted based on the quality and value of health care improvement proposals.

Funding Mechanism

Funds are provided for specific purposes and goals. The following grants have been identified as potential funding mechanisms that will aid community care clinics in preparing for a healthcare surge:

- **Ryan White CARE Act:** The Ryan White CARE Act funds health care services for low-income individuals who lack health insurance and are afflicted by HIV/AIDS. <http://hab.hrsa.gov/findcare/aboutryanwhitecare.htm>
- **Blue Shield of California Foundation:** The Blue Shield of California Foundation awards grants for specific projects that address the following issues: health care and coverage, health and technology, and Blue Shield Against Violence. <http://www.blueshieldcafoundation.org/grant-center/>
- **California Endowment:** The California Endowment is a private statewide health foundation organized around four goals: access to healthcare, culturally competent health systems, community health, and the elimination of health disparities. <http://www.calendow.org/>
- **California Healthcare Foundation:** The California Healthcare Foundation is an independent philanthropy dedicated to improving health care in California by focusing on improving the quality of care for Californians with chronic disease, reducing barriers to efficient and affordable health care for the undeserved, and promoting greater transparency and accountability in California's health care system. <http://www.chcf.org/>
- **Sierra Health Foundation:** The Sierra Health Foundation is a private philanthropy that focuses on improving the quality of life in Northern California with four main funding interests: youth development, strengthening the nonprofit sector, improving health and quality of life, and the Grizzly Creek Ranch Camp and Conference Center. <http://www.sierrahealth.org/>
- **The California Wellness Foundation:** The California Wellness Foundation aims to improve the health of Californians by creating grants for health promotion, wellness education, and disease prevention. <http://www.tcdf.org/>
- **Rural Health Outreach Grant Program:** Authorized by Section 330A (e) of the Public Health Service Act, the Rural Health Outreach Grant Program supports projects that exhibit creative or effective models of outreach and service delivery in rural

communities.

<http://ruralhealth.hrsa.gov/funding/outreach.htm>

- **Rural Health Services and Development Program:** The Rural Health Services and Development Program awards grants to "community-based, private, nonprofit, licensed primary health care clinics" in rural areas in California.

<http://www.dhcs.ca.gov/services/rural/Pages/RurHlthServDevProg.aspx>

12.2. Community Care Clinic Planning Considerations for Changes in Reimbursement during a Healthcare Surge

12.2.1. Healthcare Surge Response and Disaster Recovery

Maintaining existing revenue streams will be critical to community care 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 community care clinics during surge conditions, and understanding the methods to access additional financial resources from federal and state-funded programs.

For those community care clinics that receive significant revenue from public payers and/or commercial health plans, collaborative discussions with these payers and plans can have a significant impact on the ability of both the clinic and health plans to accommodate specific operational issues and reimbursement requirements during surge conditions. Sufficient planning and coordination between health plans and community care clinics will be essential in maintaining business continuity and sustaining operations at facilities providing medical care during a healthcare surge.

A clinic's ability to comply with administrative policies and procedures and maintain the exchange of information with public payers and commercial health plans may be impacted by a healthcare surge and should be addressed during the planning phase. Community care clinics should also be aware of the administrative and reimbursement changes that may take place with Medicare, Medi-Cal, commercial health plans, and Workers' Compensation. Part of the planning process should include identifying the actions clinics take to ensure adequate reimbursement levels from these payers.

12.2.2. Community Care Clinics and Public Payers

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. Community 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.

Medicare and Medi-Cal Waivers

Since regulations governing emergency provisions do not fully address all funding and reimbursement issues that might arise during a healthcare surge, the potential exists for the issuance of waivers and declarations to address barriers to funding and access to care. The following section outlines two applicable waivers and their areas of impact: Section 1135, which impacts 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 United States Secretary of Health and Human Services in response to a healthcare surge impacting the reimbursement process for community care 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.

Section 1135 Waivers

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 United States Secretary of Health and Human Services has the authority to waive certain requirements of federal Centers for Medicare and Medicaid Services (CMS) programs in an emergency area during an emergency period.⁵⁷ As documented in the Federal Register, “the stated purpose of Section 1135 of the Social Security Act is to enable the Secretary to ensure, to the maximum extent feasible, in any emergency area and during an emergency period, that sufficient healthcare items and services are available to meet the needs of enrollees in Medicare, Medicaid, and the State Children’s Health Insurance Program.”⁵⁸

For purposes of Section 1135 waivers, “an ‘emergency area’ is a geographical area in which, and an ‘emergency period’ is the period during which there exists an emergency declared by the President pursuant to the National Emergencies Act or the Robert T. Stafford Disaster Relief and Emergency Assistance Act and a public health emergency declared by the Secretary pursuant to section 319 of the Public Health Service Act.”⁵⁹ The term “healthcare provider” means “any entity that furnishes healthcare items or services, and includes a hospital or other provider of services, a physician or other healthcare practitioner or professional, a healthcare facility, or a supplier of healthcare items or services.”⁶⁰

A primary purpose of Section 1135 of the federal Social Security Act is to ensure “that healthcare providers that furnish such items and services in good faith, but are unable to comply with one or more requirements described in subsection (b), may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse.”⁶¹

Section 1135 waivers provide a key opportunity to facilitate clinic reimbursement by flexing some of the federal CMS regulations. However, community care clinics have little control over when and where these waivers are issued. Clinics may appeal to the California Department of Health Care Services, which can in turn submit a request to the United States Secretary of Health and Human Services, but ultimately the issuance of these waivers is at the discretion of the Secretary.

It is important to note that Section 1135 waivers or modifications can “be made retroactive to the beginning of the emergency period or any subsequent date in such period” at the Secretary’s discretion.⁶² They are issued in response to specific catastrophic emergencies and defined for a designated time and place. Some of the key rules and requirements that can be addressed by these waivers are:

- Conditions of participation
- Physician state licensure requirements
- Emergency Medical Treatment and Active Labor Act (EMTALA)
- Physician referral limitations
- Health Insurance Portability and Accountability Act of 1996 (HIPAA)
- Medicare Advantage payment limitations
- Deadlines and timetables⁶³

For the complete Section 1135 waiver under 42 U.S.C. Section 1320b-5 see the *Reference Manual* Section 9, for Full Text of Social Security Act, Section 1135 Waiver.

Section 1115 Demonstration Waivers

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.”⁶⁴ However, since the demonstration waivers have historically proven cumbersome to administer and time-consuming to take effect, community care clinics should not depend on them to provide primary relief during a healthcare surge.

For additional information on Section 1115 Demonstration Waivers, see *Volume I: Hospitals* Section 12.1.3, “Hospitals and Public Payers.”

12.2.3. Community Care Clinics and Health Plans

The majority of health plans in California provide healthcare coverage to individuals and families through either an employer-sponsored plan or individual purchase. The availability of specific networks, providers, and healthcare benefits varies based on the health plan and coverage that was purchased. When working with health plan partners, community care

clinics will want to reach agreement on revised contract language in the form of event-initiated articles or appendices, which focus on streamlined reimbursement, simplified policies and procedures, and increased access and coverage for patients during a healthcare surge. Clear and concise documentation through formal contract changes that outline the obligations of both the clinic and the health plan during a surge may eliminate confusion and be beneficial to both parties.

Below are specific steps community care clinics may want to consider when working with 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.

Rates	Policies and Procedures	Access & Coverage
<ul style="list-style-type: none"> • Consider negotiating lump sum advance payments to facilitate and maintain cash flow. • Consider negotiating contract language to obtain an automatic increase in capitation during a surge, when appropriate. • Move toward a common reimbursement system, such as a Medicare Diagnosis-Related-Group-based system, to simplify claims generation and plan payment process. 	<ul style="list-style-type: none"> • 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 emergency provisions that address rights and obligations outside the typical force majeure clauses. • Create policies to expedite cash flow from plan during a declared healthcare surge. • Consider developing 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 with billing on behalf of an existing facility during an extended healthcare surge. 	<ul style="list-style-type: none"> • For closed network models, revise pre-authorization and referral requirements to allow access to care when needed and where available.

12.2.4. Workers' Compensation for Clinic Staff

Workers' compensation covers injuries or illnesses that occur due to employment. Clinic employees may be injured at work during a catastrophic emergency and workers' compensation is an important mechanism with which community care clinics should be familiar. Human Resources Departments have specific policies and procedures for reporting injuries sustained at work and should plan for injuries during a healthcare surge. Workers' Compensation is an important funding source because it covers "every person in the service of an employer under any appointment or contract of hire or apprenticeship, expressed or implied, oral or written, whether lawfully or unlawfully employed."⁶⁵ This includes non-citizens and minors, making it one of the only funding sources to cover the costs of healthcare for individuals not entitled to other programs because of their legal status.

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."

California 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. Until the claim is accepted or denied, liability for medical treatment is limited to \$10,000. This statute does not address an employer's recovery rights on denied claims.⁶⁶

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.

The Workers' Compensation Process Flow depicts how workers' compensation may play a role during a healthcare surge for general employees and Disaster Service Workers. The Workers' Compensation Claim Form (DWC1), and all other 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/>.

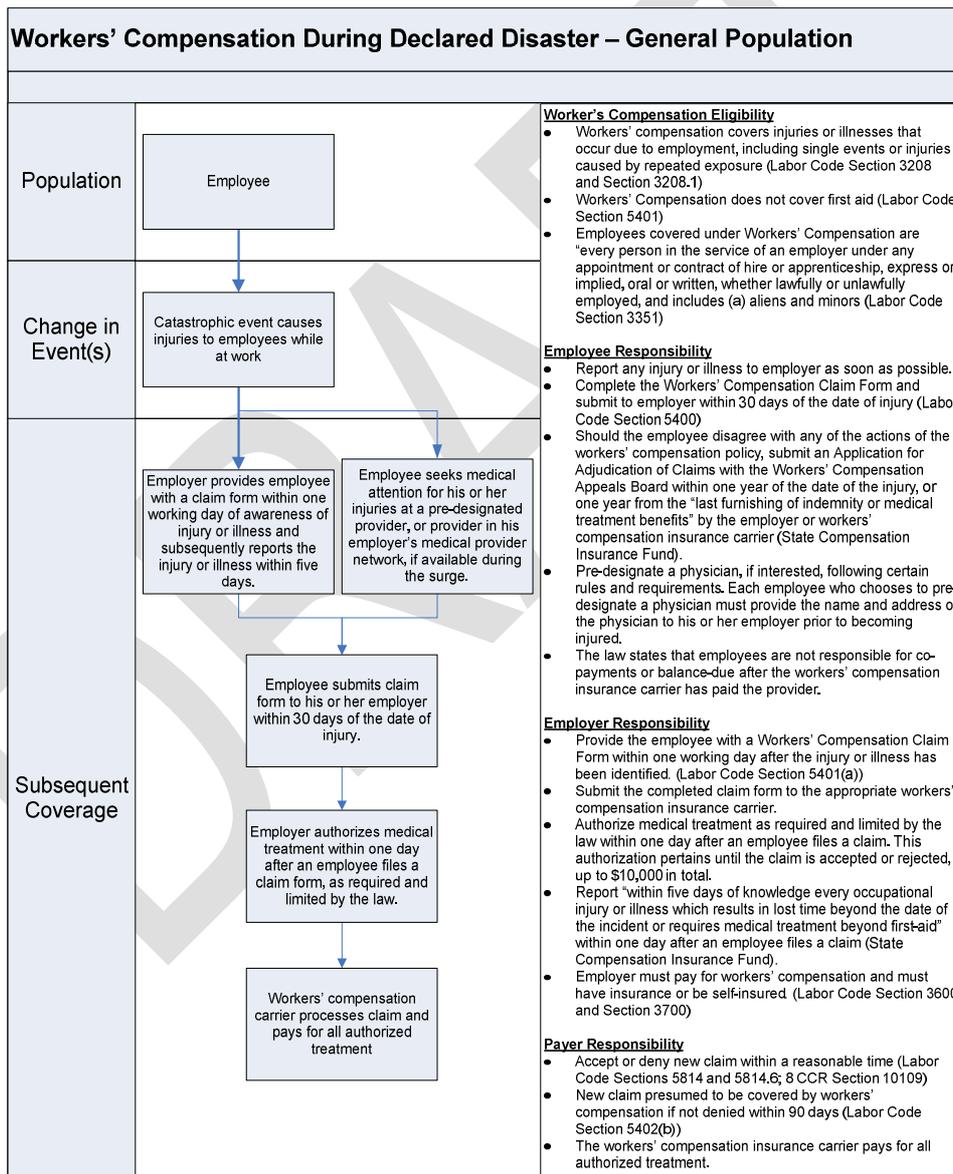
For more information of workers' compensation, see *Volume III: Payers* Section 2.1, "Health Plans and Workers' Compensation."

The Workers' Compensation Process Flow is shown below. The complete tool can also be found in the *Community Care Clinics Operational Tools Manual* on pages 149-150.

Workers' Compensation Process Flow

Instructions

Employees, employers, and payers can refer to the Workers' Compensation Process Flow for the rules and requirements that must be followed to submit claims for workers' compensation.



12.3. Administrative and Procedural Guidelines: General Planning Considerations

As discussed above, community care clinics will face challenges in sustaining operations and maintaining adequate cash flow while continuing to provide uninterrupted medical care during a healthcare surge. Complex administrative procedures for routine payment cycles may contribute to these challenges. This section outlines some of the ways in which community care clinics can maintain their current revenue stream through planning measures taken in advance of a healthcare surge.

Given the unpredictable nature of an emergency and its potential to significantly impact the healthcare system, sufficient planning and coordination between clinics and payers is essential to maintaining business continuity as well as sustaining operations at facilities providing medical care. Such coordination and planning may include modifying specific contract provisions related to administrative requirements, negotiating minimum data sets for charge capture and billing purposes, selecting third-party vendors who may assist with billing on behalf of an existing facility during an extended healthcare surge, or developing new policies to expedite cash flow during a declared surge.

The following information illustrates recommended changes to the documentation of patient information and medical services provided to support simplified registration and billing process. Community care clinics may use this information as a guide during the surge planning process.

12.3.1. Minimum Required Data Elements for Billing

In addition to charge capture, billing processes may pose a challenge for community care clinics during a healthcare surge. Whenever possible, clinics should follow normal billing processes and submit complete data. However, in the event that systems are impaired, staff are unavailable at clinic sites, and/or patient information is unavailable, the use of minimum billing elements may become necessary. Implementing minimum data elements for billing requires coordination and approval of both payers and clinics. 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 community care 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. The minimum data elements outlined in this section are recommendations and ultimately health plans and government payers must agree to accept these recommended minimum data elements from clinics for billing purposes.

Recommended Minimum Required Data Elements for Billing

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 Uniform Billing 04 Data Elements	Licensed Healthcare Professionals Centers for Medicare and Medicaid Services 1500 Data Elements
<ul style="list-style-type: none"> • Subscriber identification/policy number • Time in, time out • Work related injury Y/N <p>1: Provider name, address, phone number</p> <p>4: Type of bill</p> <p>8b: Patient name</p> <p>42: Revenue codes</p> <p>43: Revenue description</p> <p>44: Healthcare Common Procedure Coding System rates/codes</p> <p>46: Units of service</p> <p>47: Total charges</p> <p>50: Payer</p> <p>56: National Provider Identifier</p> <p>58: Insured's name</p> <p>67: Principal diagnosis code</p> <p>69: Admitting diagnosis</p> <p>74: Principal procedure code</p> <p>76: Attending</p> <p>77: Operating</p>	<ul style="list-style-type: none"> • Subscriber identification/policy number • Time in, time out • Work related injury Y/N <p>1: Select which payer: Medicare / Medicaid / Champus Champva / Group Health Plan/ Federal Employees Compensation Act Black Lung / Other</p> <p>1a: Insured's identification number</p> <p>2: Patient name</p> <p>3: Patient's birth date</p> <p>5: Patient's address</p> <p>21: Diagnosis or nature of illness or injury</p> <p>24 A-G: Date of service, place of service, type of service, procedures/services/supplies, diagnosis code, \$ charges, days or units</p> <p>24K: Condition code</p> <p>25: Federal tax identification number</p> <p>27: Accept assignment? (yes/no)</p> <p>28: Total charge</p> <p>33: Physician's/supplier's billing name, address, zip code, and phone number</p>

For information regarding Indian Health Services billing code information, refer to *Inpatient-Outpatient Medical Provider Manual*, Indian Health Services Memorandum of Agreement (pages IHS MOA 1-6 and IHS MOA cd 1-4).

12.3.2. Additional Billing and Coding Guidance

Additional guidance regarding billing and coding during an emergency is included in this section and can be used by community care clinics as a reference during the emergency planning process.

Administrative Simplification Compliance Act Waiver Application⁶⁷

According to the federal 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 and stipulates that "there are also some situations when this electronic billing requirement could be waived for some or all claims, however, a provider must obtain Medicare pre-approval to submit paper claims in these situations:

- Any situation where a provider can demonstrate that the applicable adopted HIPAA claim standard does not permit submission of a particular type of claim electronically
- Any situation where disability of all members of a provider's staff prevents use of a computer for electronic submission of claims
- Other rare situations that cannot be anticipated by the United States Centers for Medicare and Medicaid Services (CMS) where a provider can establish that, due to conditions outside of their control, it would be against equity and good conscience for CMS to enforce this requirement

A written request for this type of waiver must be to the Medicare contractor to which a provider submits claims." This waiver can provide community care clinics with flexibility in the way they bill Medicare should a healthcare surge create conditions that challenge electronic billing.

National Modifier and Condition Code to Identify Disaster-Related Claims⁶⁸

In response to the emergency healthcare needs of beneficiaries and medical providers affected by Hurricane Katrina, the federal Centers for Medicare and Medicaid Services allowed flexibility by modifying normal documentation requirements. Specifically, a new policy was issued establishing a national modifier for providers to use on claims in order to track and facilitate claims processing for individuals affected by the disaster. According to the new policy, "in order to facilitate claims processing and track services and items provided to individuals affected by Hurricane Katrina and any future disasters, a new modifier and condition code have been established for providers to use on disaster-related claims."

The new modifier and condition code are now effective nationwide and can be used by

community care clinics submitting 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.⁶⁹

International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) Coding for External Causes of Injury (E Codes)

In the event of an emergency, coding professionals should use External Cause codes (E codes) to code healthcare encounters and identify the cause of injury for those affected by the emergency.⁷⁰ The use of E codes is supplemental to the application of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) diagnosis codes. E codes are never recorded as principal diagnoses; the appropriate injury code should be sequenced before any E codes. E codes may be assigned in all healthcare settings. For the purpose of capturing complete and accurate ICD-9-CM data in the aftermath of the natural disaster, a healthcare setting should be considered any location where medical care is provided by licensed healthcare professionals.

The use of E codes is limited to injuries, adverse effects, and poisonings. They should not be assigned for encounters to treat the Medi-Cal conditions of individuals affected by an emergency when no injury, adverse effect, or poisoning is involved. E codes can be used in the following situations:

- Accidents due to natural and environmental factors
- Poisoning and adverse effects of drugs, medicinal substances, and biologicals
- Transport accidents
- Accidental falls
- Accidents caused by fire and flames
- Late effects of accidents, assaults, or self-injury
- Assaults or purposely inflicted injury
- Suicide or self-inflicted injury

Catastrophic emergencies, such as natural disasters, take priority over all other E codes with the exception of child and adult abuse and terrorism and should be sequenced before other E codes. Coders may assign as many E codes as necessary to fully explain each cause. For example, if an injury occurs as a result of a building collapsing during a natural disaster, E codes for both the natural disaster and the building collapse should be assigned with the E code for the emergency being sequenced as the first E code.⁷¹

12.3.3. Advancing and Expediting Payment

In many cases, payers do not have a formalized policy or procedure for advancing or expediting payments but may have established a practice for doing so on an “as needed” basis. Community care 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, either in advance or at the time funds are needed. The Advancing and Expediting Payment Table outlines the possible opportunities for advancing and expediting payment from a range of payers.

The Advancing and Expediting Payment table is shown below. The table can also be found in the *Community Care Clinics Operational Tools Manual* on pages 151-152.

Advancing and Expediting Payment table

Instructions

Clinics should review and understand the table for guidance on options available by payer type with respect to advancing and expediting payment during a healthcare surge.

Payer	Option Available	Examples
Medicare Part B	Advance Payments	Cash flow problems can be resolved through advance payments rather than through suspension of the mandatory payment floor which requires intermediaries to hold payment for electronic claims for thirteen days. In the past, intermediaries have been asked to immediately process any requests for advance payments or increases in periodic interim payment for providers. Intermediaries have also been authorized to increase the rate of the advance payment to 100% and extend the repayment period to 180 days on a case-by-case basis ⁷²
Medi-Cal	Advance Payments	Medi-Cal has a process in place for advancing payment to participating health care providers under certain conditions. Requests for advance payments will be considered on a case-by-case basis and will depend on the circumstances surrounding the healthcare surge. ⁷³
Private Payer	Informal Agreements	Some private payers may have informal processes set up in order to advance payment to contracted providers in times of financial need. This advance payment process can be used when providers are experiencing cash flow inadequacies, when the payer is experiencing payment delays, or when a clinic’s business operations are temporarily challenged. The amount of the advance can vary depending on clinic need, clinic volume, previous payment history, contractual parameters, and repayment factors. Upon clinic request, private payers will typically offer one of two options: 1) advance a lump-sum amount for a specified period of time to be repaid in full when the agreed period elapses or 2) advance an agreed-upon amount based upon previous payment history and clinic need to be reconciled against future claim submissions. Contracted clinics in good standing in need of expedited or advanced payment options will likely need to contact their plan or program representatives directly to discuss advancing and expediting payments and establish Memoranda of Understanding and protocols in advance or at the time funds are needed. ⁷⁴

For more information on advancing and expediting payment from healthcare payers, see *Volume III: Payers* Section 3.4, "Advancing and Expediting Payment to Provider"

12.4. Other Funding Considerations for Providers

12.4.1. Patient Transfer and Coverage Rules During a Healthcare Surge

During a healthcare surge, public health issues or specific medical needs may require patient transfers between healthcare facilities (including hospitals, community care clinics, and long-term care health facilities). 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. If a clinic accepts patients from hospitals or other inpatient care facilities or needs to transfer patients to another outpatient facility during a healthcare surge, the following issues may impact the clinic's reimbursement from public payers and commercial health plans. The Patient Transfer Table below provides guidance related to patient transfers and should be used by community care clinics as a reference tool during emergency planning.

The Patient Transfer Table is shown below. The complete tool can be found in the *Community Care Clinics Operational Tools Manual* on pages 153-155.

Patient Transfer Table

Instructions

Clinics billing for medical care should review and understand the table for guidance on how to receive payment for patient transfer during healthcare surge.

Payer	Scenario	Examples
Medicare	Evacuation to/from facility	Following a recent disaster, charges for ambulance transportation were paid according to the usual payment guidelines. The regulatory requirements must be met (for example, the vehicle must be an ambulance, the crew must be certified, the patient must need ambulance transport and the transport must be to an eligible destination). Ambulance transportation charges for patients who were evacuated from and returned to originating hospitals were included on the inpatient claims submitted by the originating hospitals. Inpatient: Payment is included in the diagnosis related group payment amounts made to hospitals paid under the prospective payment system. Outpatient: Outpatient claims were

		<p>submitted for ambulance charges incurred by patients who were transported from the originating hospitals and subsequently discharged by receiving hospitals. Medicare contractors made payment for ambulance transportations that evacuated patients from affected locations when the regulatory requirements were met.</p> <p>Recommended Approach From a claims perspective, in using the catastrophic/disaster related Healthcare Common Procedure Coding System modifier, an institutional provider should designate any service line item on the claim that is disaster related. If all of the services on the claim were disaster related, the institutional provider can use the disaster related (DR) condition code to indicate that the entire claim is disaster related⁷⁵.</p>
Other	Patient Transfer	<p>In times of a declared emergency, a variety of resources are required for an appropriate response and recovery and it is expected that these resources will be compensated. Resources should be requested through the appropriate SEMS/NIMS channels. A mission tracking number needs to be assigned which links the request to the event and, thus, to the reimbursement. The mission tracking number is defined by the CalEMA.</p> <p>Transportation resources can be broadly classified as traditional medical, ambulances, gurney vans, wheelchair cars, etc., and nonmedical, school and/or transit buses, vanpools, etc. Traditional medical resources can generally be funded through either direct fee-for-service billing or reimbursement from disaster relief funds. In order to be eligible for the latter, it is critical that resources be requested through the proper channels and in accordance with SEMS/NIMS. The request should come through the logistics branch of the appropriate emergency operations centers, either at the city, county or regional levels, generally progressing from city to region. The requests must be accompanied by a mission tasking number.</p> <p>Nonmedical transportation resources will generally only be reimbursed through available disaster relief funds. As is the case for medical resources, it is critical that resources be requested through the proper channels and in accordance with SEMS/NIMS.</p>

12.5. Other Available Funding Sources

If a community care clinic is located in a declared disaster area and has suffered any disaster-related damage, the clinic may be eligible for federal disaster assistance. The two main entities offering disaster assistance to government, nonprofit, and private businesses following a declared disaster are the Federal Emergency Management Agency (<http://www.fema.gov/>) and the United States Small Business Administration (<http://www.sba.gov/>).

12.5.1. Federal Emergency Management Agency 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 nonprofit organizations recover after a disaster. The program provides assistance in two ways: 1) for the repair, replacement, or restoration of disaster-damaged, publicly owned facilities and the facilities of certain private nonprofit organizations that are considered a critical part of a community's infrastructure; and 2) for the reimbursement of the direct costs associated with stabilizing patients following a catastrophic emergency.

While these grants are aimed at governments and organizations, their final goal is to help a community and all its residents recover from devastating natural disasters. Private nonprofit facilities are eligible for the grant program if they are open to the public and perform essential services of a governmental nature. Emergency medical facilities and other healthcare facilities, such as community care clinics, qualify to be considered as critical, private nonprofit facilities. The Federal Emergency Management Agency does not compensate for disaster-related stabilization and care administered in a private, for-profit healthcare setting. Limited funding is available to nonprofit agencies without government functions or agreements.

To be eligible for rebuilding assistance, the needed repair and recovery work must be a direct result of the disaster, in a location within the designated disaster area, and for an entity that is the legal responsibility of an eligible applicant. Work that is eligible for supplemental federal disaster grant assistance is classified as either emergency work, which includes debris removal and emergency protective measures, or permanent work, which addresses buildings and equipment.

Costs associated with stabilizing patients following a catastrophic emergency that are eligible for reimbursement may include some personnel costs, equipment, supplies, and utilities. FEMA does not provide ongoing payments for follow-up care or long-term care. FEMA compensates medical costs only when a disaster victim has made a point-of-service contact with the provider for either the stabilization of injuries incurred as a direct result of the disaster or an illness that developed in a designated disaster area during the declared emergency time period.

Recommendations to Facilitate Payment from the Federal Emergency Management Agency

There are certain steps community care clinics can take to facilitate payment from the Federal Emergency Management Agency (FEMA). The following recommendations are not guarantees of eligibility or payment but provide clinics with a basic understanding of the application process and emphasize key areas for community care clinics to focus on to improve the likelihood that their application will be well received.

- Document all services provided to patients as clearly and thoroughly as possible. It is likely that all entities receiving funds from FEMA will be audited to ensure that funds were properly used. Clinics should note that these data elements are different from the recommended minimum required data elements for billing listed in Section 12.2.1, "Minimum Required Data Elements for Billing." Clinics expecting to be eligible for payment from FEMA should be sure the following information is documented:
 - Patient's name
 - Permanent and temporary displacement addresses
 - Phone number
 - Disaster-related medical conditions or pre-existing condition flare-up
 - Specific services rendered
 - Cause of the injury or illness
 - Date, time, and location of treatment
 - Provider, provider license and Medicaid/Medicare ID number
 - Provider's signature
 - Whether treatment is for medical stabilization or regular medical care.
- Develop Mutual Aid Agreements with neighboring clinics, other nearby healthcare facilities, and/or local government entities. Mutual Aid Agreements can be in place between governments and private, nonprofit and public clinics and providers. Mutual aid agreements between clinics and local government should stipulate that emergency services are critical services performed on behalf of state/local government. These Mutual Aid Agreements may increase the likelihood that FEMA funds will flow from one eligible entity to another.
- For-profit entities may explore public-private partnerships and contracts with local government. These service agreements can strengthen existing emergency resources for rural or isolated providers. Through these agreements, FEMA will consider reimbursing direct costs to the public entity for services provided by the private entity if services are for stabilization care and no payment is collected from the patient in any form. Reimbursable costs must be reasonable and represent only the direct costs of providing care that result from the disaster and do not include costs of business interruption/lost revenue.
- Clinics should review 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. Clinics can incorporate FEMA training into existing

training curriculum and required annual training.

- Clinics should review the Public Assistance Policy Digest - Federal Emergency Management Agency Report 321 and Applicant Handbook - Federal Emergency Management Agency Report 323. Both handbooks are available online at <http://www.fema.gov/government/grant/pa/padocs.shtm> and provide a comprehensive review of the applicant's role and responsibility for Public Assistance funding.^{76, 77} Familiarity with these two handbooks will provide stakeholders, including providers, with an understanding of the process for applying for FEMA Public Assistance funds.

To assist community care clinics with FEMA's application process, the FEMA Public Assistance Process and Checklist outlines the key steps that need to be taken by stakeholders during the application process. During the actual application process FEMA provides a Public Assistance Coordinator to work with applicants. Understanding the key steps of the process, however, may facilitate the process.

The Federal Emergency Management Agency (FEMA) Public Assistance Process and Checklist is shown below. It can also be found in the *Community Care Clinics Operational Tools Manual* on pages 156-160.

Federal Emergency Management Agency (FEMA) Public Assistance Process and Checklist

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 nonprofit organizations recover after a disaster. The program provides assistance in two ways: 1) for the repair, replacement, or restoration of disaster-damaged, publicly owned facilities and the facilities of certain private nonprofit organizations that are considered a critical part of a community's infrastructure; and 2) for the reimbursement of the direct costs associated with stabilizing patients following a catastrophic emergency.

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. During the actual application process FEMA provides a Public Assistance Coordinator to work with applicants. Understanding the key steps of the process, however, may facilitate the process.

Instructions

Review the Federal Emergency Management Agency (FEMA) Public Assistance Process and Checklist when planning for potential grant assistance following a healthcare surge.

Public Assistance Steps	Stakeholder: Local Sub applicant(s) or Subgrantee(s)	Checklist
(1) Preliminary Damage Assessment (PDA)	<ul style="list-style-type: none"> Visited by Regional FEMA/state team to view damage, assess scope of damage, and estimate repair costs 	<ul style="list-style-type: none"> <input type="checkbox"/> Provides personnel to work with FEMA and the state on the damage assessment and project application process <input type="checkbox"/> Tours of all damages <input type="checkbox"/> Provides documentation, environmental or historic issues, and insurance coverage information <input type="checkbox"/> Identifies and explains immediate expenditures for emergency work and decides whether or not to apply for Immediate Needs Funding (INF) <input type="checkbox"/> Reads Public Assistance Policy Digest - FEMA Report 321
(2) Presidential Disaster Declaration	<ul style="list-style-type: none"> Pays attention to FEMA eligible costs and coverage aid types (Individual Assistance and/or Public Assistance) for eligible regions 	<ul style="list-style-type: none"> <input type="checkbox"/> Read Applicant Handbook - FEMA Report 323
(3) Applicants' Briefing by Grantee	<ul style="list-style-type: none"> Attends briefing to gather available assistance and eligibility requirements Prepare and submit requests for PA no later than 30 days of the date designation of any area. 	<ul style="list-style-type: none"> <input type="checkbox"/> Subgrantee's management representative attends Briefing <input type="checkbox"/> Meets with state liaison <input type="checkbox"/> Mentions any Immediate Needs Funds (INF) requests <input type="checkbox"/> Completes and submits FEMA form (FF) 90-49 Request for PA
(4) Submission of Request for Public Assistance by Applicant	<ul style="list-style-type: none"> If not done during briefing, submits to state/applicant request for PA 90-49 FEMA form via fax, mail, or delivery within 30 days of the date of designation of any area. 	<ul style="list-style-type: none"> <input type="checkbox"/> If not submitted at briefing then submit FF 90-49 Request for PA <input type="checkbox"/> Second chance to apply for INF
(5) Kick-off Meeting with Public Assistance Coordinator (PAC)	<ul style="list-style-type: none"> Individual meeting with FEMA PAC for which contact is made 1 week from the submittal of the request for PA State liaison provides state-specific details on documentation and reporting requirements Identify special considerations that require special review, such as insurance coverage, environmental resource issues, and historic preservation Request any clarification 	<ul style="list-style-type: none"> <input type="checkbox"/> Sends appropriate management, including risk manager, to kick off <input type="checkbox"/> Identify management that will fully manage all repair projects including small projects <input type="checkbox"/> Contacts state liaison if have not heard from PAC 2 weeks of request for PA submission <input type="checkbox"/> Regularly meets with PAC <input type="checkbox"/> Compiles list of all damages
		<ul style="list-style-type: none"> <input type="checkbox"/> Reviews with state liaison specific details on documentation and reporting requirements <input type="checkbox"/> Identify with PAC and state liaison circumstances that require special review

Public Assistance Steps	Stakeholder: Local Sub applicant(s) or Subgrantee(s)	Checklist
(6) Project Formulation and Cost Estimating	<ul style="list-style-type: none"> • Complete project worksheets • Document extent of facility damage, identify eligible scope of work estimate costs associated with scope of work for each project, plan repair work • Administratively consolidate multiple work items into single projects to expedite approval and funding and project management • Divide work projects into small (up to \$59,700 for FY2007) and large projects⁷⁸ • Identify and provide basic description of project and broad cost estimate • Maintain records of completed work and work to be completed • If necessary, specialist reviews special considerations questionnaire with subgrantee 	<ul style="list-style-type: none"> <input type="checkbox"/> Complete project worksheets: <input type="checkbox"/> Project Worksheet (PW) FF90-91 <input type="checkbox"/> PW FF90-91A Damage Description and Scope of Work Continuation Sheet <input type="checkbox"/> PW FF90-91B Cost Estimate Continuation <input type="checkbox"/> PW FF90-91C Maps and Sketches Sheet <input type="checkbox"/> PW FF90-91D Photo Sheet <input type="checkbox"/> If necessary complete FEMA Special Considerations Questions FF90-120 <input type="checkbox"/> Organize records by the following suggested summary forms: <input type="checkbox"/> Force Account Labor Summary FF 90-123 <input type="checkbox"/> Force Account Equipment Summary FF 0-127 <input type="checkbox"/> Materials Summary Record Summary FF 90-124 <input type="checkbox"/> Rented Equipment Summary Record FF 90-125 <input type="checkbox"/> Contract Work Summary Record FF 90-126 <input type="checkbox"/> Applicant's Benefits Calculation Worksheet FF 90-128 <input type="checkbox"/> Establish file for each project and record specific costs and scope of work by site <input type="checkbox"/> Retain all documentation up to 3 years from the date the state closes subgrantee grant <input type="checkbox"/> Escort PO and state representative on a site visit and collaboratively develop a complete scope of work and accurate large project cost estimate
(7) Project Review and Validation	<ul style="list-style-type: none"> • PAC schedules review with subgrantee for preparation of records for review • 20% or 2 small projects is the minimum level of review for projects submitted within 30 days after the Kickoff meeting • 100% validation for projects submitted after 30 days 	<ul style="list-style-type: none"> <input type="checkbox"/> Prepare records subject to validation
	<ul style="list-style-type: none"> • Validation can normally be completed within 15 days of submission of all Project Worksheets to the PAC • If total variances on the first sample projects do not exceed 20% of the cost of the sampled projects, the results of validation are satisfactory 	
(8) Obligation of Federal Funds and Disbursement to Subgrantees	<ul style="list-style-type: none"> • Notified of availability of federal FEMA funds and state cost share funds • Submit documentation of actual incurred costs associated with approved scope of work for subgrantees with large projects • Certify large project work has been completed in accordance with FEMA standards and policies 	<ul style="list-style-type: none"> <input type="checkbox"/> Documentation of incurred costs for large projects

Public Assistance Steps	Stakeholder: Local Sub applicant(s) or Subgrantee(s)	Checklist
(9) Appeals and Closeout	<ul style="list-style-type: none"> File appeal with supporting documents to the state 	<ul style="list-style-type: none"> Complete debris cleaning within 6 months, emergency work within 6 months, and permanent within 18 months of the date of declaration of the area. Debris and emergency work can be extended up to an additional 6 months, and permanent restoration work may be extended an additional 30 months. File appeal with state within 60 days of receipt of a notice of any action that is being appealed Provide documentation explaining why the original determination is wrong or overrun costs and the amount of adjustment being requested Closeout large projects as each project is completed, and reconcile estimated and actual costs when large projects are complete Close small projects when all small projects have been funded and completed Notify state when projects are complete Return any unused money to state Certify to the state that all funds were suspended and all the work described in the project scope of work is complete Retain documentation for up to 3 years subject to audit

*"Special considerations" is a term used by FEMA to refer to matters that require specialized attention. These include insurance, historic, environmental, and hazard mitigation issues. FEMA and the State are required to ensure that all funding actions are in compliance with current state and federal laws, regulations, and agency policy.⁷⁹

12.5.2. 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 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 community care clinic qualifies as a major source of employment in a disaster struck zone, the SBA can waive this statutory lending limit.

Applications are available online, by calling the SBA (at 1-800-U-ASK-SBA or 1-800-827-

5722), or at any Disaster Recovery Center or Business Recovery Center in the impacted area. It is not necessary to wait for insurance settlements before applying for a SBA loan. However, any eventual insurance proceeds that duplicate Small Business Administration coverage must go toward repaying the loan.

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

During the normal course of business, laws and rules prescribe what health plans must make available to their members. Many of these laws and rules impact community care clinics. During a healthcare surge, additional authority may become necessary to address the needs of health plans, their members, and the community. While general and payer-specific considerations were included in prior sections of this Volume in an effort to aid clinics in developing their own response to a healthcare surge, clinics should also be aware of the authority governing health plans that may have a direct impact on clinics in the event of a healthcare surge.

Community care clinics should understand California's authority and the types of health plan responses that may be mandated. Awareness of these authorities can enable clinics to more adequately prepare their organizations for a healthcare surge response by providing the opportunity to incorporate these possible mandates into clinic response plans.

Government Code Sections 8550 and 8567 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."⁸⁰ Government Code Section 8571 also grants power to the California Governor "during a state of war emergency or a state of emergency, [to] suspend any regulatory statute, or statute prescribing the procedure for conduct of state business, or the orders, rules or regulations of any state agency...where the Governor determines and declares that strict compliance with any statute, order, rule or regulation would in any way prevent, hinder or delay the mitigation of the effects of the emergency."⁸¹

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 and ultimately impact access to care. Specifically, the Governor could prevent cancellations of policies during an emergency for nonpayment of premiums or prescribe minimum data fields for use by health plans and healthcare providers.

Within California, there are two agencies that regulate private health plans: the California Department of Insurance and the California Department of Managed Health Care. These two agencies have different scopes of authority and ways in which they may impact private health plans during a healthcare surge. The California Department of Insurance "licenses and regulates the rates and practices of insurance companies, agents, and brokers in California."⁸² This includes all insurance products governed under the California Insurance Code. Although the California Department of Insurance has broad authority to regulate health insurance companies, its role covers consumer protections and advocacy, and the

Department would play a very limited role during a healthcare surge. 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.

The Department of Managed Health Care plays a more significant role in a healthcare surge and is discussed in the next section.

12.6.1. The California 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 California Health and Safety Code and the California Code of Regulations, Title 28. These provisions govern HMOs and grant the Department of Managed Health Care its enforcement authority.

Specifically, the Department of Managed Health Care and its Director:

- "Have charge of the execution of the laws of this state relating to healthcare service plans and the healthcare service plan business including, but not limited to, those laws directing the department to ensure that healthcare service plans provide enrollees with access to quality healthcare services and protect and promote the interests of enrollees."⁸³
- "Are responsible for the performance of all duties, the exercise of all powers and jurisdiction, and the assumption and discharge of all responsibilities vested by law in the department. The Director has and may exercise all powers necessary or convenient for the administration and enforcement of, among other laws, the laws ... [relating to healthcare service plans and the healthcare service plan business..., primarily the Knox-Keene Health Care Service Plan Act of 1975]."⁸⁴
- Have rule-making and order-making authority to "... adopt, amend, and rescind such rules, forms, and orders as are necessary to carry out the provisions of ... [the Knox-Keene Act]."⁸⁵
- "May waive any requirement of any rule or form in situations where in the Director's discretion such requirement is not necessary in the public interest or for the protection of the public, subscribers, enrollees, or persons or plans subject to ... [the Knox-Keene Act]."⁸⁶

While the general powers described above may be exercised to address a demand for healthcare services during 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. In order to cope proactively with a healthcare surge resulting from a state of emergency, protection of enrollees may necessitate:

- Keeping healthcare services available to enrollees.

- Keeping the revenue stream flowing to healthcare facilities and professionals in order to keep healthcare services available
- Transferring enrollees from one plan to another in the event of diminished plan capacity to keep healthcare services available
- Transferring provider capacity from one plan to another to mitigate a shortage of healthcare services in severely impaired geographic areas

Depending upon the nature, breadth, and severity of the state of emergency, the statutory and order-making powers of the Director of the Department of Managed Health Care may not be sufficient to protect enrollees adequately. Certain powers may have to be ordered or delegated by the Governor through, for example, Government Code Section 8572, which grants the Governor the authority to "commandeer or utilize any private property or personnel deemed by him necessary" during a state of war emergency or state of emergency.⁸⁷ The governor would delegate authority to the Director of the Department of Managed Health Care through an executive order.

Such an executive order might 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. Such delegated authority may be exercised by the Director in whole or in part and from time-to-time, depending upon the severity and duration of the healthcare surge, the state of emergency, and the need to ensure that healthcare service plans provide enrollees with access to healthcare services and that enrollees' interests are protected.

It may be helpful for community care clinics to understand in more detail the specific kinds of actions the Department of Managed Health Care may take under its delegated authority and the impact these actions will have on access to care and reimbursement. Awareness of these actions may enable clinics to work with health plans to more fully prepare their staff and organizations for mandated healthcare surge responses by providing the opportunity to incorporate these mandates into their own response plans, if applicable.

The Department of Managed Health Care might have many motivations for taking action during a healthcare surge:

- To protect enrollees' access to healthcare services
- To manage financial risk
- To ensure continuation of providers' services

To support these goals, the Department of Managed Health Care might take the following actions during a healthcare surge. The Department's authority would apply to the geographic areas of California affected by the state of emergency and healthcare surge, for specified time periods covering the duration of the state of emergency and healthcare

surge.

- To protect enrollees' access to healthcare services the Department of Managed Health Care may:
 - Direct the transfer of enrollees from an impaired health plan (due to impaired resources, financial capacity, or administrative capacity) to a health plan with greater capacity.
 - Direct transfer of providers from a health plan with adequate provider capacity to a health plan with impaired provider capacity at the compensation rates of the transferee health plan or as otherwise specified to maintain enrollee access to care.
 - Order the suspension of requirements of healthcare service plan contracts, statutes, and regulations that may prevent, hinder, or delay the mitigation of the effects of the emergency, including but not limited to:
 - Prior authorization for referrals and use of out-of-network providers
 - All prior authorization requirements or preadmission certification requirements that could delay the provision of healthcare services
 - All restrictions relative to out-of-network provider access
 - Medical necessity reviews
 - Notification of clinic admissions (when used as a basis of denial of coverage or services)
 - Requirement that enrollees first seek care from their primary care physicians, thereby allowing enrollees to seek care from providers other than their designated primary care physicians
 - Use of participating network clinics expanded to require plans to treat all area clinics as participating network clinics under existing benefit provisions
 - Out-of-network charges to enrollees suspended to allow enrollees to seek care from any available medical professional for which in-network benefits would apply
 - Assure timely access to prescription medications:
 - Directing that a 30-day supply cannot be rejected or pended regardless of date of last refill
 - Directing that maintenance medications may be dispensed in 90-day supplies
 - Assure continuity of coverage by directing that group or individual contracts cannot be cancelled or terminated during the state of emergency, even if premiums have not been paid.
 - Assure collaboration in healthcare surge response and disaster recovery:

- Directing that health plans rapidly assess the short-term impacts of the healthcare surge and disaster on their individual health plan operations and develop a disaster recovery plan according to a timeline specified by the Department of Managed Health Care
 - Directing that each health plan establish and publicize a 24-hour informational toll-free hotline for enrollees in the geographic area affected by the healthcare surge and disaster, as an information source to facilitate enrollees obtaining access to healthcare services
- To manage financial risk the Department of Managed Health Care may:
 - For pre-negotiated fee-for-service arrangements with providers, the Department of Managed Health Care may direct that when a provider submits a claim (except a Medi-Cal claim) for care of an enrollee whose premium has not been received by that enrollee's healthcare service plan, the following rules shall apply to the healthcare service plan contract providing coverage for the enrollee:
 - The enrollee is responsible for co-payments, coinsurance and deductible amounts (collectable from the enrollee by the provider) according to the enrollee's coverage contract or evidence of coverage
 - The health plan pays 50% (or other percentage as directed) of either the contracted rate or the non-participating provider rate
 - The provider accepts 50% (or other percentage as directed) as payment in full and cannot bill the enrollee (except for co-payments, coinsurance and deductible amounts)
 - If the entire premium is subsequently received by the health plan, the provider claim is to be adjusted and paid according to the provider's contract with the health plan
 - For capitated payment service arrangements with providers, the Department of Managed Health Care may direct that when a provider provides a healthcare service to an enrollee whose coverage eligibility verification identifies that the healthcare service plan providing coverage for the enrollee has not received the premium for the healthcare service plan contract, the Director of the Department of Managed Health Care may devise and order appropriate and necessary financial obligations and arrangements between and among health plans and providers in order to ensure continuity of provider operations for the benefit of enrollees.
 - For any other circumstances in which the healthcare surge and state of emergency have greatly challenged the management of financial risk, the Director of the Department of Managed Health Care may assess the circumstances and devise and direct interim modifications of financial obligations and arrangements that ensure continuity of provider operations to enable health plans to provide healthcare services and continuity of access to healthcare

services to enrollees.

- To manage continuation of provider services the Department of Managed Health Care may:
 - Authorize the establishment of a California uncompensated care pool to pay a portion of the costs of care provided to coverage-impaired enrollees.
 - Direct that health plans pay claims as in-network, regardless of whether the healthcare provider was in-network.
 - Direct that health plans establish advance payment to contracted providers for use when providers are experiencing cash flow inadequacies, where the health plan is experiencing provider payment delays, or when a provider's business operations are temporarily challenged.
 - Direct other necessary and appropriate actions identified by the Director of the Department of Managed Health Care as warranting urgent financial relief for clinics and physicians to enable continuity of healthcare services essential for the protection of enrollees.

12.7. Community Care Clinic Reference Guide and Previous Responses to Healthcare Surge

One of the challenges in preparing for the operational and financial consequences of a surge in patient volume is the highly situational nature of any healthcare surge response. As such, it may be helpful to review the California and federal laws and regulations focusing on patient care access and financing issues that might be challenged during a healthcare surge, as well as the specific responses that have occurred historically. In some cases, laws and regulations dictate how providers and health plans can respond to a catastrophic emergency, what benefits health plans are required to provide their members, and what protections their members are afforded. In other cases, past responses can provide a reference for providers of responses that might be appropriate in the future.

The tables that follow contain certain rules, regulations, requirements, and other issues that may impact community care clinics, payers, and patients. They also contain examples or applications from previous catastrophic events. The tables cover pertinent regulations and previous responses related to Medicare, Medicare Advantage, and Medi-Cal and can serve as a reference tool to assist community care clinics during the planning phase of a healthcare surge by offering examples of past practices.

Please note that the regulations identified are not all inclusive but are those deemed most appropriate and applicable when working with health plans to plan for healthcare surge. These examples are not meant to prescribe any future response but to serve as a guide during planning activities.

12.7.1. Medi-Cal: Previous Response to Healthcare Surge

The tables below summarize pertinent regulations governing clinics and licensed healthcare professionals who provide services to Medi-Cal beneficiaries, as well as summarizing Medicaid's previous responses to a healthcare surge.

Network Requirements: Issues surrounding which clinic or licensed healthcare professional provides services to a member	
<p>Pertinent California Regulations Related to Accessing Standard Emergency Care</p>	<p>For Medi-Cal, under 22 CCR 51056, "emergency services" mean services required for alleviation of severe pain, or immediate diagnosis and treatment of unforeseen medical conditions, which, if not immediately diagnosed and treated, would lead to disability or death. For purposes of treating eligible aliens, "emergency medical condition" means a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:</p> <ul style="list-style-type: none"> • placing the patient's health in serious jeopardy • serious impairment to bodily functions • serious dysfunction of any bodily organ or part
<p>Pertinent California Regulations Related to Clinic Reimbursement for Emergency Services</p>	<p>Per 22 CCR 51056:</p> <ol style="list-style-type: none"> a. "Emergency services mean services required for alleviation of severe pain or immediate diagnosis and treatment of unforeseen medical conditions, which, if not immediately diagnosed and treated, would lead to disability or death. b. For purposes of treating eligible aliens, it means a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following: <ol style="list-style-type: none"> 1. Placing the patient's health in serious jeopardy 2. Serious impairment to bodily functions 3. Serious dysfunction of any bodily organ or part"

Network Requirements: Issues surrounding which clinic or licensed healthcare professional provides services to a member

<p>Pertinent California Regulations Related to Noncontracted Clinic Reimbursement</p>	<p>Per 22 CCR 51541(c)(6), noncontracted facilities are not eligible to service Medi-Cal beneficiaries, except under one of the following:</p> <ol style="list-style-type: none"> a. They provide stabilizing services as required to program beneficiaries located in a closed health facility planning area who are in a life-threatening or emergency situation before the beneficiary may be transported to a contracting clinic. b. A beneficiary is located in a closed health facility planning area and experiencing a life-threatening or emergency situation but cannot be stabilized sufficiently to facilitate a transfer to a contracting facility, those health services medically necessary for alleviation of severe pain or immediate diagnosis and treatment of unforeseen Medi-Cal conditions which, if not immediately diagnosed and treated, could lead to significant disability or death. c. They provide services to beneficiaries who are also eligible for benefits under the federal program of clinic insurance for the aged and disabled. d. They provide services to beneficiaries who live or reside farther than the community travel time standard from a contract clinic, as defined by the department, if the clinic providing services is closer than a contract clinic. <ol style="list-style-type: none"> 1. Provision of services to beneficiary where travel time from home to contract clinic exceeds the normal practice for the community or 30 minutes (whichever is greater) and the noncontracting clinic is closer. 2. Provision of services to a Medicare cross-over patient, subsequent to exhaustion of Medicare benefits and patients in a life-threatening or emergency situation which could result in permanent impairment."
--	---

Network Requirements: Issues surrounding which clinic or licensed healthcare professional provides services to a member

Pertinent California Regulations Related to Out-of-State Facility Reimbursement

Per 22 CCR 51006, Out-of-State Coverage States:

- (a) "Necessary out-of-state medical care, within the limits of the program, is covered only under the following conditions:
- (1) When an emergency arises from accident, injury or illness; or
 - (2) Where the health of the individual would be endangered if care and services are postponed until it is feasible that he return to California; or
 - (3) Where the health of the individual would be endangered if he undertook travel to return to California; or
 - (4) When it is customary practice in border communities for residents to use medical resources in adjacent areas outside the state; or
 - (5) When an out-of-state treatment plan has been proposed by the beneficiary's attending physician and the proposed plan has been received, reviewed and authorized by the Department before the services are provided. The Department may authorize such out-of-state treatment plans only when the proposed treatment is not available from resources and facilities within the state.
 - (6) Prior authorization is required for all out-of-state services, except:
 - Emergency services as defined in 22 CCR Section 51056 and
 - Services provided in border areas adjacent to California where it is customary practice for California residents to avail themselves of such services. Under these circumstances, program controls and limitations are the same as for services from providers within the state."⁸⁸

Per 22 CCR 51006, Foreign Facilities States:

"No services are covered outside the United States, except for emergency services requiring hospitalization in Canada or Mexico."⁸⁹



Network Requirements: Issues surrounding which clinic or licensed healthcare professional provides services to a member

<p>Historic Response Example</p>	<p>Section 1135 Waivers</p> <p>Under 42 USC Section 1320b-5, the United States Secretary of Health and Human Services has authority to waive certain requirements of the federal Centers for Medicare and Medicaid Services (CMS) programs in an emergency area during a federal emergency period (Section 1135 Waivers). An “emergency area” is a geographical area in which, and an “emergency period” is the period during which, there exist two types of declared emergencies: an emergency or disaster declared by the President under the National Emergencies Act or the Stafford Act, and a public health emergency declared by the United States Secretary of Health and Human Services. 42 USC Section 1320b-5(g)(1). At the Secretary’s discretion, waivers that are authorized after the emergency has occurred may be made retroactive to the beginning of the emergency period. 42 USC Section 1320b-5(c). With two exceptions (Emergency Medical Treatment and Active Labor Act and HIPAA), the waivers generally last for the duration of the emergency period or until CMS determines that the waiver is no longer necessary. If a clinic regains its ability to comply with a waived requirement before the end of the declared emergency period, however, the waiver of that requirement no longer applies to that clinic.⁹⁰</p> <p>The United States Secretary of Health and Human Services may waive:</p> <ol style="list-style-type: none"> a. Conditions of participation or other certification requirements for an individual healthcare provider or types of providers b. Program participation and similar requirements for an individual healthcare provider or types of providers and c. Pre-approval requirements⁹¹ <p>The United States Secretary of Health and Human Services may waive sanctions under 42 USC Section 1395 (g), relating to limitations on physician referrals.⁹²</p> <p>The United States Secretary of Health and Human Services may waive “requirements that physicians and other healthcare professionals be licensed in the state in which they provide services, if they have equivalent licensing in another state and are not affirmatively excluded from practice in that state or in any state a part of which is included in the emergency area.”⁹³</p> <p>Following Hurricane Katrina, the Louisiana Medicaid program developed an expedited process to enroll providers on an emergency basis and made modifications to its billing system to allow for overrides to issue payments to providers not previously enrolled in the Louisiana Medicaid program. This process was developed quickly in response to the devastation of Hurricane Katrina and included a shortened version of its normal process. This emergency provider enrollment process required a license number or Medicaid number from the provider’s home state. Initially, providers were allowed to apply irrespective of whether they had seen displaced Louisiana Medicaid patients. As a result, Louisiana Medicaid received duplicate applications and submissions from. In response, Louisiana Medicaid began requiring a copy of a claim form with all applications. Retrospective enrollments were allowed, and, in all, Louisiana Medicaid enrolled approximately 19,000 out-of-state providers. One recommendation that came out of Louisiana’s emergency provider enrollment was to require a copy of the provider’s license, not simply the license number.⁹⁴</p>
---	---

12.7.2. Medicare and Medicare Advantage Products: Previous Response to Healthcare Surge

The tables below address the following rules/requirements/issues related to Medicare and Medicare Advantage members:

- **Physician/network requirements:** Issues surrounding which licensed healthcare professional provides services to a member
- **Pre-authorization:** Issues surrounding providing services with or without prior authorization
- **Pharmaceutical coverage:** Issues surrounding early refills and member co-payments for pharmaceutical prescriptions
- **Nonpayment of premiums and coverage continuity:** Issues surrounding non-payment of premiums and termination of coverage

Physician/Network Requirements: Issues surrounding which licensed healthcare professional provides services to a member

<p>Pertinent Regulations Related to Accessing Standard Emergency Care</p>	<p>According to the federal Centers for Medicare and Medicaid Services' website, "for Medicare enrollees of a Medicare Advantage plan, there exists no 'good faith' provision similar to the Public Health Service Act provision. Therefore, Medicare Advantage plans are required to continue providing all Part A and Part B services, or otherwise arranging for such services to be provided, so that statutory and regulatory requirements for accessibility and availability of services continue to be met.</p> <p>For Medicare enrollees, Medicare Advantage plans have financial responsibility for emergency services and 'urgently needed' services.</p> <p>The term 'urgently needed services' refers to covered services that are Medically necessary and immediately required when the Medicare beneficiary is temporarily outside of the plan's service area. Medicare Advantage plans are also required to cover urgently needed services within the service area when, due to unusual and extraordinary circumstances, the organization's provider network is temporarily unavailable or inaccessible, for example, because of a natural disaster or electrical power outage. Urgently needed services are Medically necessary and immediately required (1) as a result of an unforeseen illness, injury or condition; and (2) when it was not reasonable, given the circumstances, to obtain the services through the plan's provider network."⁹⁵</p>
--	--

Physician/Network Requirements: Issues surrounding which licensed healthcare professional provides services to a member

<p>Pertinent California Regulations Relating to Physician Requirements for Medicare Eligibility</p>	<p>Physician Requirements for Medicare Eligibility</p> <p>'Physician' refers to doctor of medicine, doctor of osteopathy (including osteopathic practitioner), doctor of dental surgery or dental medicine (within the limitations in subsection 70.2), doctor of podiatric medicine (within the limitations in subsection 70.3), or doctor of optometry (within the limitations of subsection 70.5) and, with respect to certain specified treatment, a doctor of chiropractic legally authorized to practice by a state in which he/she performs this function.</p> <p>The services performed by a physician within these definitions are subject to any limitations imposed by the state on the scope of practice.⁹⁶</p> <p>"The issuance by a state of a license to practice medicine constitutes legal authorization. Temporary state licenses also constitute legal authorization to practice medicine. If state law authorizes local political subdivisions to establish higher standards for medical practitioners than those set by the state licensing board, the local standards determine whether a particular physician has legal authorization. If state licensing law limits the scope of practice of a particular type of medical practitioner, only the services within the limitations are covered."⁹⁷</p> <p>Facility Eligibility</p> <p>An eligible provider must enroll by completing a federal Centers for Medicare and Medicaid Services (CMS) Form 855A, and upon approval, enter into a Provider Agreement per 42 USC Section 1395cc; 42 CFR 489.10, .12, .53.</p> <p>To become eligible, a facility must be licensed or approved by state licensing agency and meet applicable Conditions of Participation. 42 CFR 409.3.</p> <p>Application Procedure</p> <p>Medicare physicians and nonphysician providers use the form CMS 855B.</p>
<p>Pertinent California Regulations Related to Facility Reimbursement for Emergency Services</p>	<p>Emergency Services</p> <p>42 CFR 424.103 – Medicare pays for emergency services in nonparticipating clinic. 'Emergency' is defined at 42 CFR 424.101 as inpatient or outpatient clinic services necessary to prevent death or serious impairment of health and, because of the danger to life or health, require use of the most accessible clinic available and equipped to furnish those services.</p> <p>Retroactivity</p> <p>42 CFR 489.13(2) – Retroactive effective date if a provider or supplier meets the requirements of 42 CFR 489.13 (d)(1) and (d)(1)(i) or (d)(1)(ii), the effective date may be retroactive for up to 1 year.</p>
<p>Pertinent California Regulations Related to Out-of-State Facility Reimbursement</p>	<p>Out-of-State Facilities</p> <p>Since Medicare is a federal program, Medicare beneficiaries who are not enrolled in Medicare Advantage programs should be able receive services in any state and the same rules as for in-state facilities should apply.</p> <p>Foreign Facilities</p> <p>42 CFR 413.74 and section 1814(f) of the Act – payment for the reasonable cost of emergency and nonemergency inpatient clinic services – may only be paid to clinics in Canada and Mexico.</p>

Physician/Network Requirements: Issues surrounding which licensed healthcare professional provides services to a member

<p>Pertinent Waivers and Historic Response Example</p>	<p>Applicable Waivers</p> <p>Waivers of federal Centers for Medicare and Medicaid Services (CMS) requirements (Section 1135 Waivers) - Under 42 U.S.C. Section 1320b-5 (Section 1135 of the Social Security Act), the United States Secretary of Health and Human Services has authority to waive certain requirements of CMS programs in an emergency area during a federal emergency period. An “emergency area” is a geographical area in which, and an “emergency period” is the period during which, there exist two types of declared emergencies: an emergency or disaster declared by the President under the National Emergencies Act or the Stafford Act, and a public health emergency declared by the Secretary of Health and Human Services. 42 U.S.C. Section 1320b-5(g)(1). At the Secretary’s discretion, waivers that are authorized after the emergency has occurred may be made retroactive to the beginning of the emergency period. 42 U.S.C. Section 1320b-5(c). With two exceptions (Emergency Medical Treatment and Active Labor Act and the Health Insurance Portability and Accountability Act (HIPAA)), the waivers generally last for the duration of the emergency period or until Centers for Medicare and Medicaid Services determines that the waiver is no longer necessary. However, if a clinic regains its ability to comply with a waived requirement before the end of the declared emergency period, the waiver of that requirement no longer applies to that clinic.⁹⁸</p> <p>The United States Secretary of Health and Human Services may waive:</p> <ol style="list-style-type: none"> Conditions of participation or other certification requirements for an individual healthcare provider or types of providers Program participation and similar requirements for an individual healthcare provider or types of providers Pre-approval requirements⁹⁹ <p>Sanctions under 42 U.S.C. Section 1395nn(g), relating to limitations on physician referrals.¹⁰⁰</p> <p>The United States Secretary of Health and Human Services may waive “requirements that physicians and other healthcare professionals be licensed in the state in which they provide services, if they have equivalent licensing in another state and are not affirmatively excluded from practice in that state or in any state a part of which is included in the emergency area.”¹⁰¹</p> <p>Following Hurricane Katrina, United States Health and Human Services agency issued a waiver permitting Medicare Advantage enrollees to use out-of-network providers in an emergency situation. This waiver was applied retroactively.¹⁰²</p>
---	--

Pre-Authorization: Issues surrounding providing services with or without prior-authorization

<p>Historic Response Example</p>	<ul style="list-style-type: none"> Following Hurricane Katrina, the federal Centers for Medicare and Medicaid Services deemed it acceptable for Medicare Advantage plans to implement a liberal service authorization policy. In the past, Medicare Advantage plans have approved all urgent requests for authorizations for participating/nonparticipating providers, including facility transfers to participating/nonparticipating clinics. In addition, most plans approve urgent referral requests. In the case of Hurricane Andrew in South Florida and also the hurricanes in Florida during 2004, Medicare Advantage plans in affected states advised the Centers for Medicare and Medicaid Services of their intention to be liberal in the interpretation of emergent and urgent care during the worst days of the effects of
---	---

Pre-Authorization: Issues surrounding providing services with or without prior-authorization

	the hurricane. One health plan publicly announced that, for beneficiaries residing in a certain geographic area, the plan would pay all claims from all providers for medically necessary care during a specified number of days. ¹⁰³
--	--

Pharmaceutical Coverage: Issues surrounding early refills and member co-payments for pharmaceutical prescriptions

Historic Response Example	<ul style="list-style-type: none"> • With past emergency situations, Medicare Advantage plans have stipulated that for areas sustaining major damage, all pharmacy requests should be filled at participating benefit levels for either participating or nonparticipating pharmacies. • Following Hurricane Katrina, managed care plans in the affected areas made special arrangements to ensure that members had access to needed medications. The plans permitted early refills, lifted other restrictions and arranged with a number of major pharmacy chains across the country to fill the prescriptions. These pharmacies, in turn, contacted the managed care organization or physician if the member did not know the name of the drug. The managed care organization reimbursed the member for any out-of-pocket costs associated with the prescription drug. Further information about access to pharmacies could be received through the plans individual toll-free member hot lines.¹⁰⁴
----------------------------------	---

Non-Payment of Premiums and Coverage Continuity: Issues surrounding non-payment of premiums and termination of coverage

Historic Response Example	<ul style="list-style-type: none"> • Following Hurricane Katrina, Medicare Advantage enrollees who could not pay the premiums they owed their managed care plan had up to 60 days to submit premium payment. They were not terminated from their plan for nonpayment of the premium during the post-evacuation record. • Following Hurricane Katrina, Medicare Advantage members were not disenrolled from their plan unless they requested, even if their plan was affected by the hurricane. They remained enrolled in their Medicare managed care plan even if they were temporarily unable to use it. If they were unable to use their Medicare health plan, they recorded healthcare from healthcare providers that were not part of their managed care plan's network.¹⁰⁵
----------------------------------	--

12.7.3. Previous Health Plan Response to Healthcare Surge and Other Emergencies

The following tables address the following health plan rules/requirements/issues:

- **Network requirements:** Issues surrounding limits on which clinic or licensed healthcare professional will provide services to a member
- **Pre-authorization:** Issues surrounding providing services with or without prior authorization
- **Pharmaceutical coverage:** Issues surrounding early refills and member co-payments for pharmaceutical prescriptions
- **Co-pay requirements:** Issues surrounding member responsibility for co-payments
- **Claims management:** Issues surrounding claim payments for members with late or non-

current premium payments

- **Insurance questions and coverage verification:** Issues surrounding verifying insurance coverage and other insurance communication needs

Network Requirements: Issues surrounding which clinic or licensed healthcare professional provides services to a member	
<p>Pertinent California Regulations Related to Accessing Standard Emergency Care</p>	<p>Per 28 CCR 1300.67, "the basic health care services required to be provided by a health care service plan to its enrollees shall include, where medically necessary, subject to any co-payment, deductible, or limitation of which the Director of Managed Health Care may approve:</p> <ul style="list-style-type: none"> • Emergency healthcare services which shall be available and accessible to enrollees on a twenty-four hour a day, seven days a week basis within the healthcare service plan area. Emergency healthcare services shall include ambulance services for the area served by the plan to transport the enrollee to the nearest twenty-four hour emergency facility with physician coverage, designated by the Health Care Service Plan. • Coverage and payment for out-of-area emergencies or urgently needed services involving enrollees shall be provided on a reimbursement or fee-for-service basis and instructions to enrollees must be clear regarding procedures to be followed in securing such services or benefits. Emergency services defined in 28 CCR 1317.1 include active labor. 'Urgently needed services' are those services necessary to prevent serious deterioration of the health of an enrollee, resulting from an unforeseen illness, injury or complication of an existing condition, including pregnancy, for which treatment cannot be delayed until the enrollee returns to the plan's service area. 'Urgently needed services' include maternity services necessary to prevent serious deterioration of the health of the enrollee or the enrollee's fetus, based on the enrollee's reasonable belief that she has a pregnancy-related condition for which treatment cannot be delayed until the enrollee returns to the plan's service area."¹⁰⁶
<p>Pertinent California Regulations Relating to Coverage During Acts of War</p>	<p>Per 28 CCR 1300.67.05, "no healthcare service plan contract executed or amended on or after the effective date of this regulation shall limit or exclude healthcare services based on a determination that the need for the healthcare service arose as a result of an act of war.</p> <p>The term 'act of war' includes any act or conduct, or the prevention of an act or conduct, resulting from war, declared or undeclared, terrorism or warlike action by any individual, government, military, sovereign group, terrorist or other organization."¹⁰⁷</p>

Network Requirements: Issues surrounding which clinic or licensed healthcare professional provides services to a member

<p>Pertinent Federal Regulations Relating to Standard Emergency Care for Health Maintenance Organization Members</p>	<p>42 USC Section 300e indicates that "basic health services (and only such supplemental health services as members have contracted for) shall, within the area served by the health maintenance organization, be available and accessible to each of its members with reasonable promptness and in a manner which assures continuity, and when medically necessary be available and accessible twenty-four hours a day and seven days a week, except that a health maintenance organization which has a service area located wholly in a nonmetropolitan area may make a basic health service available outside its service area if that basic health service is not a primary care or emergency healthcare service and if there is an insufficient number of providers of that basic health service within the service area who will provide such service to members of the health maintenance organization. A member of a health maintenance organization shall be reimbursed by the organization for expenses in securing basic and supplemental health services other than through the organization if the services were medically necessary and immediately required because of an unforeseen illness, injury or condition."¹⁰⁸</p>
<p>Pertinent Federal Regulations Relating to Coverage During a Natural Disaster</p>	<p>42 USC Section 300e further indicates, "to the extent that a natural disaster, war, riot, civil insurrection or any other similar event not within the control of a health maintenance organization (as determined under regulations of the Secretary) results in the facilities, personnel or financial resources of a health maintenance organization not being available to provide or arrange for the provision of a basic or supplemental health service in accordance with the requirements of paragraphs (1) through (4) of this subsection, such requirements only require the organization to make a good-faith effort to provide or arrange for the provision of such service within such limitation on its facilities, personnel or resources."¹⁰⁹</p>



Network Requirements: Issues surrounding which clinic or licensed healthcare professional provides services to a member

<p>Pertinent California Regulations Pertaining to Utilizing Out-of-State Healthcare Professionals</p>	<p>Business and Professions Code Section 900 states:</p> <ul style="list-style-type: none"> a. "Nothing in this division applies to a healthcare practitioner licensed in another state or territory of the United States who offers or provides healthcare for which he or she is licensed, if the healthcare is provided only during a state of emergency as defined in Government Code Section 8558(b), which emergency overwhelms the response capabilities of California healthcare practitioners and only upon the request of the Director of the Emergency Medical Services Authority. b. The Director shall be the medical control and shall designate the licensure and specialty healthcare practitioners required for the specific emergency and shall designate the areas to which they may be deployed. c. Healthcare practitioners shall provide, upon request, a valid copy of a professional license and a photograph identification issued by the state in which the practitioner holds licensure before being deployed by the director. d. Healthcare practitioners deployed pursuant to this chapter shall provide the appropriate California licensing authority with verification of licensure upon request. e. Healthcare practitioners providing healthcare pursuant to this chapter shall have immunity from liability for services rendered as specified in Government Code Section 8659. f. For the purposes of this chapter, 'healthcare practitioner' means any person who engages in acts which are the subject of licensure or regulation under this division or under any initiative act referred to in this division. g. For purposes of this chapter, 'Director' means the Director of the Emergency Medical Services Authority who shall have the powers specified in Division 2.5 of the Health and Safety Code Section 1797."¹¹⁰
--	--

Network Requirements: Issues surrounding which clinic or licensed healthcare professional provides services to a member

<p>Pertinent California Regulations Relating to Utilizing Healthcare Professionals with Lapsed or Inactive Licenses</p>	<p>Per California Business and Professions Code Section 921 - 922, Health Care Professional Disaster Response Act:</p> <p>"This chapter shall be known and may be cited as the Health Care Professional Disaster Response Act.</p> <p>The Legislature finds and declares the following:</p> <ol style="list-style-type: none"> 1. In times of national or state disasters, a shortage of qualified healthcare practitioners may exist in areas throughout the state where they are desperately required to respond to public health emergencies. 2. Healthcare practitioners with lapsed or inactive licenses could potentially serve in those areas where a shortage of qualified healthcare practitioners exists, if licensing requirements were streamlined and fees curtailed. <ol style="list-style-type: none"> a. It is, therefore, the intent of the Legislature to address these matters through the provisions of the Health Care Professional Disaster Response Act.¹¹¹ 1. A physician and surgeon who satisfies the requirements of Business and Professions Code Section 2439 but whose license has been expired for less than five years may be licensed under this chapter. 2. To be licensed under this chapter, a physician and surgeon shall complete an application, on a form prescribed by the Medical Board of California, and submit it to the board, along with the following: <ol style="list-style-type: none"> a. Documentation that the applicant has completed the continuing education requirements described in Business and Professions Code Section 2190, Chapter 5, Article 10 for each renewal period during which the applicant was not licensed. b. A complete set of fingerprints as required by Business and Professions Code Sections 144 and 2082, together with the fee required for processing those fingerprints. 3. An applicant shall not be required to pay any licensing, delinquency, or penalty fees for the issuance of a license under this chapter."¹¹²
--	--

Network Requirements: Issues surrounding which clinic or licensed healthcare professional provides services to a member

<p>Historic Response Example</p>	<p>Following Hurricane Katrina, under the authority of the Governor of Louisiana's numerous emergency declarations and executive orders, the Commissioner of Insurance for the State of Louisiana issued Emergency Rules 15, 17, 19 and 20.</p> <ul style="list-style-type: none"> • These emergency rules suspended certain statutes and regulations regarding health insurance in Louisiana.¹¹³ • These rules applied to primary and limited secondary parishes in Louisiana affected by the hurricanes over specific time periods.^{114,115} • These rules applied only to products regulated by the Louisiana Department of Insurance. • These rules waived all restrictions relative to out-of-network access. <p>Along with the Governor's emergency rules:</p> <ul style="list-style-type: none"> • Aetna implemented policies for its members in the affected area to receive in-network benefits for care out of their network in any state, and seek care from providers, including dentists, other than their designated primary care physicians.¹¹⁶ • United Healthcare provided emergency transportation and treated all area clinics as participating network clinics under existing emergency benefit provisions.¹¹⁷ • Members from the affected disaster areas who could not access CIGNA participating physicians, clinics or other providers for the dates of service from August 27, 2005, to September 30, 2005, were able to seek care as needed, for which in-network benefits applied. If members were unable to see their primary care physician, they sought care as needed from any available medical professional.¹¹⁸ • Blue Cross of California made revisions that applied to members who were living in Alabama, Louisiana and Mississippi at the time of the disaster that allowed the affected members to see any physician necessary to provide access to care • Blue Cross of California paid all claims as in-network, regardless of whether or not the healthcare provider was in network.¹¹⁹
<p>Historic Response Example, Medicare Covered Services Provided by Rural Health Clinics and Federally Qualified Health Centers</p>	<p>Following Hurricane Katrina, the federal Centers for Medicare and Medicaid Services issued the following guidance:</p> <p>Hurricane Katrina Evacuees who are Medicare beneficiaries may receive covered services from any Medicare participating RHC or FQHC, subject to applicable co-pays. The Medicare portion of the payment to the RHC or FQHC is based on the clinic's costs, subject to a limit.</p> <p>Under law, Medicare <u>covered</u> RHC and FQHC services include:</p> <ul style="list-style-type: none"> • Services by physicians, nurse practitioners, physician assistants, clinical psychologists, and clinical social workers • Services and supplies incident to the services of these professionals; Certain visiting nurse (VN) services to the homebound • Pneumococcal and influenza vaccines and their administration • For FQHCs only, certain other preventive primary services

Pre-Authorization: Issues surrounding providing services with or without prior authorization

<p>Pertinent California Regulations Relating to Authorization for Medically Necessary Services</p>	<p>Per 28 CCR Section 1300.71.4, "the following rules set forth emergency Medi-Cal condition and post-stabilization responsibilities for Medically necessary healthcare services after stabilization of an emergency Medi-Cal condition and until an enrollee can be discharged or transferred. These rules do not apply to a specialized healthcare service plan contract that does not provide for Medically necessary healthcare services following stabilization of an emergency condition.</p> <ol style="list-style-type: none"> a. Prior to stabilization of an enrollee's emergency medical condition or during periods of destabilization (after stabilization of an enrollee's emergency medical condition) when an enrollee requires immediate medically necessary healthcare services, a healthcare service plan shall pay for all medically necessary healthcare services rendered to an enrollee. b. In the case in which an enrollee is stabilized but the healthcare provider believes that the enrollee requires additional Medically necessary healthcare services and may not be discharged safely, the following applies: <ol style="list-style-type: none"> 1. A healthcare service plan shall approve or disapprove a healthcare provider's request for authorization to provide necessary post-stabilization medical care within one half hour of the request. 2. If a healthcare service plan fails to approve or disapprove a healthcare provider's request for authorization to provide necessary post-stabilization medical care within one half-hour of the request, the necessary post-stabilization medical care shall be deemed authorized. Notwithstanding the foregoing sentence, the healthcare service plan shall have the authority to disapprove payment for (A) the delivery of such necessary post-stabilization medical care or (B) the continuation of the delivery of such care; provided that the healthcare service plan notifies the provider prior to the commencement of the delivery of such care or during the continuation of the delivery of such care (in which case, the plan shall not be obligated to pay for the continuation of such care from and after the time it provides notice to the provider, subject to the remaining provisions of this paragraph). In both cases the disruption of such care (taking into account the time necessary to affect the enrollee's transfer or discharge) does not have an adverse impact upon the efficacy of such care or the enrollee's medical condition. 3. Notwithstanding the provisions of subsection (b) of this rule, a healthcare service plan shall pay for all Medically necessary healthcare services provided to an enrollee necessary to maintain the enrollee's stabilized condition up to the time that the healthcare service plan effectuates the enrollee's transfer or the enrollee is discharged. c. In the case where a plan denies the request for authorization of post-stabilization medical care and elects to transfer an enrollee to another healthcare provider, the following applies: <ol style="list-style-type: none"> 1. When a healthcare service plan responds to a healthcare provider's request for post-stabilization medical care authorization by informing the provider of the plan's decision to transfer the enrollee to another healthcare provider, the plan shall effectuate the transfer of the enrollee as soon as possible. 2. A healthcare service plan shall pay for all medically necessary healthcare services provided to an enrollee to maintain the enrollee's stabilized condition up to the time that the healthcare service plan effectuates the enrollee's transfer. d. All requests for authorizations and all responses to such requests for authorizations, of post-stabilization medically necessary healthcare services shall be fully documented. Provision of all medically necessary healthcare
---	--

Pre-Authorization: Issues surrounding providing services with or without prior authorization

<p>Historic Response Example</p>	<p>services shall be fully documented. Documentation shall include, but not be limited to, the date and time of the request, the name of the healthcare provider making the request and the name of the plan representative responding to the request.¹²⁰</p> <p>Following Hurricane Katrina, under the authority of the Governor of Louisiana's numerous emergency declarations and executive orders, the Commissioner of Insurance for the State of Louisiana issued Emergency Rules 15, 17, 19 and 20.</p> <ul style="list-style-type: none"> • These rules suspended: <ul style="list-style-type: none"> – Medical certifications – Referrals – Medical necessity reviews – Notification of clinic services – Right to conduct medical necessity reviews (for nonelective services)¹²¹ <p>Some private payers in California updated their force majeure clauses to excuse parties from some of the terms and conditions of the contract if a major disaster occurs.</p> <p>In addition to the foregoing emergency rules:</p> <ul style="list-style-type: none"> • Aetna implemented policies for its members in the affected area to receive treatment covered under their plan without medical pre-certification, referrals or notification of clinic services.¹²² • CIGNA temporarily modified certain standard claim approval requirements including requirements for pre-certification, referrals, medical necessity determinations and clinic intake procedures. Essentially, this entailed suspending the need for members and their providers to get pre-certifications or referrals for procedures and treatments that usually require it. Similarly, reviewing claims for medical necessity were not subject to review.¹²³ • WellPoint Health Networks, the parent company of Blue Cross of California, made revisions that applied to members who were living in Alabama, Louisiana and Mississippi at the time of Hurricane Katrina that: <ul style="list-style-type: none"> – Suspended requirements for prior authorization and pre-certification – Suspended requirements for authorization or referral from a primary care physician¹²⁴
---	--

Pharmaceutical Coverage: Issues surrounding early refills and member co-payments for pharmaceutical prescriptions

<p>Historic Response Example</p>	<p>Following Hurricane Katrina, under the authority of the Governor of Louisiana's numerous emergency declarations and executive orders, the Commissioner of Insurance for the State of Louisiana issued Emergency Rules 15, 17, 19 and 20.</p> <ul style="list-style-type: none"> • These rules stipulated that claims for an initial 30-day supply of prescription medication could not be rejected or pended regardless of date of last refill.¹²⁵ <p>In addition to the foregoing emergency rules:</p> <ul style="list-style-type: none"> • Aetna implemented policies for its members in the affected area to refill prescriptions even if they were not due to be filled and, for those who used Aetna's mail-order pharmacy to, receive replacement for any lost or damaged prescriptions for no additional costs.¹²⁶
---	--

Pharmaceutical Coverage: Issues surrounding early refills and member co-payments for pharmaceutical prescriptions

	<ul style="list-style-type: none"> WellPoint Health Networks, parent company of Blue Cross of California, made revisions that applied to members who were living in Alabama, Louisiana and Mississippi at the time of the disaster that: <ul style="list-style-type: none"> Suspended early refill limits and shipped prescriptions to members at alternative addresses Waived co-payments for prescriptions¹²⁷ United Healthcare allowed members who needed prescription refills to replace them quickly at local pharmacies or via mail service. Even before the hurricane hit, United Healthcare began allowing members to obtain early refills and extra prescription levels in Alabama, Louisiana and Mississippi. United Healthcare notified local pharmacies in the affected areas of the following changes: Members were given a toll-free number to call with any questions on how to replace lost prescriptions. Members who normally used mail pharmacy services and who were in short supply were eligible to obtain medications through their local retail pharmacy. Mail pharmacy orders were expedited by key zip codes to crisis areas. All mail orders for temperature-sensitive prescriptions were assessed on a daily basis to determine appropriate and safe handling for fulfillment.¹²⁸ CIGNA Pharmacy Management allowed members to order refills of their prescription medications early in order to replace medicines lost or destroyed, and waived medical necessity reviews. Members who normally received their prescriptions in the mail through CIGNA Tel-Drug were allowed to have medications shipped overnight at no additional cost. If shipping to the member was not feasible, the member could request that the prescription be transferred to a local retail pharmacy. CIGNA Tel-Drug replaced lost or damaged medication at no charge to members.¹²⁹
--	--

Co-Pay Requirements: Issues surrounding member responsibility for co-payments

<p>Historic Response Example</p>	<p>Following Hurricane Katrina, under the authority of the Governor of Louisiana's numerous emergency declarations and executive orders, the Commissioner of Insurance for the State of Louisiana issued Emergency Rules 15, 17, 19 and 20.</p> <ul style="list-style-type: none"> These rules stipulated that when a claim is submitted but the premium has not been received, the insured was responsible for co-payments, deductibles and coinsurance.¹³⁰ <p>In addition to the foregoing emergency rules:</p> <ul style="list-style-type: none"> WellPoint Health Networks made revisions that applied to members who were living in Alabama, Louisiana and Mississippi at the time of the disaster that waived co-payments for prescriptions.¹³¹
---	---

Claims Management: Issues surrounding claim payments for members with late or non-current premium payments

<p>Historic Response Example</p>	<p>Following Hurricane Katrina, under the authority of the Governor of Louisiana's numerous emergency declarations and executive orders, the Commissioner of Insurance for the State of Louisiana issued Emergency Rules 15, 17, 19 and 20.</p> <ul style="list-style-type: none"> • These rules stipulated that when a claim is submitted but the premium has not been received: <ul style="list-style-type: none"> • The insured was responsible for co-payments, deductibles and coinsurance. • The insurer paid 50% of either the contracted rate or the non-participating rate. • The provider accepted 50% as payment in full and could not bill the patient. • If the entire premium was subsequently received, the claim was readjusted and paid according to the contract.¹³²
---	---

Insurance Questions and Coverage Verification: Issues surrounding verifying insurance coverage and other insurance communication needs

<p>Historic Response Example</p>	<ul style="list-style-type: none"> • America's Health Insurance Plans published a 1-800 number where anyone could call to find their coverage/doctors. America's Health Insurance Plans connected them with their appropriate health plan. Most health plans had a 1-800 number as well. This process remains enabled for future emergency or disaster situations.¹³³ • United Healthcare established a 24-hour crisis toll-free hotline for anyone in the Gulf Coast.¹³⁴
---	---

Endnotes

- 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/>
- ² Depending upon the jurisdiction, the designated official may be the director of emergency services, the Director or Medi-Cal Director of the local emergency Medi-Cal services agency, or Medi-Cal health operational area coordinator. A description of these officials is provided later in this document.
- ³ California Primary Care Association. "California Profile of Community Clinics and Health Centers," 2009.
- ⁴ United States Health and Human Services, "Federally Qualified Health Centers Fact Sheet."
- ⁵ United States Health and Human Services Agency, Health Resources and Services Agency. "Federally Qualified Health Centers Look-Alike Guidelines and Application." Available at <http://bphc.hrsa.gov/policy/pin0321.htm>
- ⁶ United States Health and Human Services, "Rural Health Centers Fact Sheet."
- ⁷ 2009 State of California Emergency Plan, Section 7: 7.3.9 "Tribal Governments"
- ⁸ New York State Workgroup on Ventilator Allocation in an Influenza Pandemic, New York State Department of Health / New York State Task Force on Life & the Law. *Allocation of Ventilators in an Influenza Pandemic: Planning Document - Draft for Public Comment*. New York, 15 March 2007
- ⁹ Ethical Considerations in the Allocation of Organs and Other Scarce Medi-Cal Resources Among Patients. (*Arch Intern Med*. 1995; 155: 29-40). © 1993 American Medi-Cal Association.
- ¹⁰ *Altered Standards of Care in Mass Casualty Events*, (an Agency for Healthcare Research and Quality (AHRQ) Publication, April 2005)
- ¹¹ The Agency for Healthcare Research and Quality
- ¹² Adapted from Medi-Cal Board of California, Division of Licensing, Standard of Care for California Licensed Midwives. *Midwifery Standards of Care*. http://www.mbc.ca.gov/allied/midwives_standards.pdf
- ¹³ Virginia Jury Instructions, Civil Instruction No. 35.000. Steven D. Gravely, Troutman Sanders LLP. *Altered Standards of Care: An Overview*. http://www.vdh.State.va.us/EPR/pdf/Health_and_Medi-Cal_Subpanel.pdf
- ¹⁴ Federal Emergency Management Administration, Fact Sheet, NIMS Implementation for Hospital and Healthcare Systems, September 12, 2006. http://www.fema.gov/pdf/emergency/nims/imp_hos_fs.pdf
- ¹⁵ 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.
- ¹⁶ Government Code Section 8607(d).
- ¹⁷ Government Code Section 8607(e).
- ¹⁸ Government Code Section 8607(a)(1); 19 CCR 2401, 2402(l), and 2405.
- ¹⁹ Government Code Section 8559(b), 8605, and 8607(a)(4);
- ²⁰ Government Code Section 8559(b), 8605.
- ²¹ Government Code Section 8605.
- ²² 19 CCR 2402(c).
- ²³ *The Hospital Incident Command System Guidebook* (August 2006) can be found at <http://www.emsa.ca.gov/hics>.
- ²⁴ *Health Care at the Crossroads: Strategies for Creating and Sustaining Community-wide Emergency Preparedness Systems* (2003)
- ²⁵ *Health Care at the Crossroads: Strategies for Creating and Sustaining Community-wide Emergency Preparedness Systems*, The Joint Commission, 2003, page 18.
- ²⁶ CNA Corporation, *Medi-Cal Surge Capacity and Capability: A Management System for Integrating Medi-Cal and Health Resources during Large-Scale Emergencies*, August, 2004
- ²⁷ *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/>
- ²⁸ Adapted from National Fire Protection Association 1600, 2004, and the Veterans Health Administration Guidebook, 2004.

- ²⁹ National Fire Protection Association 99 Standard for Healthcare Facilities, 2005 edition.
- ³⁰ National Fire Protection Association 1600 Standard on Disaster/Emergency Management and Business Continuity Programs, 2007 Edition. Available at <http://www.nfpa.org>.
- ³¹ Health Systems Research Inc., *Altered Standards of Care in Mass Casualty Events*, an Agency for Healthcare Research and Quality publication, April 2005, and the recommendations of an expert panel on inpatient and outpatient healthcare surge capacity, *Guidelines for Managing Inpatient and Outpatient Surge Capacity*, State of Wisconsin, November 2005
- ³² Awaiting final review comments from California Department of Public Health, Medi-Cal Waste Program
- ³³ The Self-Assessment Project Partnership between the California Department of Health Services and the California Healthcare Association. "Self-Assessment Manual for Proper Management of Medi-Cal Waste, 2nd edition" March 16, 1999. Available at <http://www.cdph.ca.gov/certlic/Medi-Calwaste/Documents/Medi-CalWaste/SelfAssessmentManual.pdf>
- ³⁴ Adapted from :*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).
- ³⁵ California Emergency Services Authority. Hospital Incident Command System (HICS) Guidebook. August 2006. http://www.emsa.ca.gov/HICS/files/Guidebook_Glossary.pdf
- ³⁶ The California Dental Association; *Bioterrorism Policy Statement*: http://www.cda.org/advocacy_&_the_law/issues_&_policies/bioterrorism
- ³⁷ Medi-Cal Board of California: Department of Consumer Affairs: *Medi-Cal Assistance*: http://www.medbd.ca.gov/allied/Medi-Cal_assistants_questions.html#2
- ³⁸ Civil Code Section 1714.5.
- ³⁹ Health and Safety Code 1317(a), see also 42 USC Section 1395dd and corresponding regulations at 42 CFR Section 489 *et seq.*
- ⁴⁰ Health and Safety Code 1317(a), see also 42 USC Section 1395dd and corresponding regulations at 42 CFR Section 489 *et seq.*
- ⁴¹ Health and Safety Code Section 1317(c).
- ⁴² California Governor's Office of Emergency Services. *Disaster Service Worker Volunteer Program (DSWVP) Guidance*. April 2001.
- ⁴³ California Emergency Services Act [California Government Code Section 8550-8668] and the California Disaster Assistance Act [Cal. Gov. Code §§ 8680-8690.7].
- ⁴⁴ California Business and Professions Code, Section 4062, subdivision (b).
- ⁴⁵ California Business and Professions Code, Section 4051.
- ⁴⁶ California Business and Professions Code, section 900 and section 4062.
- ⁴⁷ California Business and Professions Code, Section 4062, subdivision (a).
- ⁴⁸ The Joint Commission. *Comprehensive Accreditation Manual for Ambulatory Care*. Oakbrook Terrace: Joint Commission Resources. 2007
- ⁴⁹ 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.
- ⁵⁰ *Kaiser Daily Health Policy Report*, Prescription Drugs | Pandemic Flu Could Cause Breakdown of Drug-Supply Chain [Jan 12, 2006].
- ⁵¹ Patent Storm, United States Patent 5537313, "Point of supply use distribution process and apparatus," <http://www.patentstorm.us/patents/5537313-description.html>
- ⁵² Stopford BM, Jevitt L, Ledgerwood M, Singleton C, Stelmack M. Development of Models for Emergency Preparedness. Prepared by SAIC under contract No. 290-00-0023. AHRQ Publication No. 05-0099. Rockville, MD: Agency for Healthcare Research and Quality. August 2005.
- ⁵³ James Lenthall. Director, Safety/Security & Emergency Management, Saddleback Memorial Medi-Cal Centers.
- ⁵⁴ Adapted from Treating Hospital Incident Command System, <http://www.emsa.ca.gov/HICS/default.asp>
- ⁵⁵ Adapted from UC Davis Health System
- ⁵⁶ Adapted from Tenet Health Systems, Business Office Procedure Manual, 2003.
- ⁵⁷ MA Influenza Pandemic Preparedness Plan, "Section 10: Legal Considerations For Pandemic Influenza," October 2006
- ⁵⁸ Federal Register Vol. 71, No. 129, page 38264, July 6, 2006, <http://a257.g.akamaitech.net/7/257/2422/01jan20061800/edocket.access.gpo.gov/2006/pdf/06-6029.pdf>

- ⁵⁹ 42 U.S.C. Section 1320b-5 (g)(1)
- ⁶⁰ 42 U.S.C. Section 1320b-5 (g)(2)
- ⁶¹ 42 U.S.C. Section 1320b-5 (a)(2)
- ⁶² 42 U.S.C. Section 1320b-5 (c)
- ⁶³ 42 U.S.C. Section 1320b-5 (b)
- ⁶⁴ Baumrucker, Evelynne , April Grady, Jean Hearne, Elicia Herz, Richard Rimkunas, Julie Stone, and Karen Tritz. "Hurricane Katrina: Medicaid Issues", *CRS Report RL33083 for Congress*, September 15, 2005
- ⁶⁵ Labor Code Section 3351
- ⁶⁶ State of California Division of Workers' Compensation, Frequently Asked Questions - Employers
<http://www.dir.ca.gov/dwc/WCfaqEmployer.html>
- ⁶⁷ http://www.cms.hhs.gov/ElectronicBillingEDITrans/07_ASCAWaiver.asp
- ⁶⁸ <http://www.nubc.org/R1810TN.pdf>
- ⁶⁹ <http://www.nubc.org/R1810TN.pdf>
- ⁷⁰ <http://www.cdc.gov/nchs/data/icd9/icdguide.pdf>
- ⁷¹ http://www.ahacentraloffice.com/ahacentraloffice/images/Katrina_coding%20advice.pdf
- ⁷² U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, "Hurricane Questions and Answers,"
http://questions.cms.hhs.gov/cgi-bin/cms_hhs.cfg/php/enduser/std_adp.php?p_faqid=5605
- ⁷³ Information gleaned from interviews with representatives from Medi-Cal, May 2007.
- ⁷⁴ Discussions with several California private payer representatives during the development of this volume.
- ⁷⁵ U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, "Hurricane Questions and Answers,"
http://questions.cms.hhs.gov/cgi-bin/cms_hhs.cfg/php/enduser/std_adp.php?p_faqid=5605
- ⁷⁶ Federal Emergency Management Agency Public Assistance Policy Digest.
<http://www.fema.gov/pdf/government/grant/pa/321print.pdf>.
- ⁷⁷ Federal Emergency Management Agency Public Assistance Applicant Handbook.
<http://www.fema.gov/pdf/government/grant/pa/apphndbk.pdf> Accessed 14 May 2007.
- ⁷⁸ Federal Register. October 10, 2006 (Volume 71, Number 195) pp. 59513-59514.
http://www.fema.gov/txt/government/grant/pa/frn_small_proj.txt Accessed 14 May 2007.
- ⁷⁹ United State Department of Homeland Security Federal Emergency Management Authority Public Assistance Special Considerations. <http://www.fema.gov/government/grant/pa/considerations.shtm>. Accessed 11 May 2007.
- ⁸⁰ Government Code Section 8550
- ⁸¹ Government Code Section 8571
- ⁸² California Department of Insurance, <http://www.insurance.ca.gov/>
- ⁸³ Health and Safety Code Section 1341(a)
- ⁸⁴ Health and Safety Code Section 1341(c)
- ⁸⁵ Health and Safety Code Section 1344(a)
- ⁸⁶ Health and Safety Code Section 1344(a)
- ⁸⁷ Government Code Section 8572
- ⁸⁸ 22 CCR 51006
- ⁸⁹ 22 CCR 51006
- ⁹⁰ MA Influenza Pandemic Preparedness Plan, "Section 10: Legal Considerations For Pandemic Influenza," October 2006
- ⁹¹ 42 USC Section 1320b-5(b)(1)
- ⁹² 42 USC Section 1320b-5(b)(4)
- ⁹³ 42 USC Section 1320b-5(b) (2)
- ⁹⁴ Interview with LA Medicaid Provider Enrollment Department, May 2007.
- ⁹⁵ US Department of Health and Human Services, Centers for Medicare and Medicaid Services, "Hurricane Questions and Answers," http://www.cms.hhs.gov/Emergency/02_Hurricanes.asp#TopOfPage
- ⁹⁶ Medicare General Information, Eligibility and Entitlement Manual, Chapter 5, Section 70
- ⁹⁷ Medicare General Information, Eligibility and Entitlement Manual, Chapter 5, Section 70
- ⁹⁸ MA Influenza Pandemic Preparedness Plan, "Section 10: Legal Considerations For Pandemic Influenza," October 2006
- ⁹⁹ 42 U.S.C. Section 1320b-5(b)(1)
- ¹⁰⁰ 42 U.S.C. Section 1320b-5(b)(4)

- ¹⁰¹ 42 U.S.C. Section 1320b-5(b) (2)
- ¹⁰² Health and Human Services - Section 1135 Waiver, Hurricane Katrina. September 4 2005
- ¹⁰³ US Department of Health and Human Services, Centers for Medicare and Medicaid Services, "Hurricane Questions and Answers,"
http://questions.cms.hhs.gov/cgibin/cmshhs.cfg/php/enduser/std_adp.php?p_faqid=5605
- ¹⁰⁴ US Department of Health and Human Services, Centers for Medicare and Medicaid Services, "Hurricane Questions and Answers,"
http://questions.cms.hhs.gov/cgibin/cmshhs.cfg/php/enduser/std_adp.php?p_faqid=5605
- ¹⁰⁵ US Department of Health and Human Services, Centers for Medicare and Medicaid Services, "Hurricane Questions and Answers,"
http://questions.cms.hhs.gov/cgibin/cmshhs.cfg/php/enduser/std_adp.php?p_faqid=5605
- ¹⁰⁶ 28 CCR 1300.67(g)
- ¹⁰⁷ 28 CCR 1300.67.05
- ¹⁰⁸ 42 USC Section 300e
- ¹⁰⁹ 42 USC Section 300e
- ¹¹⁰ Business And Professions Code Section 900
- ¹¹¹ Business And Professions Code Section 921
- ¹¹² Business And Professions Code Section 922
- ¹¹³ Louisiana State Medical Society, "Louisiana Department of Insurance's Final Emergency Rules and Directives relative to Suspension of Certain Health Insurance Laws and Regulations Governing Louisiana Licensed Health Insurers Post Hurricane Katrina and Rita"
- ¹¹⁴ Louisiana Title 37, Insurance, Part XI Chapter 27: Emergency Rule 15 and 17
- ¹¹⁵ Louisiana Department of Insurance, "Hurricanes Katrina and Rita Health Insurance Protections,"
http://www.lds.state.la.us/Documents/Health/LHCC/2006_HealthCareConference/HealthInsuranceProtectionsPrintFile.ppt.
- ¹¹⁶ "Aetna Lifts Policy Requirements to Help Members in Hurricane Katrina's Wake"
http://www.aetna.com/news/2005/pr_20050902.htm
- ¹¹⁷ United Healthcare Responds to Support Hurricane Victims, August 31, 2005.
<http://healthandwellbeing.com/news/rel2005/0831Hurricane.htm>
- ¹¹⁸ America's Health Insurance Plans, "Response to Hurricane Ike", <http://www.ahip.org/HurricaneResponse/>
- ¹¹⁹ America's Health Insurance Plans, "Hurricane Katrina Disaster Response",
<http://www.ahip.org/HurricaneResponse/>
- ¹²⁰ 28 CCR 1300.71.4
- ¹²¹ 28 CCR 1300.71.4
- ¹²² Aetna Lifts Policy Requirements to Help Members in Hurricane Katrina's Wake"
http://www.aetna.com/news/2005/pr_20050902.htm
- ¹²³ America's Health Insurance Plans, "Response to Hurricane Ike", <http://www.ahip.org/HurricaneResponse/>
- ¹²⁴ America's Health Insurance Plans, "Response to Hurricane Ike", <http://www.ahip.org/HurricaneResponse/>
- ¹²⁵ Louisiana Department of Insurance, "Hurricanes Katrina and Rita Health Insurance Protections,"
http://www.lds.state.la.us/Documents/Health/LHCC/2006_HealthCareConference/HealthInsuranceProtectionsPrintFile.ppt.
- ¹²⁶ Aetna Lifts Policy Requirements to Help Members in Hurricane Katrina's Wake"
http://www.aetna.com/news/2005/pr_20050902.htm
- ¹²⁷ America's Health Insurance Plans, "Hurricane Disaster Response",
<http://www.ahip.org/HurricaneResponse/>
- ¹²⁸ United Healthcare Responds to Support Hurricane Victims, August 31, 2005.
<http://healthandwellbeing.com/news/rel2005/0831Hurricane.htm>
- ¹²⁹ America's Health Insurance Plans, "Hurricane Katrina Disaster Response",
<http://www.ahip.org/HurricaneResponse/>
- ¹³⁰ Louisiana Department of Insurance, "Hurricanes Katrina and Rita Health Insurance Protections,"
http://www.lds.state.la.us/Documents/Health/LHCC/2006_HealthCareConference/HealthInsuranceProtectionsPrintFile.ppt.
- ¹³¹ America's Health Insurance Plans, "Response to Hurricane Ike", <http://www.ahip.org/HurricaneResponse/>
- ¹³² Louisiana Department of Insurance, "Hurricanes Katrina and Rita Health Insurance Protections,"
http://www.lds.state.la.us/Documents/Health/LHCC/2006_HealthCareConference/HealthInsuranceProtectionsPrintFile.ppt.

¹³³ Interview with America's Health Insurance Plan representatives, January 30, 2007

¹³⁴ United Healthcare Responds to Support Hurricane Victims, August 31, 2005.

<http://healthandwellbeing.com/news/rel2005/0831Hurricane.htm>

DRAFT