

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

Volume II: Government-Authorized Alternate Care Sites



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: Licensed Healthcare Clinics (available 2008)

Volume V: Long-Term Care Facilities (available 2008)

Volume VI: Licensed Healthcare Professionals (available 2008)

Hospital Operational Tools Manual

Government-Authorized Alternate Care Site Operational Tools Manual

Foundational Knowledge Training Guide

Hospital Training Guide

Government-Authorized Alternate Care Site Training Guide

Payer Training Guide

Reference Manual

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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 state-wide healthcare delivery system. While California has built a strong network of healthcare services and agencies through local health departments, local emergency medical services agencies, hospitals, clinics, long term care facilities and healthcare professionals, developing a coordinated response to a dramatic increase in the number of individuals requiring medical assistance following a catastrophic event will be challenging. The overwhelming increase in demands for medical care arising out of such an event is called healthcare surge. While many hospitals, clinics and other healthcare providers have developed individualized healthcare surge plans, the sheer magnitude of a disaster or wide-spread disease may require a different 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, individual healthcare practitioners, and medical support services.
- Coordinated response is essential: An effective healthcare system response to major events usually requires support from public safety agencies and other community response entities that are not normally partnered with the community healthcare systems during everyday operations.
- Bridging the "public-private divide": Healthcare organizations have traditionally planned and responded to emergencies as individual entities. This has occurred in part because of the "public-private divide," the legal, financial, and logistical issues in planning and coordination between public agencies and primarily private healthcare entities. Healthcare organizations must view themselves as an integrated component of a larger response system.
- Public health as an essential partner: Public health departments are not traditionally integrated with other community emergency response operations, including the acute care medical and mental health communities. Public health departments are an essential partner in any successful response to a healthcare surge.

- The need for robust information processing: Medical issues that arise from large scale incidents are rarely immediately apparent, and 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 any routinely used healthcare system.
- The need for effective overall management: Medical response to a healthcare surge situation can be exceedingly complex, with many seemingly diverse tasks. Responsibility for each of these activities can vary significantly among organizations in different communities. Even within a single healthcare system, many actions require coordination between disparate operating units that don't work together on a regular basis. Despite these challenges, all necessary functions must be adequately addressed for a successful mass casualty or mass effect response.
- Medical system resiliency: A major hazard impact that creates the need for healthcare surge capacity also is likely to impact the normal functions of the everyday healthcare systems (i.e., some degree of mass effect). Medical system resiliency is necessary for the system to maintain its usual effectiveness and, at the same time, to provide a reliably functioning platform upon which medical surge may occur. Medical system resiliency is achieved by a combination of mitigation measures and adequate emergency preparedness, assuring continuity of healthcare system operations despite emergency.

Healthcare providers face several challenges achieving optimal emergency preparedness. 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 not only be prepared to provide services on individual basis but also be prepared to participate in an overall emergency community response. An effective response will assure healthcare system resiliency as well as the most efficient care for victims given the severity of the event.

1.1 California Department of Public Health Initiates Planning for Healthcare Surge

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

A key predecessor to the *Development of Standards and Guidelines for Healthcare Surge*

during Emergencies project was the California Hospital Surge Capacity Survey that CDPH conducted in February 2006. Survey findings determined that many California healthcare providers could improve their planning process to identify the resources that would be needed to treat patients during surge emergencies. Based upon these findings, the State Budget Act for fiscal year 2006-2007 authorized CDPH to initiate the *Development of 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, local health departments, healthcare providers, health plans and community organizations to identify issues and develop recommendations to address those issues. The project placed particular emphasis on a framework for standards of care and scope of practice during an emergency, liability of healthcare providers during a surge, reimbursement of care provided during an emergency, planning for and operating alternate care sites and surge capacity operating plans at individual hospitals.

The results of these earlier activities form the basis for the healthcare standards and guidelines manuals, operational tools, 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 disasters.

1.2 Healthcare Surge Standards and Guidelines Manuals, Operational Tools and Training Curriculum

The surge planning materials have been assembled into healthcare surge standards and guidelines manuals which contain recommendations and options for consideration by communities and providers planning for a healthcare surge. Materials should be evaluated for implementation based upon specific needs of the emergency but 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 community and provider structure.

The Standards and Guidelines Manuals issued from this project are:

- **Foundational Knowledge.** This manual defines healthcare surge, 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 to population-based care in a severe surge. This manual is prerequisite to volumes I -III, operational tools, reference manual and training curriculum described below.

- **Volume I: Hospitals.** Primarily developed for use by hospitals, but also beneficial for use by other providers and health plans, this manual contains information on general emergency response planning and related integration activities for hospitals. This manual also includes guidance for hospitals related to increasing capacity and expanding existing workforce during a surge, augmenting both clinical and non-clinical staff to address specific healthcare demands, addressing challenges related to patient privacy and other relevant operational and staffing issues during surge conditions. This manual 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 manual contains planning information related to the establishment of government-authorized Alternate Care Sites that may be used for healthcare delivery 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 manual 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.
- **Other Reference Material:**
 - **Operational Tools Manuals.** Includes forms, checklists and templates that might be used by providers and health plans to assist in the implementation of recommendations and strategies outlined in the respective Standards and Guidelines Manual.
 - **Reference Manual.** The reference manual contains an overview of federal and State regulations and compliance issues, including statutes, laws, regulations and standards and their corresponding legal interpretations and potential implications for use during a healthcare surge. Also included in the reference manual is detailed information regarding Hospital Incident Command System roles and responsibilities to assist 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 those funding sources that were used during previous states of emergency.

- **Training Curriculum.** Outlines the intended audience, methods of delivery and frequency of training for the information presented in the manuals.

These volumes are meant to be actively used for community and provider planning for a healthcare surge. The information contained in the materials will be updated as new information is learned and community surge planning practices evolve.

Additional volumes, operational tools and training curriculum that address clinics, licensed healthcare professionals and long-term care facilities are in development and are scheduled to be issued in 2008.

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 manuals for California.

During a catastrophic emergency, the movement from individual-based care to population-based outcomes challenges the professional, regulatory, and ethical paradigms of the healthcare delivery system. The standard of care will focus on saving the maximum number of lives possible. 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.

Under current state statute 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 following his/her issuance of a declaration of emergency may result in suspensions that allow for flexibility. The manuals provide relatively straightforward examples of Executive Standby Orders and possible suspensions that may be put into effect 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 in hospitals, long-term care facilities, community care clinics, public health departments, other primary and secondary care providers, resources and/or emergency medical services. The local health official uses the situation assessment information provided from the healthcare

delivery system partners to determine overall local jurisdiction/Operational Area medical and health status.

The coordination of activities during a healthcare surge entails significant responsibilities for local government as well as hospitals and other 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 provide a coordinated and integrated response.

A key barrier to effective healthcare surge response is the complexity of the healthcare delivery system. The intent of the *Development of 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. This is primarily addressed by considering the elements of response from an operating rather than a regulatory point of view.

While the current healthcare delivery system is complex, several areas can be simplified, such as professional scope of practice, recruitment of personnel, and patient tracking for clinical and administrative purposes. This simplification emphasizes the operational necessities 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 hospitals can take proactive steps to preserve a revenue stream during a surge event, while 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, behave differently than they may have been trained, and cooperate with each other in unprecedented ways. The purpose of these and future surge standards and guideline materials is to proactively engage California communities in advance planning for a healthcare surge and provide tools and training to support the surge planning process.

1.4 Overview of Government-Authorized Alternate Care Sites Volume

A catastrophic emergency, whether a natural disaster, infectious disease or terrorist attack, will dramatically impact California's healthcare system. It is critical that hospitals, healthcare professionals and health plans doing business in California proactively work together to redefine the nature of their relationships to prepare for a healthcare surge and mitigate its potential impact on patient care, access and funding. Given the unpredictable nature of a disaster and its potential to significantly impact the healthcare delivery system, sufficient

planning and coordination between providers and payers will be essential to maintain business continuity and sustain operations at facilities providing medical care.

During a healthcare surge, the delivery of care will be different. The standard of care may change based on available resources. The scope of a provider's practice may change based on need, sites of care may look different due to access issues, and the traditional methods of claims identification and submission may be forced to undergo adjustments that require practical solutions. Additionally, during a catastrophic emergency, the primary focus of the healthcare community will be on responding to the emergency and caring for the ill and injured. These changes will require 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. For 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.

In the event of a declared healthcare surge, the development of Alternate Care Sites will follow when all available healthcare resources responding to injured or ill patients have reached maximum capacity. The complexity of developing community Alternative Care Sites, which includes the development of an ongoing communication and integration plan with the local healthcare delivery system responding to the emergency, emphasizes the importance of a proactive and collaborative planning process.

Key points in this volume include:

- Government-Authorized Alternate Care Sites are designated under the authority of local government when the existing healthcare delivery system is unable to accommodate the existing or anticipated patient volume resulting from a disaster.
- With primary direction from the local health department, establishment of the Alternate Care Site Planning team will involve a multi-disciplinary approach, bringing together team members from across public and private sectors.
- Any Alternate Care Site has a designated and formalized response system that is established and operated by the Standardized Emergency Management System (SEMS) and the National Incident Management System (NIMS) emergency response. Understanding this system will assist providers and other responders in their own surge planning efforts.

- The standard of care for patients may shift in the alternative care setting due to the specific setting or location, the availability of resources and the healthcare demands particular to the site or region. Staffing and workforce planning will differ based on the medical needs that result from the specific trigger event.
- Reimbursement for Alternate Care Site operations will be made on a time and materials basis rather than through the complex day-to-day healthcare payment system.

2. Definition and Description of Government-Authorized Alternate Care Sites

For surge planning purposes in California, 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, inpatient and/or outpatient 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 general acute care hospitals, clinics, or long term care facilities), but rather are designated under the authority of the local government.

A government-authorized Alternate Care Site **DOES** include mobile field hospitals, schools, shuttered hospitals, stadiums, arenas, churches, and other facilities not currently licensed to provide healthcare services that, under the authority of local government, are designated as an Alternate Care Site to help absorb the patient load after all other healthcare resources are exhausted. For additional information regarding suggested facilities for use as Alternate Care Sites, see Section 8: Facility Selection.

A government-authorized Alternate Care Site **DOES NOT** include sites that are established as part of an expansion of existing healthcare facilities, such as tents set up for patient care in the parking lot of a hospital or sites set up for patient triage by Emergency Medical Services, such as field treatment sites. For information regarding expansion of existing healthcare facilities by adding temporary space, please see Volume 1: Hospitals, Section 5: Managing Facility Space and Operations during a Healthcare Surge.

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 an Alternate Care Site, except for a mobile field hospital, will operate in a non-healthcare facility, it cannot fully replicate a hospital setting.

The objective for establishing a government-authorized Alternate Care Site is to manage the patient load until the local healthcare system (e.g., hospitals, clinics, and long term care facilities) can manage the demands of patients. In planning for an Alternate Care Site, it is important to consider event-specific needs for patient care to understand the types of Alternate Care Site that will need to be established. The Alternate Care Site Planning Team should consider three basic criteria:

- Patient type
- Level of care
- Facility type

Patient Type

While it is difficult to predict the patient needs that will present at an Alternate Care Site, general assumptions can be made based on the type of catastrophic emergency. In any scenario, basic patient care requirements of an Alternate Care Site will need to accommodate the variety of types of patients that present. These requirements can be classified by three patient types:

- Inpatient/Outpatient: Patient presents with inpatient care requirements or general outpatient care requirements.
- Critical: Patient presents with complex and/or critical care requirements, such as surgery or intensive care unit needs.
- Supportive: Patient presents with palliative care requirements or an existing condition with maintenance care requirements (e.g., renal failure, diabetes).

Level of Care

The level of care at an Alternate Care Site will differ from that typically provided by existing healthcare facilities, because that care will be driven by resource availability.

An Alternate Care Site, at a minimum, must have the ability to provide both inpatient/outpatient healthcare services in order to meet patient demands and alleviate the existing healthcare system during a healthcare surge. By providing basic inpatient/outpatient services, the Alternate Care Site will be able to treat less ill patients who can be transferred from nearby hospitals, thereby creating capacity at the hospital for more critical patients.

An Alternate Care Site may also need to care for patients with critical and supportive needs. For example, patients may present at an Alternate Care Sites with severe dehydration. These patients will require inpatient monitoring and treatment with intravenous fluid to prevent further complications, such as seizures or permanent brain damage. The Alternate Care Site established to treat these types of patients will require specific supplies, equipment and staff, and will be dependent on resource availability during a healthcare surge. For additional guidance on level of care considerations, refer to Section 7.2: Patient Care Provided at an Alternate Care Site.

Facility Type

When selecting a site for an Alternate Care Site facility, planners should consider that at a minimum, the facility must have the ability to provide both inpatient/outpatient healthcare services. For government-authorized Alternate Care Sites, suggested facilities include but are not limited to: arenas, football fields, churches, gyms, community centers, parking lots, fairgrounds, medical shelters, shuttered hospitals, mobile field hospitals and campus dormitories. Refer to Section 8: Facility Selection for additional guidance on site assessment criteria for selecting Alternate Care Site facility type.

3. Authority to Establish a Government-Authorized Alternate Care Site

Under the California Department of Public Health (CDPH) Pandemic Influenza Response Plan, responsibility for identifying and planning for a government-authorized Alternate Care Site resides with the Local Health Department. The Local Health Department is not expected to operate the Alternate Care Site. Each local jurisdiction will determine who will operate or be authorized to operate the Alternate Care Site based on the availability of public and private resources.

The California Emergency Services Act recognizes the role of the State and its political subdivisions to mitigate the effects of an emergency. Under this authority, local governments can contract with local public and private entities to establish and operate government-authorized Alternate Care Site in order to mitigate the effects of man-made or natural catastrophic disasters. CDPH acknowledges that most local governments are not currently providing direct patient care, and that successful planning for a government-authorized Alternate Care Site is a community planning responsibility dependent on the expertise of existing healthcare providers, local law enforcement and other government and private resources. Although Local Health Departments are responsible for planning and coordinating a government-authorized Alternate Care Site, other government entities such as the County Office of Emergency Services, Local Emergency Medical Services Agencies, Local Sheriff's Office or private entities may play a significant or primary role in the setup and operation of a government-authorized Alternate Care Site.

4. Alternate Care Site Planning

A substantial amount of advance preparation is required by local governments to be prepared when a disaster necessitates the opening of an Alternate Care Site. The identification of Alternate Care Site locations will require key local authorities to work together to identify the availability of potential private or public resources to set up and operate an Alternate Care Site.

It is recommended that Local Health Departments formalize an Alternate Care Site Planning Team to establish the minimum planning and operational requirements for establishing an Alternate Care Site in a local community. The team should have a designated team leader who will maintain contact with team members, arrange meetings and represent the team with government authorities while the team takes on the responsibility of planning for an Alternate Care Site. The Alternate Care Site Planning Team should include individuals with expertise in the following areas, and who ideally will have knowledge of healthcare delivery under emergency conditions:

- Disaster response/emergency management coordination (management, coordination of work with involvement of multiple entities)
- Organization of clinical care
- Clinical staffing
- Facility set-up, operations, and management
- Security
- Patient transport
- Patient information management
- Procurement and coordination of supplies, equipment and pharmaceuticals
- Engineering

The Alternate Care Site Planning Team should engage in community-based planning efforts as they prepare to establish a government-authorized Alternate Care Site. The inclusion of non-healthcare entities in the community is an important element of the community-based surge capacity planning, and those entities should be integrated into planning efforts. For example, office supply vendors may have large storage warehouses situated in close proximity to a hospital that may be an ideal location for the establishment of an Alternate Care Site. (For additional information, see Section 4.1: Developing the Alternate Care Site Planning Team.)

An Alternate Care Site must be established and operated under the SEMS/NIMS emergency response structure. See Foundational Knowledge, Section 3.9: Standardized Emergency Management System, for additional information on how Alternate Care Sites fit into the SEMS/NIMS structure.

4.1 Developing the Alternate Care Site Planning Team

An important element of the Alternate Care Site Planning Team is the inclusion and integration of public and private partners in the community in both planning for and operation of Alternate Care Sites. The Alternate Care Site Community Participant Checklist shown below gives examples of the types of community members to consider for community-based planning and operation of sites.

The Alternate Care Site Community Participant Checklist is shown below. The checklist can also be found in the Government-Authorized Alternate Care Site Operational Tools Manual on pages 9-11.

	Community Participant	Potential Role
Local, State, and Federal organizations		
<input type="checkbox"/>	Law enforcement, fire, and coroner	Emergency first responders, security, enforcement of quarantine/isolation orders, fatality management
<input type="checkbox"/>	Local emergency medical services agencies	Local implementing arm of the Emergency Medical Systems Agencies
<input type="checkbox"/>	Local federal offices	Personnel, planning
<input type="checkbox"/>	Local public health	Public health planning, personnel, technical assistance
<input type="checkbox"/>	Local State offices	Personnel, planning
<input type="checkbox"/>	National Guard and military establishments	Transportation and infrastructure support, security, enforcement
Volunteer organizations		
<input type="checkbox"/>	Community Emergency Response Teams (CERT)	Volunteers
<input type="checkbox"/>	Medical Reserve Corps (MRC)	Volunteers
<input type="checkbox"/>	Neighborhood Emergency Response Teams (NERT)	Volunteers
<input type="checkbox"/>	Red Cross/Salvation Army and other non-profit organizations	Volunteers and supplies aid
Commercial organizations and business partners		
<input type="checkbox"/>	Area airports	Transportation, facilities
<input type="checkbox"/>	Board of Realtors	Coordination of additional space for healthcare facilities

	Community Participant	Potential Role
<input type="checkbox"/>	Chambers of commerce	Business community support
<input type="checkbox"/>	Communication companies (e.g., private cell, two-way radio, broadcast television)	Communication needs
<input type="checkbox"/>	Major employers and business community, especially big-box retailers (e.g., Costco, Sam’s Club)	Essential supplies and services
<input type="checkbox"/>	Mortuaries	Burial and cremation services
<input type="checkbox"/>	Private security firms	Security services
<input type="checkbox"/>	Public works and local utility companies	Critical infrastructure
<input type="checkbox"/>	Restaurants, caterers, party supply stores	Facilities, food, supplies
Community organizations		
<input type="checkbox"/>	City unified school districts and community colleges	Alternate Care Sites, personnel/services, supplies
<input type="checkbox"/>	Faith-based organizations	Facilities, volunteers, supplies, translation
<input type="checkbox"/>	Public transportation	Transportation
<input type="checkbox"/>	Nursery schools/preschools	Facilities, personnel, child care
<input type="checkbox"/>	Veterinary shelters/pet boarding and care	Pet care for workers/evacuees
Other partners		
<input type="checkbox"/>	Miscellaneous services	Financial, accounting, general services

4.2 General Planning Considerations for Alternate Care Sites

The Alternate Care Site Planning Team must delineate the specific medical functions and treatment objectives of the Alternate Care Site facility.³ Successful establishment of an Alternate Care Site will require the Alternate Care Site Planning Team to ensure that the Alternate Care Site has adequate medical resources to meet the event-specific patient care needs. The planning considerations in this document take an “all-hazards” approach, outlining the basic considerations for the establishment and execution of an Alternate Care Site. However, it is recommended that the Alternate Care Site Planning Team consider two scenarios in planning an Alternate Care Site. In the AHRQ Publication No. 06-0029, “*Reopening Shuttered Hospitals to Expand Surge Capacity*,” the following planning

considerations for a generic catastrophic emergency and an infectious agent or communicable disease epidemic (e.g., smallpox, flu, severe acute respiratory syndrome) scenario are suggested:

Scenario One: A generic catastrophic event (conventional terrorism or war, weapon of mass destruction or natural disaster) in which hundreds of ambulatory medical/surgical patients need to be transferred from tertiary care hospital to make capacity for catastrophic individuals. In this scenario, every possible patient at the major tertiary hospitals would be transferred to other settings of care and all elective non-urgent admissions and procedures would be delayed. If this approach does not reduce demand sufficiently, an Alternate Care Site may be opened. The most critically ill patients would remain in the tertiary care facilities, and the most medically stable patients would be relocated to the healthcare surge facility. It is also conceivable that there would be a "domino effect" in which patients from tertiary care setting would be transferred to community hospital and then less acutely ill patients in the community hospital would be transferred to an Alternate Care Site.

Scenario Two: An infectious agent or communicable disease epidemic (e.g., small pox, flu, severe acute respiratory syndrome) that requires the creation of an infectious-disease/isolation or quarantine hospital as the healthcare surge facility. Special considerations for a healthcare surge facility under an isolation scenario such as this include willingness of facility owners to allow this use at their facility, prophylaxis of staff working at the healthcare surge facility, security and perimeter control, medical waste removal and treatment, isolation air handling, negative pressure room wards, laundering and contaminated linens, and (possibly) body disposal.

The successful establishment and operation of an Alternate Care Site is, by its very nature, a complex undertaking with a variety of issues. As with all aspects of emergency preparedness, these issues are best investigated and planned for well in advance of their implementation. The following general planning assumptions should be considered by the Alternate Care Site Planning Team as it develops an integrated plan for the continuum of healthcare delivery, regardless of the type of catastrophic event:

1. Government-authorized Alternate Care Sites should be viewed as a last resort in the healthcare response to a catastrophic disaster.
2. Government-authorized Alternate Care Sites should plan to operate for a duration of two to eight weeks, depending on the nature of the healthcare surge and patient needs.
3. Community planning requires participation from public and private entities as well as healthcare and non-healthcare service entities to establish a government-authorized Alternate Care Site based on an "all-hazards" approach.
4. Lifesaving response will be performed by local emergency responders and residents in the impacted area regardless of the efficiency of State and federal response systems.

5. Government-authorized Alternate Care Sites will operate in an uncertain environment and will require a community “all-hands” approach:
 - a) The number, type and location of casualties; the status of roads and the emergency transportation system; and other factors such as weather, day of the week, time of day, etc. cannot be predicted. These factors will strongly influence not only the demand for medical care, but also the availability of medical resources.
 - b) The magnitude of the disaster and disruptions to communications systems will require decision makers to act without complete information regarding the number, type and location of casualties and impact on healthcare facilities.
6. Affected populations will adopt strategies that appear to be most effective for obtaining medical care. This will result in convergence on known medical facilities, such as hospitals and clinics, regardless of their operational status. Affected populations will also converge on government-authorized Alternate Care Sites if their location is known to the public.
7. Government-authorized Alternate Care Sites will require significant resource coordination, which will be arranged through the SEMS/NIMS process.

4.3 Planning for Pandemic Influenza

Under the expected patient surge associated with pandemic influenza, the primary assumptions are that 25% of the population will become ill, 4.4% of those who become ill will be admitted to the hospital, 15% of those admitted will require intensive care unit care and 7.5% will require ventilator care. California may be required to treat 58,723 patients above existing daily staffed bed capacity, with the majority requiring intensive care (39,699 in intensive care units) and ventilators (34,028 ventilators). These projections were derived using FluSurge 2.0 software developed by the Centers for Disease Control (CDC) and assumed a pandemic midway between the mild 1968 influenza pandemic and the severe 1918 influenza pandemic.

While healthcare surge conditions would exist throughout the pandemic, the greatest need for surge capacity is expected to occur in 2 to 3 waves lasting 6 to 8 weeks over an 18 to 24 month period. The highest demand is projected to occur in week 5 of the first wave.

The following chart lists by county the needed 58,723 surge beds followed by the number of beds each hospital within the county indicated they could surge in the 2006 CDPH Hospital Surge Capacity Survey. These numbers provide a starting point for planning; however, if the pandemic influenza is more severe, these surge numbers could increase by two or three fold. These numbers do not consider any surge patients moving from one county to another or coming from across the State border.

Pandemic Influenza Surge Estimates

County	Estimated Population Jan 2007	Percentage of Population	Share of 58,723 Surge Patients	Hospital Bed Surge Capacity*	Needed Surge Beds
ALAMEDA	1,419,801	3.7698%	2,214	595	1,619
ALPINE	1,261	0.0033%	2	0	2
AMADOR	38,435	0.1021%	60	106	-46
BUTTE	218,069	0.5790%	340	140	200
CALAVERAS	46,028	0.1222%	72	99	-27
COLUSA	21,951	0.0583%	34	2	32
CONTRA COSTA	1,042,341	2.7676%	1,625	719	906
DEL NORTE	29,341	0.0779%	46	25	21
EL DORADO	178,674	0.4744%	279	61	218
FRESNO	917,515	2.4361%	1,431	317	1,114
GLENN	28,915	0.0768%	45	22	23
HUMBOLDT	131,959	0.3504%	206	186	20
IMPERIAL	172,672	0.4585%	269	162	107
INYO	18,383	0.0488%	29	12	17
KERN	801,648	2.1285%	1,250	689	561
KINGS	151,381	0.4019%	236	42	194
LAKE	64,276	0.1707%	100	123	-23
LASSEN	36,375	0.0966%	57	12	45

* As Reported in 2006 California Healthcare Surge Capacity Survey

County	Estimated Population Jan 2007	Percentage of Population	Share of 58,723 Surge Patients	Hospital Bed Surge Capacity	Needed Surge Beds
LOS ANGELES	10,331,939	27.4329%	16,109	3,641	12,468
MADERA	148,721	0.3949%	232	35	197
MARIN	255,982	0.6797%	399	71	328
MARIPOSA	18,254	0.0485%	28	0	28
MENDOCINO	90,291	0.2397%	141	105	36
MERCED	251,510	0.6678%	392	150	242
MODOC	9,721	0.0258%	15	73	-58
MONO	13,985	0.0371%	22	10	12
MONTEREY	425,960	1.1310%	664	244	420
NAPA	135,969	0.3610%	212	35	177
NEVADA	99,766	0.2649%	156	217	-61
ORANGE	3,098,121	8.2260%	4,831	1,359	3,472
PLACER	324,495	0.8616%	506	286	220
PLUMAS	21,128	0.0561%	33	39	-6
RIVERSIDE	2,031,625	5.3943%	3,168	901	2,267
SACRAMENTO	1,406,804	3.7353%	2,193	479	1,714
SAN BENITO	57,803	0.1535%	90	10	80
SAN BERNARDINO	2,028,013	5.3847%	3,162	942	2,220
SAN DIEGO	3,098,269	8.2264%	4,831	3,089	1,742
SAN FRANCISCO	915,191	2.4300%	1,427	463	964
SAN JOAQUIN	679,687	1.8047%	1,060	408	652
SAN LUIS OBISPO	264,900	0.7034%	413	160	253
SAN MATEO	733,496	1.9475%	1,144	681	463
SANTA BARBARA	424,425	1.1269%	662	320	342
SANTA CLARA	1,808,056	4.8007%	2,819	552	2,267
SANTA CRUZ	264,125	0.7013%	412	135	277

County	Estimated Population Jan 2007	Percentage of Population	Share of 58,723 Surge Patients	Hospital Bed Surge Capacity	Needed Surge Beds
SHASTA	181,401	0.4816%	283	158	125
SIERRA	3,485	0.0093%	5	0	5
SISKIYOU	45,953	0.1220%	72	51	21
SOLANO	424,823	1.1280%	662	559	103
SONOMA	481,765	1.2792%	751	162	589
STANISLAUS	521,497	1.3847%	813	244	569
SUTTER	93,919	0.2494%	146	0	146
TEHAMA	61,774	0.1640%	96	30	66
TRINITY	14,171	0.0376%	22	8	14
TULARE	429,006	1.1391%	669	244	425
TUOLUMNE	57,223	0.1519%	89	72	17
VENTURA	825,512	2.1919%	1,287	357	930
YOLO	193,983	0.5151%	302	106	196
YUBA	70,745	0.1878%	110	232	-122
TOTALS	37,662,518	100.0000%	58,723	19,940	38,783

5. When to Establish a Government-Authorized Alternate Care Site

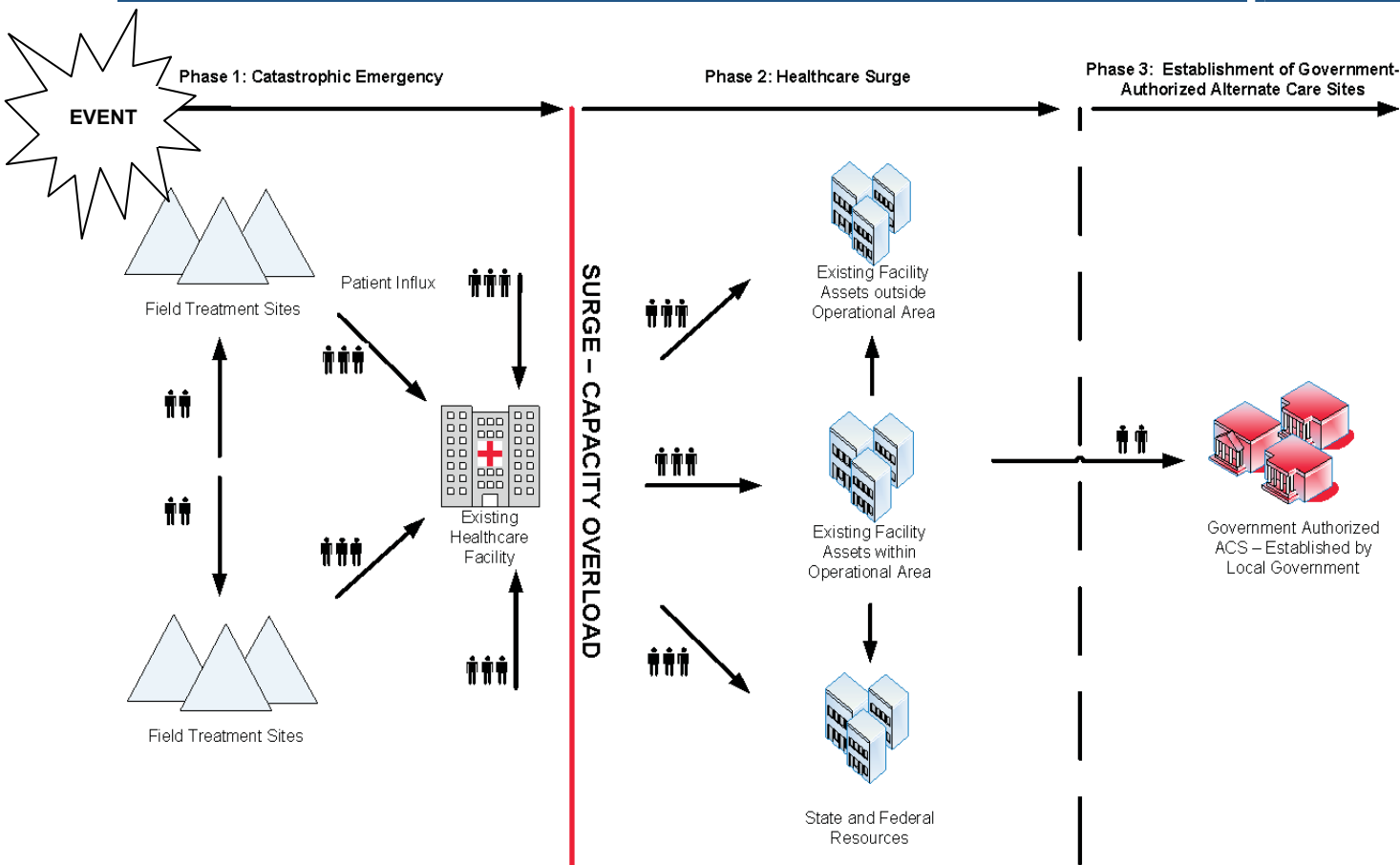
For purposes of surge planning in California, healthcare surge is defined as the following:

A healthcare surge is proclaimed in a local jurisdiction when an authorized local official, such as a local health officer or other appropriate designee,⁴ 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. The local health official uses the situation assessment information provided from the healthcare delivery system partners to determine overall local jurisdiction/Operational Area medical and health status.

Healthcare surge is **not** the frequent emergency department overcrowding experienced by healthcare facilities (for example, Friday/Saturday night emergencies). It is also not a local casualty emergency that might overcrowd nearby facilities and have little to no impact on the overall healthcare delivery system.

When a catastrophic event occurs, the population affected will seek medical care from the existing local hospitals and healthcare facilities. However, as the demand for healthcare services increases and existing healthcare facility assets become exhausted, local government will have a responsibility to step in and establish a government-authorized Alternate Care Site to absorb the patient load until the local healthcare system can manage the demands of patients.

The following diagram depicts how the healthcare delivery system will expand to meet patient care demands during a healthcare surge.



Phase 1: Catastrophic Emergency Occurs, Healthcare Surge Is Declared

When a catastrophic emergency occurs, affected individuals will move or be relocated to the most appropriate available facility. As time passes, these healthcare facilities may experience an influx of patients that eventually exceeds capacity. When this occurs, existing healthcare facilities will call upon local government to determine whether to declare a healthcare surge.

In addition to existing healthcare facilities, field treatment sites may be set up at or near the event location. Field treatment sites are medical response sites that can provide triage and emergency medical treatment of injuries for a period of 48 hours, until patients stop arriving or until transported to an area healthcare facility, Alternate Care Site, or out-of-the area.

Field treatment sites are primarily a medical response function of the Local Emergency Medical Services Agency. Patients may be transported from a field treatment site to available hospitals in or out of the area. When the field treatment site is demobilized, patients may be transferred to an Alternate Care Site for continued treatment if healthcare facilities capacity is still overwhelmed.

Phase 2: Patients Transferred to Additional Healthcare Facility Entities upon Surge - Capacity Overload

When capacity is reached, patients may be transferred to additional healthcare facilities. Neighboring State and/or federal resources will also be requested to help alleviate the patient demand on the local healthcare system.

Phase 3: Establishment of Government-Authorized Alternate Care Site

Once a decision has been made that government-authorized Alternate Care Sites are needed, it may require 72 hours or more to set up a site. At this point, less critical patients will be directed to an Alternate Care Site rather than to hospitals.

The ability to establish a government-authorized Alternate Care Site will be dependent on the resources available at the time of activation. In planning, the Alternate Care Site Planning Team should consider that the emergency may require the Alternate Care Site to care for patients needing one or more of the following levels of care:

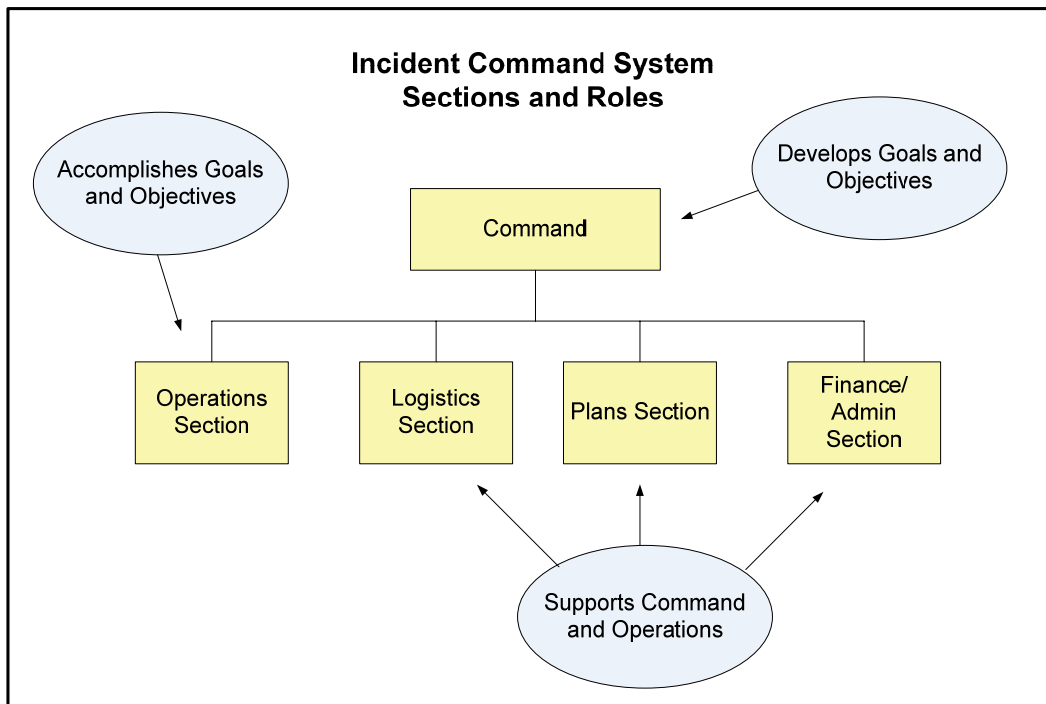
- Inpatient/Outpatient: Facilities providing inpatient/outpatient care will treat patients who present with general inpatient or outpatient care requirements.
- Critical: Facilities providing critical care will treat patients with complex and/or critical care requirements, such as surgery or intensive care unit needs. Every attempt should be made to keep critical care patients in hospitals.
- Supportive: Facilities providing supportive care will treat patients with palliative care requirements or existing conditions with maintenance care requirements (e.g., renal failure, diabetes).

6. Incident Command System

SEMS/NIMS is based on the concept of the Incident Command System⁵ which organizes emergency management during an incident response through eight core concepts: common terminology, integrated communications, modular organizations, unified command structures, manageable span of control, consolidated action plans, comprehensive resource management and pre-designated incident facilities.

Under the SEMS structure, once the impact of an emergency is sufficient to impact multiple emergency response disciplines (law enforcement, fire, public health), a Unified Command organization will be established close to the incident to manage the tactical operations of managing the response. At this time, all healthcare providers, including activated Alternate Care Sites, will be integrated into this unified incident command management structure for coordination of patient movement and resource allocation. This will facilitate the integration of healthcare professionals into a single consolidated incident action plan that will result in optimum patient care for the community.

Within an Alternate Care Site, a modified Incident Command System structure will need to be established to accomplish patient care objectives within the Alternate Care Site and connect to the Unified Command System to obtain resources. The recommended structure is shown in the chart below.



Within this structure, the following Incident Command System functions should be filled:

Command: The Command retains overall responsibility for effective performance of the Alternate Care Site. The Command provides oversight of the management sections (listed below), and has primary responsibility for the performance and actions of the Command/Management Staff. The Command includes the Health and Safety Officer, the Public Information Officer, and the Liaison Officer, as well as the Section Chiefs of the following sections:

Operations Section: The Operations Section is responsible for managing the tactical operations that achieve the incident objectives focusing on reducing the immediate hazard, saving lives and property, establishing situational control, and restoring normal operations. Actions under this section are guided by the Operations Section Chief through directed strategies, specific tactics, resource assignments, and direct supervision for each operational period. The Operations Section may be organizationally subdivided through the use of branches, with divisions (for geographic organization) or groups (for functional organization).

Logistics Section: According to the *National Incident Management System*⁶, “the Logistics Section is responsible for all support requirements needed to facilitate effective and efficient incident management, including ordering resources from off-site locations. It also provides facilities, transportation, supplies, equipment maintenance and fuel, food services, communications and information technology support, and emergency responder medical services.” The Logistics Section may be sub-divided into branches, usually a Support Branch and a Services Branch, to maintain effective span of control.

Planning Section: The *National Incident Management System* states, “the Planning Section collects, evaluates, and disseminates incident situation information and intelligence to the Alternate Care Site Command or Unified Command and incident management personnel; prepares status reports; displays situation information; maintains status of resources assigned to the incident; and develops and documents the Incident Action Plan based on guidance from the Alternate Care Site Command or Unified Command.” An important responsibility of this section is processing incident information.

Administration/Finance: The Administration/Finance Section supports management and operations by addressing specific needs for financial, reimbursement (individual and agency or department), and/or administrative services to support incident management activities.

For more information on the Incident Command System and Unified Command, see Foundational Knowledge, Section 3.9: Standardized Emergency Management System.

7. Patient Care

7.1 Standard of Care

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 personnel, 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 their respective scope of practice each provider is licensed or authorized to provide. The standard of care provides a framework to identify and evaluate objectively the professional responsibilities of licensed personnel, and permits individual licensed personnel to be rationally evaluated to ensure that is safe, ethical and consistent with the professional practice of the licensed profession in California.⁷ Standard of care encompasses the diagnosis and treatment of patients and the overall management of patients.⁸ 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.

Under normal conditions, providers are responsible for employing appropriate health and medical resources and responses to improve the health status and/or save the life of an individual patient. However, during a healthcare surge, the standard of care will shift from focusing on patient-based outcomes to population-based outcomes. According to a report by Health Systems Research Inc., *Altered Standards of Care in Mass Casualty Events*, (an AHRQ Publication, April 2005), providers should anticipate "a shift to providing care and allocating scarce equipment, supplies and personnel in a way that saves the largest number of lives in contrast to the traditional focus on saving individuals."

7.2 Patient Care Provided at an Alternate Care Site

The Alternate Care Site Planning Team should recognize that services provided at an Alternate Care Site will not include all services found in hospitals. Care at an Alternate Care Site will be determined by resource availability and event-specific patient needs as well as by the patient types described earlier in this volume.

It is likely that limited laboratory testing will be performed at an Alternate Care Site, with the possible exception of an Alternate Care Site treating critically complex patients. Rather than try to establish a laboratory in an Alternate Care Site, it will be easier to employ bedside point-of-care testing for common tests and use courier service to private laboratory testing companies or other hospitals for more advanced tests.

7.3 Patient Decontamination

An Alternate Care Site should have a plan or program for radioactive, biological, and chemical isolation and decontamination. Some of the key recommendations for protecting healthcare providers and managing patients at an Alternate Care Site in the event of hazardous exposure include:

- Alternate Care Sites are encouraged to establish relationships and notification procedures with appropriate local agencies (e.g., local Emergency Medical Systems) in order to:
 - Ensure communication between the field and Alternate Care Site
 - Ensure that properly trained and equipped field responders decontaminate patients in the field in order to protect the Alternate Care Site as much as possible
 - Understand the local protocols and capabilities for field decontamination of patients
- During a hazardous material emergency, an Alternate Care Site will play an important role in triaging, treating, decontaminating and medically screening patients as necessary. It is recommended that:
 - Alternate Care Sites work collaboratively with the community and local government to meet the challenges of a surge of contaminated patients, as an influx of contaminated patients may overwhelm an Alternate Care Site.
 - Alternate Care Sites be prepared for potentially contaminated patients who self-refer and present to the Alternate Care Site.
 - 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 situations 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 Systems transport who have been decontaminated on scene so that these patients can be quickly assessed for adequacy of decontamination and be triaged to medical screening more quickly

8. Facility Selection

The location for an Alternate Care Site is critical for its successful operations. Early in the planning process, a thorough assessment of potential facilities should be conducted. **It is recommended that the Alternate Care Site Planning Team determine the appropriate individuals to participate in the facility assessment. Appropriate individuals would include, but are not limited to, security professionals, supply and equipment contractors, and environmental engineers.**

The following sections outline considerations for the designated Alternate Care Site Planning Team members as they assess potential Alternate Care Site locations.

8.1 Site Selection

Recommended existing structures suitable for use as an Alternate Care Site include: National Guard armories, shuttered hospitals, mobile field hospitals, airports, airport hangars, arenas, stadiums, fairgrounds, parks, schools, churches, community centers, football fields, government buildings, hotels/motels, meeting halls, warehouses, gymnasiums, civic sports centers, conference rooms, health clubs, and convention centers. Large tents or similar “soft” structures can also be used. Armories and public schools are particularly attractive because they are publicly owned structures, making it easier for emergency coordinators to rapidly secure them in the event of a disaster.

Important considerations to assist the Alternate Care Site Planning Team in selecting an Alternate Care Site facility include:

- Close proximity to a hospital for ease of transferring patients and sharing of resources, such as laboratories and diagnostic function
- Sufficient number and types of existing communications (hardwire telephones and high-speed internet ports)
- Adequate parking and loading ramps
- Utilities: electrical power (a backup generator is highly desirable), ventilation, heating, air conditioning, water and plumbing systems
- Separate rooms with large floor space for patient care or the ability to partition open space to separate patients
- Men and women's restrooms and shower function for patients
- Kitchen facilities
- Rooms for registration and family waiting area
- Climate control
- Waste removal ability
- Area for hand-washing stations and other safe hygiene techniques
- Staff support / rest break area / shower areas
- Adequate staging areas for supplies and storage

- Isolation areas for mental health patients
- Wheelchair / gurney access
- Fire protection safety and equipment (e.g., fire extinguishers, fire alarms)
- Refrigeration/cold storage for medical supplies and food
- Limited number of secured entrances and exits
- Support area for laundry and general supplies
- Break area for staff
- Shower area to be used by staff and patients as needed
- Central medical command center located near medical volunteer entrance and triage station and administrative services such as registration and lost and found.
- The triage station can include patient staging area
- Perimeter that segregates patient populations such as children in an area away from the elderly
- Mental health station
- Isolation area for patients
- Area to stage dead bodies out of the Alternate Care Site.

8.2 Roadway Access and Security

An Alternate Care Site should be accessible to at least two roadways. This would provide continued access to the Alternate Care Site in the event that one roadway becomes blocked or inaccessible. These roadways should connect directly to the Alternate Care Site property. This would allow for easy set up of traffic stop points to limit access and check personnel identification or vehicles if needed during healthcare surge use.

8.3 Building Size Considerations

The building size is also an important factor when selecting an Alternate Care Site structure. The building should be large enough to effectively care for the patients. The exact allocation of space will be largely determined by the facility design; however, for reference, the minimum size of a functional Alternate Care Site with a 250-bed capacity is approximately 40,000 square feet. The minimum sized building required for a 50-bed Alternate Care Site is approximately 9,000 square feet. The total size and number of beds will be directly influenced by factors such as facility layout, number of patients, patient acuity, and medical logistics support.

8.4 Building Security

An Alternate Care Site should have a limited number of building entrance-ways that are readily controllable for security purposes. In addition, it should be capable of being secured and providing secure storage for controlled substances and other sensitive medical materials.

8.5 Clinical Considerations

When selecting an Alternate Care Site, it is important to consider the clinical care requirements necessary for treating patients. Considerations for providing care at an Alternate Care Site include:

- Triage-focused areas for patients requiring various levels of care
- Pharmacy area that provides pharmaceuticals necessary for patient care
- Laboratory/blood testing capabilities
- Isolation and decontamination capabilities
- Sufficient equipment support for clinical care, including medical gases
- On-site imaging capabilities
- Oxygen supply and cylinder refill capability
- Mortuary support

8.6 Physical Configuration

Flexibility in the physical configuration of an Alternate Care Site is an important consideration. The type of catastrophic event will determine patient needs and, in turn, will dictate the physical requirements of the Alternate Care Site. Although it is difficult to predict patient needs during a healthcare surge, Alternate Care Site configuration models can be used to plan for physical configuration of a government-authorized Alternate Care Site to provide effective care for different patient types.

As a result of the impact of Hurricane Katrina, treating facilities were presented with a unique set of physical configuration considerations. The following list of recommendations provides examples of the physical configuration considerations and practices used during the aftermath of Hurricane Katrina. Although the list is based on a single event, it may be reasonable to expect that such considerations could apply to multiple disaster scenarios.

- Food service areas should be spaced away from treatment areas to prevent the smell of food. For example, food service areas may be located on an upper floor level.
- Availability of food services to staff and patients will be required 24 hours a day/7 days a week.

- Portable hand washing stations should be located in triage areas, patient care units, laboratory areas, pharmacy areas, x-ray areas. Hand disinfectant dispensers should be located in all patient receiving areas.
- Sleeping area should be designated for staff and include cots, blankets and pillows.
- Configuration should include divided sections for the following patient care units: prescriptions/minor care, adult unit, pediatric unit, psychiatric unit, isolation unit (large enough for single family) and should be organized to maximize provider access to patients that are segregated by services and adult and pediatrics. Ancillary support such as pharmacy, x-ray and central supply should be in close proximity.
- Patient care units should include triage nurse, waiting areas, and drug dispensing area (adult units only).
- Isolation capacity should be planned for either inside or outside the site, (e.g. High Efficiency Particulate Air-Filters [HEPA], trailers, negative air pressure tents, etc.).
- Controlled entrance(s) should be established for all staff, volunteers, patients and visitors.

8.7 Site Assessment Tool

The Alternate Care Site Assessment Tool can be used to assist planners in assessing potential locations for use as an Alternate Care Site and identifying the minimum physical requirements for operations of an Alternate Care Site. The tool will assist in determining the criteria/requirements/standards for a particular Alternate Care Site location as it relates to:

- Location considerations for an Alternate Care Site: What are the types of facilities that can be considered for Alternate Care Sites? Suggested facilities include but are not limited to: National Guard armories, shuttered hospitals, mobile field hospitals, airports, airport hangers, arenas, stadiums, fairgrounds, parks, schools, churches, community centers, football fields, government buildings, hotels/motels, meeting halls, warehouses, gymnasiums, civic sports centers, conference rooms, health clubs, and convention centers. Large tents or similar “soft” structures can also be used.
- Clinical care requirements: What are the minimum clinical requirements to provide patient care?
- Infrastructure: Is there sufficient square footage to provide space for patient cots or mats and space for work area for healthcare providers, ancillary workers and support staff? Is there space to store supplies? Can access to the building be safely controlled? Is the building environmentally safe for patients and workers?
- Total space and layout: Is there an area where patients can easily be transferred from ambulances into the building? Is there ample parking for workers and patient families? Is there adequate space to safely store contaminated waste until pick-up?
- Utilities: Does the building have a system of back up power? Electrical outlets? Sanitary facilities? Running water?

- **Communication:** Can multiple phone lines and internet connections be quickly activated at the site? Who do they need to serve? Is the wiring sufficient to support phone lines and internet connections?
- **Other services:** Is there an area where food can be prepared safely or received from a catering service?

The Alternate Care Site Assessment Tool is shown below. The tool can also be found in the Government-Authorized Alternate Care Site Operational Tools Manual on pages 3-8.

Alternate Care Site Assessment Tool

Required Attachments Needed With This Assessment: Site Map and/or Floor plan drawing of facility structure.

Site Name:
Address:
Thomas Brothers Map and Page grid #:

Items to Be Completed Prior to Survey Visit

Alternate Care Site Planning Team completing assessment:	
Date of assessment:	Phone:
Point of Contact for site access:	Phone:
After business hours point of contact:	Phone:
Point of Contact for facility maintenance (if applicable):	Phone:
Point of Contact for site security (if applicable):	Phone:
Total square feet:	Covered square feet: 40K required if requesting Alternate Care Site with 250-bed unit capacity (circle) One floor or Multilevel # of floors:
# of buildings available:	

The following is a list of basic facility requirements to establish an Alternate Care Site. Determine if the requirement is present, not present or reasonably accommodated (potential to be present with refitting/renovation).
P = Present; NP = Not Present; RA = Reasonably Accommodated

I. Infrastructure	P/NP/RA	Comments
Door size adequate for gurneys, 46" width		
Floors		
Loading dock		
Parking for staff and visitors		
Roof		
Toilet facilities/showers (#, _____)		
Hand-washing facilities (# and location)		
Heating, Ventilation and Air Conditioning (HVAC) system for adequate ventilation		
Climate control		
Walls		
Wheelchair access		
II. Total Space Layout	P/NP/RA	Comments
Auxiliary spaces (pharmacy, counselors)		
Equipment/supply storage area		
Family waiting		
Food and supply prep area		
Morgue/holding area		
Patient decontamination/isolation area		
Min 40 sq. feet per bed, per person		
Staff support/rest break areas		
III. Utilities	P/NP/RA	Comments
Air conditioning		
Electrical power (backup generator)		
Heating		
Lighting		
Water		
Fire protection safety and equipment		

Refrigeration for safe storage of medical supplies and food, morgue			
IV. Communications	P/NP/IRA		Comments
Phone capability (#: _____)			
Two-way radio capability			
Wired for IT and internet access			
V. Clinical Requirements - Adequate space for:	P/NP/IRA		Comments
Triage/ER patient care			
Pharmacy			
Laboratory/blood testing			
VI. Other Services	P/NP/IRA		Comments
Ability to lock down facility			
Provide secure storage for controlled substance and medical materials			
Accessibility/proximity to public transportation			
Biohazard & other waste disposal/storage space			
Oxygen/medical gases delivery capability			
Answer the following questions:			
Has this site been identified for use in other emergencies?		Y	N
Americans with Disabilities Act (ADA) access for persons with disabilities?		Y	N
Size of largest open room: _____ feet x _____ feet			
Total covered area square feet. (estimate for 200 casualties + staff = 15,000-20,000 square feet):			
Are there any other indigenous communications resources (e.g., security radios, intercom, and internet)?			
Comments:			
Generator capacity: _____ watts.			
Fuel onsite: _____ gallons			Runtime with existing fuel? _____ Hours
Nearest major thoroughfare:			
Road size and number of lanes for access to site:			
How does the general layout look?		Good	Fair
Material needed to be relocated to use this facility/site:			Congested
Estimate # of nonambulatory casualties in all areas (@50 sq. ft. per patient) for inpatient services.			

Problems, major stumbling blocks? Comments.

Attach diagram of roads, parking, traffic plan.

What would have to be brought in? (excluding medical supplies)

- Utilities
- Communications
- Equipment
- Food, Water

Overall Findings and Recommendations

Provide your overall assessment of the facility.

Based on the walk-through, this facility would accommodate (circle one):	
1	No potential for healthcare surge capacity use
2	Potential for an outpatient care during a healthcare surge
3	Potential for outpatient and inpatient care during a healthcare surge
4	Potential for critical care during a healthcare surge
5	Potential for supportive care during a healthcare surge

8.8 Facility Contract Considerations

A contract is generally required to secure premises for operating a government-authorized Alternate Care Site on a private, public or tribal property. The Alternate Care Site Planning Team should enter into formal agreements for the acquisition of facility locations under the authority of local government in the event of a declared healthcare surge. It is recommended that a memorandum of understanding or letter of arrangement be established between the local government, Local Health Department, and facility owners.

A Sample Memorandum of Understanding Template is shown below. The template can also be found in the Government-Authorized Alternate Care Site Operational Tools Manual on pages 104-107.

<p>(County)</p> <p>MEMORANDUM OF UNDERSTANDING (MOU) FOR USE OF FACILITIES IN THE EVENT OF A MASS MEDICAL EMERGENCY</p> <p>(County), and (name of facility) agree that:</p> <p>In the event of a catastrophic medical emergency in the State of California, resources will be quickly committed to providing the necessary healthcare services. Such an event may require a facility to support the activation of an Alternate Care Site. The Alternate Care Site will serve as a site where patient care can be provided to individuals impacted by a large-scale catastrophic emergency.</p> <p>(County) and (name of facility) enter into this partnership as follows:</p> <ol style="list-style-type: none"> 1. Facility Space: (County) accepts designation of (name of facility) located at (address of facility) as an Alternate Care Site, in the event the need arises. 2. Use of the Facility: Request to use facility as an Alternate Care Site will occur as soon as possible through the local Emergency Operations Center. Designation and use of (name of facility) will be mutually agreed upon by all parties to this agreement. 3. Modification or Suspension of Normal Facility Business Activities: (name of facility) agrees to alter or suspend normal operations in support of the Alternate Care Site as needed. 4. Use of Facility Resources: (name of facility) agrees to authorize the use of facility equipment such as forklifts, buildings, communications equipment, computers, Internet services, copying equipment, fax machines, etc. Facility resources and associated systems will only be used with facility management authorization and oversight to include appropriate orientation/training as needed. 5. Costs: All reasonable and eligible costs associated with the emergency and the operation of the Alternate Care Site that include modifications or damages to the facility structure, equipment and associated systems directly related to their use in support of the Alternate Care Site facility operations will be submitted for consideration and reimbursement through established disaster assistance programs. 6. Liability: The Emergency Services Act, Government Code 8550 et seq. addresses immunity from liability for services rendered voluntarily in support of emergency operations during an emergency or disaster declared by the Governor. 7. Contact Information: (name of facility) will provide (County) the appropriate facility 24 hour/7 day contact information, and update this information as necessary. 8. Duration of Agreement: The minimum term of this MOU is two years from the date of the initial agreement. Subsequent terms may be longer with the concurrence of all parties. 9. Agreement Review: A review will be initiated by (County) and conducted following a disaster event or within two years after the effective date of this agreement. At that time, this agreement may be negotiated for renewal. Any changes at the facility that could impact the execution of this agreement will be conveyed to the
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identified primary contacts or their designees of this agreement as soon as possible. All significant communications between the Parties shall be made through the primary contacts or their designees.

- 10. Amendments: This agreement may be amended at any time by signature approval of the parties' signatories or their respective designees.
- 11. Termination of Agreement: Any Party may withdraw at any time from this MOU, except as stipulated above, by transmitting a signed statement to that effect to the other Parties. This MOU and the partnership created thereby will be considered terminated thirty (30) days from the date the non-withdrawing Party receives the notice of withdrawal from the withdrawing Party.
- 12. Capacity to Enter into Agreement: The persons executing this MOU on behalf of their respective entities hereby represent and warrant that they have the right, power, legal capacity, and appropriate authority to enter into this MOU on behalf of the entity for which they sign.

Facility Official _____ Date _____

(County) Official _____ Date _____

Public Health Department Official _____ Date _____

Hospital Official _____ Date _____

To authorize facility use, call:

Name

Daytime phone number

After-hours/emergency phone number

To open facility, call:

Name

Daytime phone number

After-hours/emergency phone number

Alternate contact to open facility, call:

Name _____

Daytime phone number _____

After-hours/emergency phone number _____

8.9 Facility Liability Protections

California statute provides liability protection to facility owners for use of their facility during an emergency. The following provisions can be cited to facility owners to address concerns regarding liability:

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

California Civil Code Section 1714.6 further defines that “no person shall be liable for negligence as a matter of law, or prosecuted for violation of any statute or ordinance, where the act or omission involved was required in order to comply with any regulation, directive, or order of the Governor under the California Emergency Services Act. During a declaration of a disaster by the Governor, if an Alternate Care Site is established to mitigate the effects of an emergency, no liability shall fall on the owners of the Alternate Care Site facilities, unless an act of willful omission is committed.”

9. Staffing

A critical aspect of planning for the operation of an Alternate Care Site is the development of a plan for the acquisition and effective use of staff. A catastrophic event will likely limit the number of medical professionals and support staff available to care for patients in an Alternate Care Site since many may already be providing care in healthcare facilities, or may be among the population requiring care after a catastrophic emergency. Therefore, the Alternate Care Site Planning Team must develop plans to quickly identify sources for the acquisition of medical professionals and support staff to provide services at an Alternate Care Site.

The recommended guidelines and operational tools identified in this section can be used by the Alternate Care Site Planning Team to develop plans to ensure appropriate and adequate personnel coverage during a healthcare surge.

9.1 Planning for the Workforce

In order to effectively manage an Alternate Care Site, the Alternate Care Site Planning Team must consider staffing needs for site set-up, site administration, clinical and allied health functions, support functions, and operations of the site command system.

It is recommended that an Alternate Care Site staffing plan be established for the first three-seven days of operation. During this time period, especially if other healthcare facilities are involved, there may be no opportunity to call upon other organizations for assistance or to begin to recruit volunteers to assist, given the time necessary to implement these processes.

The Alternate Care Site Sample Estimated Staffing Levels for Healthcare Surge Scenarios chart below has been adapted from AHRQ Publication No. 06-0029, *“Reopening Shuttered Hospitals to Expand Surge Capacity,”* and provides guidance on staffing levels across the spectrum of staff needed to operate an Alternate Care Site. The chart identifies the number of clinical, supportive, and command staff that will be needed per site or per patient.

The Alternate Care Site Sample Estimated Staffing Levels for Healthcare Surge Scenarios Chart is shown below. The chart can also be found in the Government-Authorized Alternate Care Site Operational Tools Manual on pages 61-66.

Alternate Care Site Sample Estimated Staffing Levels for Healthcare Surge Scenarios

Staff Type	Staff Classification	Scenario: Medical/Surge or Infectious Disease	Discussion
Setup Staff			
	Staffing requirements to be determined by the Alternate Care Site Planning Team		Some areas to consider are cleaning needs, configuration, electrical engineering and laborers
Clinical Staff			
Physician and Physician Extenders	Chief Medical Officer	1	One person responsible for medical care 24 hours per day/ 7 days per week. Physically onsite 8 hours/day, M-F, available off-shift and weekends.
	Internist	3-7 FTEs/ 7AM-7PM 1 FTE/ 7PM-7AM	Each MD, assuming 10-15 minutes per patient, could see 48-72 patients over 12 hours (7A-7P) plus at least one person for night coverage (7P-7A).
	Radiologist	As needed	Adjust according to patient acuity. May be an increased need with an infectious disease population.
	Infectious Disease Specialist	As needed	Likely needed only for infectious disease population.
	Nurse Practitioner/ Physician Asst	As needed to supplement internists or nurses	Must work under the supervision of an MD, could supplement internist coverage if adequate number of physicians not available or supplement nursing coverage (supervisor or RN).
Nursing	Nursing Director	1 RN	One person responsible for nursing care 24 hours per day/7 days per week. Physically onsite 8 hours/day, M-F, available off-shift and weekends.
	Supervisor	1 RN per shift	Prefer RN supervisor, but if none available, an experienced LVN would suffice.

Staff Type	Staff Classification	Scenario: Medical/Surge or Infectious Disease	Discussion
	RN	1:5-1:15 RN to patient ratios	Could go as high as 1:40 with adequate LVN, nurse aide and ancillary staff coverage, but highly dependent on patient acuity. Precaution procedures in an infectious disease scenario would require increased staffing levels to accommodate the additional time needed for gowning, disposal of medical waste, etc.
	LVN	1:5-1:15 RN to patient ratios	Could go as high as 1:40 with adequate LVN, nurse aide and ancillary staff coverage, but highly dependent on patient acuity. Precaution procedures in an infectious disease scenario would require increased staffing levels to accommodate the additional time needed for gowning, disposal of medical waste, etc.
	Nurse Aide	1:6 (day shift) 1:8 (eve shift) 1:15 (night shift) NA to patient ratios	Adjust nurses up or down according to licensed nurse coverage and ancillary staff support. Precaution procedures in an infectious disease scenario would require increased staffing levels to accommodate the additional time needed for gowning, disposal of medical waste, etc.
Allied Health	Dietitian	1 FTE RD	Dependent on the level of supervision needed in Dietary Department, number of admissions and discharges, level of patient acuity.
	Discharge Planner	2-4 FTEs (M-F normal business hours) Discharge planners or social workers	Adjust as needed according to number of admissions and discharges. Assumed one SW per two units (80 beds).
	EKG Technician	1 FTE to cover 7AM-3PM, M-F	If no EKG tech available, EKGs may be done by nurses, NP/PAs, physicians, EMTs. Interpretation done by physician or interpretive software program if available.

Staff Type	Staff Classification	Scenario: Medical/Surge or Infectious Disease	Discussion
	Laboratory Technician	2.1 FTEs (7AM-7PM, 7 days/ week) One person to run basic hematology, chemistry, urinalysis, bacteriology tests. Assume no blood bank, no type and x-match needed.	Adjust up according to the number of specimens processed. May not be needed if specimens are sent out. Nursing able to perform certain screens (e.g., dipstick urine, hemocult) on the unit.
	Medical Records	1 FTE	Adjust up according to the number of admissions and discharges.
	Mental Health Worker/ Social Worker	2-4 FTEs (M-F, 8AM-4PM)	Adjust up according to patient, family and staff needs. Assumed one social worker per two units (80 beds).
	Pharmacist	2.1 FTEs RPh (7AM-7PM, 7 days/week)	Adjust up according to patient needs. If drugs were supplied from another location, would not be needed.
	Pharmacy Technician	1-2 FTEs Certified Pharmacy Technicians	Adjust up according to patient needs. Must be supervised by pharmacist.
	Phlebotomist	1 FTE able to perform venipuncture 7AM-3PM, M-F	If not available, some nurses, NP/PAs, physicians and EMTs would be able to draw blood.
	Respiratory Therapist	1 FTE RT needed primarily to set up, monitor and troubleshoot problems with ventilators	Adjust according to patient needs. Nurses/physicians/ NP/PAs, and EMTs are able to assess lung sounds, provide chest physical therapy.
	X-Ray Technician	1 FTE	May not be needed on a daily basis, but requires specialized skills. It's likely that coverage would not be available from other staff types.

Staff Type	Staff Classification	Scenario: Medical/Surge or Infectious Disease	Discussion
Support Staff			
All Other Types of Staff	Administrative Support	3-6 FTEs (8AM-4PM, M-F)	Includes payroll (1 person), billing (1 person) and 1-4 people to assist with unit clerk-level work.
	Biomedical Engineering	1 FTE 7AM-3PM, M-F and on-call	As needed to deal with problems associated with medical monitoring equipment.
	Central Supply/ Materials Management	2-4 FTEs 1-2 people covering 7AM-7PM, 7 days/week	To oversee ordering, distribution of supplies. Adjust up as needed based on acuity of patients.
	Food Service Supervisor	1 FTE (M-F, 8AM-4PM)	To oversee the dietary department, order food and supplies, schedule dietary staff.
	Cook	2-4 per meal	Food Service Supervisor may also act as cook.
	Food Service Workers	4-6 per meal	Increased staff needed at peak meal times.
	Housekeeping	5-9 people 7AM-7PM 1-2 people 7PM-7AM	Assuming one person per unit (40 beds) plus one person for common areas, trash from 7AM-7PM. 1-2 people 7PM-7AM.
	Human Resources	1 FTE (M-F, 8AM-4PM)	Assist with staff support/ dependent care. May need to recruit dependent care staff/volunteers to cover all shifts as needed.
	Laundry	2-4 FTEs 1-2 people covering 7AM-7PM, 7 days/week	Adjust depending on equipment available and acuity of patients assuming three complete bed changes per day.
	Maintenance	3-4 FTEs (1-3 people, 8AM-4PM, 7 days per week)	May assist with housekeeping, safety and security as needed.
	Morgue Worker	1 FTE	As needed.
	Safety Manager	1 FTE	May have maintenance responsibilities also.
Security	8-12 FTEs (1-3 people per shift, 7 days per week, 24 hours per day)	Adjust according to scenario, number of entrances, facility location.	

Staff Type	Classification	Scenario: Medical/Surge or Infectious Disease	Discussion
	Transport	1.5-3 FTEs (1-2 people covering M-F, 7AM-7PM)	Adjust according to staff availability. All staff capable of transport.
	Volunteers	As available	Assist with transport, delivery of supplies and meals, administrative/clerical functions, dependent care, etc.
	Volunteers	As available	Assist with transport, delivery of supplies and meals, administrative/clerical functions, dependent care, etc.
Command Staff			
Command	1 FTE required for each activated position; 6 FTEs identified in a call down list for each position	1 FTE required for each activated position; 6 FTEs identified in a call down list for each position	This includes the command functions such as Alternate Care Site Director, Logistics Section Chief, Planning Section Chief, Operations Section Chief, Finance/Administration Section Chief. The number of FTEs ensures adequate coverage for multiple shifts.

9.2 Set-up Staff

The Alternate Care Site Planning Team should first determine how many staff will be necessary to set-up the Alternate Care Site. Many factors should also be considered such as where the supplies and equipment are stored, the condition of the buildings that will be used as Alternate Care Sites, cleaning needs, configuration of set-up, electrical needs, engineering needs and the need for set-up of tents.

During planning, one key decision will be how an Alternate Care Site will be set-up. The Alternate Care Site Planning Team should consider assessing areas within local government that have limited or no response role during an emergency or private entities that could be on-call to provide staff that have the capacity for setup of Alternate Care Sites. Considerations should be given to the Red Cross, Boy Scouts, and large businesses such as department stores.

The Alternate Care Site Planning Team should consider additional options such as a housecleaning service for initial cleaning the site or an engineering company to assist in configuring the site. Local government should develop memoranda of understanding/contracts with these resources to describe the conditions and expectations for the scope of work to be performed during set-up. The designated site set-up staffing resources should participate in training and exercises to test the process.

9.3 Clinical Staff

Identification of who will provide clinical care in an Alternate Care Site is a critical decision. During a healthcare surge, clinical staff will be limited as many will be providing care at other healthcare facilities or may require care themselves. It is likely that clinical staff at an Alternate Care Site may be arranged from the public or private sector. The Alternate Care Site Planning Team should consider using non-practicing licensed healthcare professionals, exploring the use of registries for acquiring medical staff, examining local government resources and establishing relationships with existing hospitals, clinics, private physician offices, and medical schools for the recruitment of an Alternate Care Site clinical workforce.

A potential source for the acquisition of clinical staff is through the California Medical Volunteers. The Emergency Medical Services Authority developed the California Medical Volunteers (California's Emergency System for the Advanced Registration of Volunteer Health Professionals [ESAR-VHP]) which is an electronic registry for licensed nurses, physicians, and paramedics to register for emergency or disaster service. The Alternate Care Site Planning Team may use the system to identify available local clinical resources and document contact information for each resource for use at the time of Alternate Care Site activation.

It is difficult to determine how many clinical staff will be necessary to provide care in an Alternate Care Site. The level of care delivered will be highly dependent on the availability of staff and healthcare resources. Based on the staffing level guidance detailed in Section 9.1: Planning for the Workforce, the Alternate Care Site Planning Team may use the following staffing suggestions for a 50 inpatient site:

Function	Suggested Clinical Staff per Shift
Chief Medical Officer/Physician	1-2
Nurses (Nursing Director, Registered Nurses, Licensed Vocational Nurses, Nurses Aide)	3-5
Dietician	1
EKG Technician	1
Laboratory Technician	1
Mental Health Worker/Social Worker	1-2
Pharmacist	1
Phlebotomist	1
Respiratory Therapist	1

Staffing plans should remain flexible in order to cover all necessary clinical roles. The Alternate Care Site Planning Team should consider the best use of clinical staff supplementing with support staff and family members. For example, expanding the role of a Licensed Vocational Nurse or having family members monitor patient vital signs subsequent to just-in-time training would extend the use of limited staff. In addition, specific scenario driven patient needs will impact staffing needs. For example, during a pandemic influenza, additional respiratory therapists or staff trained in this function will be needed.

Even with local planning, staffing an Alternate Care Site may require staffing resources beyond local availability. If additional staffing resources are needed they must be requested through SEMS/NIMS. Requests for additional staff should be made from the Alternate Care Site Command to the Unified Command. Staffing requests should be specific to ensure that resource needs are met. For example, when requesting a Registered Nurse, the Alternate Care Site Command should identify specific skill sets needed. If a catastrophic event results in a scarcity of resources, resource requests will be prioritized by policymakers within the SEMS/NIMS structure and some resource requests may remain unfilled. See SEMS overview in Foundational Knowledge, Section 3.9: Standardized Emergency Management System for additional information.

Staffing resources that can be accessed through SEMS/NIMS are regional, state, and federal assets such as Medical Reserve Corps, Community Emergency Response Teams, Disaster Medical Assistance Teams/ California Medical Assistance Teams, Ambulance Strike Teams, and Mission Support Teams. In addition, a statewide emergency volunteer recruitment plan will be implemented over the next 12-18 months.

The following information provides Alternate Care Site Planning Teams and other appropriate facility representatives with a list of available resources to investigate as potential sources for augmented staffing and develop Memorandum of Understanding or Memorandum of Agreement as deemed necessary.

The List of Potential Staffing Sources during Healthcare Surge is shown below. The list can also be found in the Government-Authorized Alternate Care Site Operational Tools Manual on pages 100-103.

Organization Brief Background & History	Additional Information May Be Found at:
<p>American Red Cross (ARC)</p> <p>The mission of American Red Cross Disaster Services is to ensure nationwide disaster planning, preparedness, community disaster 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>The most visible and well-known of Red Cross disaster relief activities are sheltering and feeding.</p>	<p>http://www.redcross.org</p> <p>Information is available for both the national chapter as well as links to local chapters.</p>
<p>California Medical Assistance Team (CaIMAT)</p> <p>Three 120-person California Medical Assistance Teams (CaIMATs) have been created under State control to respond to catastrophic disasters. Each CaIMAT consists of volunteers drawn from the private, not-for-profit and existing State and local government healthcare delivery sector.</p>	<p>http://www.emsa.ca.gov/def_comm/viii092706_d.asp</p>

Organization Brief Background & History	Additional Information May Be Found at:
<p>The CalMATs will maintain caches that contain medical supplies, medical equipment, tents, pharmaceuticals and interoperable (compatible) communications.</p> <p>The CalMAT program will be supported on-site by an EMS Authority-led Mission Support Team (MST) for administrative direction and logistical direction and re-supply.</p>	
<p>Community Emergency Response Teams (CERT)/Neighborhood Emergency Response Teams (NERT)</p> <p>The Community Emergency Response Team (CERT) 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, CERT members can assist others in their neighborhood or workplace following an event when professional responders are not immediately available to help. CERT 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 CERT concept was developed and implemented by the Los Angeles Fire Department (LAFD) 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 LAFD created the Disaster Preparedness Division to train citizens and private and government employees.</p>	<p>http://www.citizencorps.gov/cert</p> <p>Information is available for the local chapter as well as links to the national chapter.</p>
<p>Disaster Medical Assistance Team (DMAT)</p> <p>DMAT is a group of professional and para-professional medical personnel (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 (MOA) with the U.S. Department of Health and Human Services.</p> <p>DMATs 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. DMATs 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.</p> <p>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. DMATs 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.</p> <p>Under the rare circumstance that disaster individuals are evacuated to a different locale to receive definitive medical care, DMATs may be activated to support patient reception and disposition of patients to hospitals. DMATs are principally a community resource available to support local, regional and State requirements. However, as a national resource they can be federalized.</p>	<p>http://www.ndms.dhhs.gov/teams/dmat.html</p> <p>California DMAT http://www.emsa.ca.gov/Dms2/dmatinfo.asp</p>

Organization Brief Background & History	Additional Information May Be Found at:
<p>Disaster Service Worker (DSW)</p> <p>Disaster service worker includes 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 Medical Volunteers (formerly ESAR-VHP)</p> <p>California Medical Volunteers is an electronic database of healthcare personnel who volunteer to provide aid in an emergency. The California Medical Volunteer system: (1) registers health volunteers, (2) applies emergency credentialing standards to registered volunteers, and (3) allows for the verification of the identity, credentials and qualifications of registered volunteers in an emergency.</p>	<p>http://www.hrsa.gov/esarvhp/guidelines/default.htm</p> <p>California Medical Volunteer https://medicalvolunteer.ca.gov/ (currently serves as a volunteer registration site)</p>
<p>Los Angeles County Emergency System for the Advance Registration of Volunteer Health Professionals (ESAR VHP)</p> <p>Medical professionals that pre-register and are accepted as Los Angeles County ESAR VHP volunteers 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 that wish to be on the Hospital Surge Capacity Team or the Alternate Care Site Team will have their information forwarded to CheckPoint Credentials Management for further credentialing.</p> <p>All other medical and mental health professionals do not require additional credentialing.</p> <p>As required by the national ESAR VHP program, all potential volunteers are screened using the Federal Exclusion List.</p>	<p>Los Angeles ESAR-VHP http://www.vcla.net/esar</p>
<p>Medical Reserve Corps (MRC)</p> <p>The Medical Reserve Corps (MRC) 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 MRC 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 for ongoing efforts in public health.</p> <p>There is no “typical” MRC unit. Each unit organizes in response to their area’s specific needs. At the local level, each MRC unit is led by an MRC 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>

9.3.1 Special Considerations for Pharmacists

The California State Board of Pharmacy Waiver

In response to the potential of a healthcare surge, the California State Board of Pharmacy issued a Disaster Response Policy Statement in January 2007 to ensure proper preparation and an effective response to a local, State or national disaster. The purpose of the policy statement and potential waivers as part of Business and Professions Code Section 4062 (b) is to encourage pharmacists to take all possible actions to do the most good for the greatest number of people.

In the event of a declared disaster or emergency, the board expects to use its authority under the Business and Professions Code, including Sections 4005(b) and 4062, to encourage and permit emergency provision of care to affected patients and areas, including waiver of requirements that may be implausible to meet during surge events. This policy takes into account what would otherwise be normal operating procedures that may not be able to be performed during a healthcare surge, such as record-keeping 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.⁹

The board expects licensees to use their judgment and training to provide medication in the best interest of the patients, with circumstances on the ground dictating the extent to which regulatory requirements can be met in affected areas. The board also expects that the highest standard of care possible will be provided, and once the emergency has dissipated, its licensees will return to practices conforming to State and federal requirements.¹⁰

How the Waiver is Communicated

In the event the waiver is activated, the California State Board of Pharmacy would communicate this information to the Office of Emergency Services to be widely distributed. Information would also be posted on their website at www.pharmacy.ca.gov and communicated via phone at (916) 574-7900.

California State Board of Pharmacy Disaster Response Policy Statement

Below is a copy of the California State Board of Pharmacy Disaster Response Policy Statement. It describes the purpose of the California State Board of Pharmacy waiver and how it will be used in the event of a healthcare surge.

California State Board of Pharmacy Disaster Response Policy Statement

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 CDPH 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 www.medicalvolunteer.ca.gov (California) and 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) thereof, 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 national 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 expanded 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 (Government Code Sections 8550-8668) and the California Disaster Assistance Act (Government Code Sections 8680-8690.7), among others. Section 8571 of the 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. 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, Subdivision (b) thereof, 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, Sections 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, Sections 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.

Distribution and/or Dispensing of Pharmaceuticals by Nonlicensed Pharmacists

During a healthcare surge, there is a possibility that there may not be a licensed pharmacist on-site to dispense pharmaceuticals or oversee the process from a liability perspective. 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 Section 4040 of a prescriber unless he or she is a pharmacist under this chapter.”¹¹ Situations when a pharmacist may authorize the initiation of a prescription to non-licensed pharmacists/healthcare providers other than a pharmacist are when:

1. The pharmacist has access to prescription, patient profile, or other relevant medical information for purposes of patient and clinical consultation and advice.
2. Access to the information is secure from unauthorized access and use.

The California State Board of Pharmacy may therefore waive application of any provisions of this chapter or the regulations adopted if, in the Board of Pharmacy's opinion, the 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 Business and Professions Code Sections 4005(b) and 4062.

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

With the possibility for limited pharmacy staff in a catastrophic emergency, many volunteers may present to an Alternate Care Site to assist in providing services that a pharmacist, intern pharmacist and/or pharmacy technician would provide under normal operating procedures. To effectively utilize volunteers it is essential to prepare for this situation and understand any potential liability that may exist.

The California State Board of Pharmacy encourages persons outside of California to assist California residents. In the event of a declared disaster or emergency, the board expects to use its powers under the Business and Professions Code, including Sections 900, 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.¹²

Furnishing Medications without a Prescription

During a healthcare surge, there may be limited time or access to a physician to receive a prescription. Therefore, 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.¹³ This section 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. The pharmacist shall communicate this information to the patient's attending physician as soon as possible.

9.3.2 Credentialing and Personnel Verification for Clinical Staff

Local government has an obligation to verify credentials and to ensure competency through oversight of the healthcare professionals and care delivered in an Alternate Care Site.

Alternate Care Sites, by their very definition — a location that is not currently providing healthcare services and will be temporarily converted to enable the provision of healthcare services to support, at a minimum, inpatient and outpatient care required during a healthcare surge — are not subject to Joint Commission standards nor are they equipped to conduct credentialing and personnel verification procedures. However, it is recommended that a streamlined process be developed and conducted in order to verify healthcare professionals' competency.

The Joint Commission Comprehensive Accreditation Manual for Hospitals (2007) defines “credentialing” as the process of obtaining, verifying and assessing the qualifications of a healthcare professional to provide patient care services in or for a healthcare provider. It is recommended that the Alternate Care Site Planning Team adopt a streamlined process for completing the credentialing and personnel verification processes.

The following table provides Alternate Care Sites with a template for verifying health professional credentials.

The Alternate Care Site Credentialing Matrix Log for Licensed Healthcare Professionals is shown below. The matrix can also be found in the Government-Authorized Alternate Care Site Operational Tools Manual on pages 15-16.

Alternate Care Site Credentialing Matrix Log for Licensed Healthcare Professionals

Instructions for Use

For each licensed health professional who presents at an Alternate Care Site, the Alternate Care Site will intake the following information:

- Health professional’s full name
- Government-issued identification (driver's license/passport)
- Current picture healthcare facility identification card that clearly identifies professional designation
- Current license and/or certification to work
 - Identification/documentation indicating that the individual is a member of the California Medical Assistance Team, a Disaster Medical Assistance Team or Medical Reserve Corps, California Medical Volunteers or other recognized State or federal organization or groups
 - Identification by an employee of a current healthcare facility with personal knowledge regarding the volunteer’s ability to act as a licensed healthcare professional during a disaster (if applicable)

Once the health professional’s identity and ability to practice has been verified, the volunteer will list their skill sets in the column labeled “Declared Competencies.” This information will be used to determine where to assign the healthcare professional.

Alternate Care Site Credentialing Matrix Log for Licensed Healthcare Professionals						
Individual Name	Proposed Minimum Identification Requirements during Surge (Select all applicable)					Declared Competencies
	Govt-Issued Photo ID (Required)	Hospital ID	Current License & Picture	Volunteer (e.g., CalMAT, DMAT) ID	Other - specify	

9.3.3 Use of Out-of-State or Inactive Credentials

In some instances, state statute automatically facilitates the use of healthcare professionals with out-of-state or inactive credentials:

- 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 professional.
- 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 a disaster without the administrative delay required to verify qualifications of the healthcare professional.
- Business & Professions Code Section 921, as part of the Healthcare Professional Disaster Response Act, permits the use of providers with lapsed or inactive licenses in disaster areas where shortage exists. However, the administrative requirements of this statute may be prohibitive if time is of the essence.

9.4 Support Staff

Much like a hospital, the operation of an Alternate Care Site involves a number of support staff, in addition to licensed healthcare professionals, to carry out various functions within the Alternate Care Site. Staffing considerations will need to include functions such as administration, food service, child care, laundry, traffic control, security, engineering, pastoral care, housekeeping, transport services and maintenance. The Alternate Care Site Planning Team should identify which functions can be performed by local government, community based organizations, volunteer staff, and/or private contractors.

In regard to the provision of child care and dependent care (adults requiring supervision or support), it is recommended that an Alternate Care Site identify staff members who can provide child care and dependent care as needed during a healthcare surge. In addition, it may be beneficial to establish contracts with outside agencies or vendors who will be responsible for providing qualified and licensed professionals for child and 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.

Even with local planning, staffing an Alternate Care Site may require resources beyond local availability. Additional staffing must be requested through SEMS/NIMS, from the Alternate Care Site Command to the Unified Command in the jurisdiction. Staffing requests should be

as specific as possible to ensure resource needs are met. For example, when requesting an engineer, the Alternate Care Site Command should identify the tasks to be accomplished. During catastrophic events resulting in scarcity of resources, resource requests will be prioritized by policymakers within the SEMS structure and some requests will remain unfilled. See SEMS/NIMS overview in Foundational Knowledge, Section 3.9: Standardized Emergency Management System.

To effectively utilize support staff at an Alternate Care Site it will be important to identify the volunteers presenting at an Alternate Care Site and also to identify the skill set of volunteers. This will allow for proper assignment of support staff to the appropriate area of the Alternate Care Site where their skills will best be utilized. The Alternate Care Site Volunteer Application Form shown below can be used for registering all support staff volunteers and will serve as a tool to identify skills of volunteer staff, verify identification of volunteers, and capture needed professional information to facilitate effective use of staff.

The Alternate Care Site Volunteer Application for Support Staff is shown below. The tool can also be found in the Government-Authorized Alternate Care Site Operational Tools Manual on pages 94-96.

ALTERNATE CARE SITE VOLUNTEER APPLICATION (Support Staff)		
APPLICATION DATE: / /	DATE YOU CAN START: / /	
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:		
Current Address: Street: City: State: Zip:	Previous Address: Street: City: State: Zip:	
Phone number: ()	Pager/ Cell Phone: ()	
Are you 18 years or older? <input type="checkbox"/> No <input type="checkbox"/> Yes	Social Security number:	
Birth Date (mm/dd/yyyy):	Birth Place (City, State):	
NEXT OF KIN & EMERGENCY CONTACT		
Give name, telephone number and relationship of two individuals who we may contact in the event of an emergency.		
Name	Telephone Number	Relationship
1.	()	
2.	()	
3.	()	
DEPENDENTS		
List any dependents for which you are responsible.		
Name	Place of Residence/ Telephone Number	Relationship
1.		
2.		
3.		
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 Medical Volunteers <input type="checkbox"/> Medical Reserve Corps (MRC) <input type="checkbox"/> California Medical Assistance Team (CalMAT) <input type="checkbox"/> Disaster Medical Assistance Team (DMAT) <input type="checkbox"/> Other. Specify _____ Check the areas in which you are experienced and can provide services. <input type="checkbox"/> Ability to supervise children <input type="checkbox"/> Administrative/ clerical duties <input type="checkbox"/> Computer skills <input type="checkbox"/> Facilities management (e.g., electrician, plumbing, maintenance) <input type="checkbox"/> First aid (e.g., wound care) <input type="checkbox"/> Other – specify _____		

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

Do you speak, write, and/or read 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

Initial	
	I agree that the information I provide and the representations I make will be truthful, complete, accurate, and free of any attempt to mislead.
	I acknowledge that by completing this form 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.
	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.
	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 ALTERNATE CARE SITE ADMINISTRATION SECTION CHIEF OR DESIGNEE - PERSONNEL VERIFICATION

Proper identification was verified and copied.

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

To be completed by administrator or his/her authorized designee.

I authorize this individual to volunteer.

Signature of administrator:

Date: / /

9.5 Alternate Care Site Command Staff

As previously mentioned, an Alternate Care Site will need to establish a modified Incident Command System structure to accomplish patient care objectives within the Alternate Care Site and connect to the Operational Area Unified Command System to obtain resources. This Command structure will facilitate the integration of healthcare professionals into a single consolidated incident action plan that will result in optimum patient care at the Alternate Care Site. During planning for the establishment of an Alternate Care Site, it is important to identify the appropriate individuals who fill the roles to manage the Alternate Care Site Command.

The Alternate Care Site Planning Team should consider the best options for staffing the Alternate Care Site Command with local government staff who are familiar with the Unified Command System and the likely response partners. In planning for staffing the Command functions, the Alternate Care Site Planning Team should consider filling these positions six-deep to ensure coverage for long-term events. Staff should participate in training, drills and exercises to test plans and procedures.

In order to accomplish patient care objectives within the Alternate Care Site and connect to the Unified Command System to obtain resources, the following Command System functions within the Alternate Care Site should be filled:

Command: The Command retains overall responsibility for effective performance of the Alternate Care Site as well as the oversight of the management sections (listed below) and for the performance of the Command/Management Staff activities. The incident command includes the Health and Safety Officer, the Public Information Officer, and the Liaison Officer. The Section Chiefs have primary responsibility for the following sections:

Operations Section: The Operations Section is responsible for managing the tactical operations that achieve the incident objectives which focus on reduction of the immediate hazard, saving lives and property, establishing situational control, and restoration of normal operations. Actions under this section are guided by the Operations Section Chief through directed strategies, specific tactics, resource assignments, and direct supervision for each operational period. The Operations Section may be organizationally sub-divided through the use of branches, with divisions for geographic organization or groups for functional organization.

Logistics Section: According to the National Incident Management System 14, “the Logistics Section is responsible for all support requirements needed to facilitate effective and efficient incident management, including ordering resources from off-site locations. It also provides facilities, transportation, supplies, equipment maintenance and fuel, food services, communications and information technology support, and emergency responder medical services.” The Logistics Section may be sub-divided into branches, usually a Support Branch and a Services Branch to maintain effective span of control.

Planning Section: The National Incident Management System states, “the Planning Section collects, evaluates, and disseminates incident situation information and intelligence to the Alternate Care Site Command or Unified Command and incident management personnel; prepares status reports; displays situation information; maintains status of resources assigned to the incident; and develops and documents the Incident Action Plan based on guidance from the Alternate Care Site Command or Unified Command.” An important responsibility of this section is processing incident information.

Administration/Finance Section: The Administration/Finance Section supports management and operations by addressing specific needs for financial, reimbursement (individual and agency or department), and/or administrative services to support incident management activities.

9.6 Maintaining Personnel

This section addresses the standards and guidelines for the necessary precautions to safeguard the health and safety of the workforce, provide support services such as dependent care and ensure workforce resiliency. Specific guidelines regarding these three areas are outlined along with recommended tools and templates to facilitate effective planning.

9.6.1 Workforce Health and Safety and Workers Rights

Health and safety is an integral part of any disaster and preparedness planning. Although Alternate Care Sites are not a “traditional” workplace or employer, Alternate Care Site should maintain the general duty of employers to safeguard the health and safety of its workforce.

A key component of planning for a response to healthcare surge is considerations that local government must make to ensure the health and safety of an Alternate Care Site workforce. This includes compliance with occupational safety and health requirements set forth in federal and State statutes and regulations, including the California Labor Code, California Occupational Safety and Health Administration and federal Occupational Safety and Health Administration regulations. Together, these bodies of law dictate the overarching primary obligation of employers (including hospitals) to provide for the health and safety of their employees. This concept is especially crucial during a healthcare surge.

One of the methods by which an Alternate Care Site can protect the health and safety of its workforce is in the provision of personal protective equipment. Under Labor Code 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.

Another workforce health and safety issue that may arise during a healthcare surge, such as a pandemic influenza, is the vaccination of employees and volunteers. Health and Safety Code 1288.5 et seq. establishes the Hospital Infectious Disease Control Program which requires that CDPH, healthcare facilities and general acute care facilities implement various measures relating to disease surveillance and the prevention of healthcare associated infection. For example, this law requires healthcare facilities provide influenza vaccinations free of charge to all employees. This is not a mandated vaccination and employees and volunteers may decline to be vaccinated. In an emergency, if vaccinations are available, healthcare facilities may require it for direct patient care and reassign those who refuse vaccination.

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.

During a locally declared emergency, it is likely that the California Occupational Safety and Health Administration will work with the Safety Officer in the Regional or Operational Area Emergency Operation Center to assist with achieving compliance with occupational safety standards and regulations.

In conjunction with their obligation to safeguard the health and safety of their workforce, employers have responsibility to honor employees' rights. A healthcare surge would affect the way in which employers (in this case healthcare facilities or public health) would be able to address workers' rights, for example requiring staff and administrators to remain at a facility or report to work (after leave) during a disaster. Planners should consider contract provisions of public employees and develop policies for staff hours, requirements to report to work, and other staff issues. Planners may also want to consider California Industrial Welfare Commission Order Number 4-2001, 3(B)(9)-(10) which outlines the number of hours and conditions under which professional, technical, clerical, mechanical, and similar occupations can be required to work.

To address employers' ability to have employees' return to work from a disability leave during a disaster, 8 CCR 9776.1 discusses employers' general requirement of a return-to-work release with limitations and/or accommodations before returning an employee to work. This 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 would allow facilities to potentially return certain staff members to work in an expedited manner, thereby increasing the workforce pool.

The Alternate Care Site Planning Team should develop an employee health and safety checklist, which should be incorporated in the operational plans of an Alternate Care Site.

9.6.2 Support Provisions for Staff

Unlike hospitals and other types of healthcare facilities, Alternate Care Sites are not held to Joint Commission standards. However, Joint Commission requirements offer planning guidance to the Alternate Care Site Planning Team, outlining the support services that should be provided for staff to ensure that staff remain available and are able to focus on patient care.

Support provisions under Joint Commission standards include:

- Activities related to care, treatment, and services (e.g., scheduling, modifying, or discontinuing services; controlling information about patients; referrals; transporting patients)
- Staff support activities (e.g., housing, transportation, incident stress debriefing)
- Staff family support activities
- Logistics relating to critical supplies (e.g., pharmaceuticals, supplies, food, linen, water)
- Security (e.g., access, crowd control, traffic control)

It is recommended that the Alternate Care Site Planning Team consider developing a staff support provision plan that includes critical stress management and workforce health and safety. It is also recommended that the Alternate Care Site Planning Team develop and implement a dependent care policy. The following tools are provided to assist in the development and planning for staff support provisions: a list of support considerations, a sample workforce resiliency policy, a sample policy for provision of dependent care, and a sample tracking form for dependent care.

The Alternate Care Site Considerations for Staff Support Provisions is shown below. The list can also be found in the Government-Authorized Alternate Care Site Operational Tools Manual on pages 12-14.

Purpose: The following information is intended as a starting point for the Alternate Care Site Planning Team in outlining necessary policies and provisions to support staff during a healthcare surge.

Staff Support Considerations

The following are issues that the Alternate Care Site Planning Team should consider for its staffing plans and strategies:

1. Some staff will not be able to report to work because they or their loved ones may have been directly involved in the incident.
2. Some staff will refuse to report to work because of concerns about their own and their family members' safety and health. In the case of a biological incident, they may have fear of contracting the disease or bringing the disease home.
3. Many staff will have concerns about childcare. The normal childcare provider may not be able to provide these services in an incident. These same concerns apply to staff who may be caring for their parents or others. There should be options available for childcare/eldercare so that staff is free to report to work.
4. Some staff may have concerns about the shelter and care of their pets. Consideration should be made for pet care during healthcare surge. Designated kennel or housing provisions should be considered for Alternate Care Site staff members.
5. The Alternate Care Site should consider the provision of rooms for staff for rest and sleep and personal hygiene needs (blankets, pillows, sheets, showers, towels, soap, shampoo, etc.). In the case of a biological incident, there may be implementation of work quarantine in addition to staff working longer shifts or not being able to go home. The Alternate Care Site may also want to consider what is available in local hotels, churches and other such organizations for sleeping accommodations and showers.
6. The Alternate Care Site should consider areas for staff to eat and have refreshments.
7. Staff may be away from home for extended shifts and need to communicate with family members and other loved ones. The Alternate Care Site should consider the availability of telephones to call home and computer access for e-mail.
8. For staff working extended shifts or not able to go home, there may be the need for laundry services or the provision of scrubs. Staff members should also consider having an "emergency kit" with personal items such as underwear, socks, toiletries, a supply of medications, etc. readily available.
9. Staff should have a "family plan" so that everyone in the family knows what will need to happen and who is responsible for various duties if a family member who works at the Alternate Care Site needs to work longer shifts or is quarantined at the healthcare facility.
10. The Alternate Care Site should also give consideration for back-up of essential services such as food services, laundry, housekeeping and other services, especially

if these services are out-sourced and the incident affects the ability of the contractor to continue to provide these services and if the surge of patients and visitors overwhelms the capacity of these contractors.

11. The Alternate Care Site should consider a back-up system for notifying staff should the telephone lines be down or the circuits busy.
12. The Alternate Care Site should consider pre-identifying staff persons who will manage and supervise volunteers and in which areas or departments the healthcare facility is likely to use volunteers.
13. Job descriptions should be available for all positions so that staff can receive “just-in-time” training by reading the job descriptions.

Based on these recommendations, the following support provisions should be considered by the Alternate Care Site Planning Team:

- Behavioral/mental healthcare care for staff
- Behavioral/mental healthcare for dependents
- Dependent care (children and adults)
- Meal provisions for 3-7 days
- Water for 3-7 days
- Pet care
- Designated rooms for rest/sleeping
- Designated restrooms
- Personal hygiene provisions (blankets, pillows, sheets, showers, towels, soap, shampoo, etc.)
- Designated eating areas
- E-mail/telephone access to communicate with family
- Clothing or laundry services for staff and dependents
- Emergency kits (personal items such as underwear, socks, toiletries, a supply of medications, etc.), staff store at the place of work
- Family emergency plan

The Alternate Care Site Policy for Workforce Resilience during a Disaster is shown below. The policy can also be found in the Government-Authorized Alternate Care Site Operational Tools Manual on pages 57-60.

Purpose:

This policy offers guidelines for dealing with needs and training to optimize workforce resilience in the event of a disaster. An Alternate Care Site will adopt a modified version of this policy based on the event specific staffing. It is important that the intent of this policy is carried out when staffing an Alternate Care Site in order to provide proper support, protection and training to staff and volunteers. The term “worker” is used to refer to facility personnel during a time of healthcare surge, which could consist of paid employees or volunteers.

Rationale:

The response to a disaster will pose substantial physical, personal, social and emotional challenges to healthcare providers. During an influenza pandemic, however, the occupational stresses experienced by healthcare providers are likely to differ from those faced by workers in the aftermath of other disasters. Globally and nationally, a pandemic might last for more than a year, while disease outbreaks in local communities may last 5 to 10 weeks. Workers and their families will be at personal risk for as long as a disaster continues in their community. Therefore, special planning is needed to help employees maximize personal resilience and professional performance.

Worker Needs

Physical:

- Rest areas for each department are located __ (list departments and areas) __.
- Provisions for showers are _____.
- Food will be served or provided __ (where and how often) __.
- Healthcare in case of illness or injury will be provided __ (where and when) __.
- Transportation to and from work will be provided __ (situation and contact) __.

Additional Considerations for Pandemic Influenza: Describe what will happen if worker too sick to be at work.

Personal:

- Telephones for personal calls are located __ (include rules) __.
- Televisions, radios and internet access for keeping apprised of events are located __ (include rules) __.
- Childcare is provided at _____.
- Care for disabled or elderly family members is provided at _____.
- Pet care is provided at _____.

Additional Considerations for Pandemic Influenza: Guide sheets are provided for workers to deal with sickness in their homes.

Emotional:

- Management will provide all workers with regular updates of status of disaster in community and response activities within the organization. Supervisors will brief workers at least once per shift.
- Managers and supervisors will be alert to recognize worker distress.
- Management will provide a stress control team to help workers deal with stress.
- Chaplain or other appropriate religious services will be offered.

Additional Considerations for Pandemic: Stress control teams will be trained in infection control precautions.

Training

There are four main categories of training to be addressed in preparation for response to a disaster: training for all workers, department-specific training, training for ad hoc counselors and information packets for handout.

1. All employees will receive training in the following:
 - a. Stressors related to pandemic influenza
 - b. Signs of distress
 - c. Traumatic grief
 - d. Psychosocial aspects related to management of mass fatalities
 - e. Stress management and coping strategies
 - f. Strategies for building and sustaining personal resilience
 - g. Behavioral and psychological support resources
 - h. Strategies for helping children and families in times of crisis
 - i. Strategies for working with highly agitated patients
2. Department-specific training will be developed by department managers as appropriate to the type of services provided.
3. If there are not enough behavioral health specialists available for response to staff needs in a disaster, (Affiliate name) will provide basic counseling training to selected individuals to assist in meeting worker emotional needs.
4. (Affiliate name) has developed information packages that will be available for distribution to workers and their families.

Deployed Workers

In the event of a major disaster, especially one that lasts for weeks, workers may be deployed from their normal work site to an Alternate Care Site or even to assist at other locations in the community. Workers may be requested to use transferable skills to do work that are not in their current job descriptions or scopes of practice. For instance, a nurse may be asked to work in the laboratory to assist with drawing blood.

Deployment within the Alternate Care Site

- Pre-deployment, workers 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 they are positioned in so adequate education is provided.
- All deployed workers have a responsibility to advise the 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 should be established to help employees support each other.
- Workers will be trained on self-help activities.

Deployment outside of the Alternate Care Site

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

- (Contact person) will coordinate with the Incident Command System commander to determine how many workers can be spared, and then will send a call for volunteers for deployment.
- Pre-deployment, workers will be briefed on:
 - Status of community or agency which they are going to
 - Work that is expected of them
 - Stress management, coping skills and resilience
 - Self-help activities
 - Approximate time they will be needed

The Alternate Care Site Sample Policy for Dependent Care is shown below. The policy can also be found in the Government-Authorized Alternate Care Site Operational Tools Manual on pages 67-69.

Purpose:

This procedure outlines the process by which an Alternate Care Site can provide shelter and food for staff and volunteer dependents during a disaster or other emergency situation.

Definition:

Dependent care area is located in [Alternate Care Site Facility-Designated Area].

Policy:

In the event of an extended emergency response or civil disturbance where staff will remain at [Alternate Care Site Name] for long periods, dependents, including children, elderly and disabled persons, 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 director, 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 area to remove any unsafe objects and to secure any equipment that could pose a safety hazard.
- C. Staff
 1. Staff and volunteers shall sign in and out when reporting to assist.
 2. Staff shall monitor the area continuously for safety issues and to respond to dependents' needs.
 3. If additional assistance is needed, for example, 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
 1. Post signs indicating “Dependent Care Area – Responsible Adult Must Register Dependent.”
 2. Assign each family a family number.
 3. All dependents shall be assigned a dependent number and shall register using the dependent care registration form. 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 an armband to each dependent upon arrival with name and department number.
 5. Take a picture of each dependent with person responsible for them, and attach to dependent care registration form.
 6. Special sign-in and sign-out procedures shall be provided for minor or incompetent dependents.
 - i. Implement a positive identification system for all children younger than 10 years of age.
 - 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.
- 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 provided to individual dependents, such as medications, psychological services, toileting or dressing.
 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 person.
 2. Check identification, verify name and obtain signature of responsible person picking up dependent.
 3. Retrieve and send all medications and personal items with dependent.
 4. Collect arm-bands.

The Alternate Care Site Sample Tracking Form for Dependent Care is shown below. The form can also be found in the Government-Authorized Alternate Care Site Operational Tools Manual on pages 70-72.

Alternate Care Site 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	
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:			
<u>Dependent Care Staff:</u>			
<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			

Dependent Name		Dependent Number
Date/ Time	Type of Care Given	Notes

9.7 Immunities from Liability for Alternate Care Site Staff

Disaster Service Workers

During a healthcare surge and at the point of Alternate Care Site activation, all clinical, support and Command staff presenting at an Alternate Care Site will be volunteers providing disaster-related services. These volunteers are Disaster Service Workers and afforded qualified immunity protection under the Emergency Services Act. In addition, contractors, if acting as an agent of state or local governmental entities charged with providing or arranging to provide services in an Alternate Care Site shall also be considered Disaster Service Workers by order of the Governor under the Emergency Services Act. (Government Code Section 8656, Government Code Section 8657, and the applicable laws incorporated by reference).

A Disaster Service Worker is defined as:¹⁵

- A Disaster Service Worker is any person registered with a disaster council or the Governor's Office of Emergency Services, or a state agency granted authority to register disaster service workers, for the purpose of engaging in disaster service without pay or other consideration pursuant to the California Emergency Services Act.
- Disaster Service Workers include public employees, and also include any unregistered person impressed 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.
- Public employees are all persons employed by the state or any county, city, city and county, state agency or public district, excluding aliens legally employed.

The State of California provides strong protection for Disaster Service Workers (Emergency Services Act, Government Code Section 8657), by providing qualified immunity from liability for care or other services provided during a disaster. This qualified immunity from liability protects the political subdivision or political entity and the Disaster Service Worker volunteer from any civil litigation resulting in personal injury or property damage, if performing appropriate disaster-related services, duties or functions in good faith, absent a willful act or omission. Immunity from liability does not apply, for example, in cases of willful intent to harm, unreasonable acts beyond the scope of disaster service worker training, or a criminal act if committed. The Emergency Services Act also provides workers' compensation in certain circumstances (e.g., if not otherwise covered).

The Emergency Services Act also provides additional and specific immunity from liability protection for licensed physicians, pharmacists, nurses and dentists acting as volunteers:

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

Volunteers

In addition to the Emergency Services Act, Alternate Care Site volunteer staff members are afforded liability protections under the following provisions of law:

- Volunteer Protection Act of 1997: The federal Volunteer Protection Act of 1997 provides that no volunteer of a nonprofit organization or governmental entity shall be liable for harm caused by an act or omission of the volunteer on behalf of the organization or entity if the volunteer was acting within the scope of the volunteer's responsibilities in the nonprofit organization or governmental entity at the time of the act or omission; if appropriate or required, the volunteer was properly licensed, certified, or authorized by the appropriate authorities for the activities or practice in the State in which the harm occurred, where the activities were or practice was undertaken within the scope of the volunteer's responsibilities in the nonprofit organization or governmental entity; the harm was not caused by willful or criminal misconduct, gross negligence, reckless misconduct, or a conscious, flagrant indifference to the rights or safety of the individual harmed by the volunteer; and the harm was not caused by the volunteer operating a motor vehicle, vessel, aircraft, or other vehicle for which the State requires the operator or the owner of the vehicle, craft, or vessel to a) possess an operator's license; or b) maintain insurance (42 USC Sections 14501 - 14505).
- Government Code Section 8657: Volunteers duly enrolled or registered with the Office of Emergency Services or any disaster council of any political subdivision, or unregistered persons duly impressed into service during a state of war emergency, a state of

emergency, or a local emergency, in carrying out, complying with, or attempting to comply with, any order or regulation issued or promulgated pursuant to the provisions of this chapter or any other local ordinance, or performing any of their authorized functions or duties or training for the performance of their authorized functions or duties, shall have the same degree of responsibility for their actions and enjoy the same immunities as officers and employees of the state and its political subdivisions performing similar work for their respective entities.

Below are additional provisions of law which offer limited liability protections for specific licensed healthcare professionals, including volunteers and others registered as Disaster Service Workers:

- California Civil Code Sections 1714.2 and 1714.21 states that a licensed healthcare professional “if trained in basic cardiopulmonary resuscitation (CPR) by the American Heart Association or the American Red Cross and in good faith renders cardiopulmonary resuscitation at the scene of an emergency is not liable for any civil damages unless grossly negligent.” This code is not applicable to those expecting compensation (e.g., staff/volunteers trained in cardiopulmonary resuscitation who render aid during duty hours). A person is not liable for any civil damages if an automatic external defibrillator (AED) is rendered at the scene of an emergency and the requirements of Health and Safety Code 1797.196 are complied with.
- California Business & Professions Code Section 1627.5 applies to dentists and states that “no person licensed under this chapter [dentists], who in good faith renders emergency care at the scene of an emergency occurring outside the place of that person’s practice, or who, upon the request of another person so licensed, renders emergency care to a person for a complication arising from prior care of another person so licensed, shall be liable for any civil damages as a result of any acts or omissions by that person in rendering the emergency care.”
- California Business & Professions Code Section 2395 applies to physicians and surgeons and states that “no licensee, who in good faith renders emergency care at the scene of an emergency or during a medical disaster, shall be liable for any civil damages as a result of any acts or omissions by such person in rendering the emergency care. ‘The scene of an emergency’ as used in this section shall include, but not be limited to, the emergency rooms of hospitals in the event of a medical disaster. ‘Medical disaster’ means a duly proclaimed state of emergency or local emergency declared pursuant to the California Emergency Services Act (Chapter 7 [commencing with Section 8550] of Division 1 of Title 2 of the Government Code). Acts or omissions exempted from liability pursuant to this section shall include those acts or omissions which occur after the declaration of a medical disaster and those which occurred prior to such declaration but after the commencement of such medical disaster. The immunity granted in this section shall not apply in the event of a willful act or omission.”

- California Business & Professions Code Section 2727.5 applies to nurses and states that “a person licensed under this chapter [nurse] who in good faith renders emergency care at the scene of an emergency which occurs outside both the place and the course of that person’s employment shall not be liable for any civil damages as the result of acts or omissions by that person in rendering the emergency care. This section shall not grant immunity from civil damages when the person is grossly negligent.”
- California Business & Professions Code Section 2861.5 applies to licensed vocational nurses and states that “a person licensed under this chapter [licensed vocational nurse] who in good faith renders emergency care at the scene of an emergency which occurs outside both the place and the course of his employment shall not be liable for any civil damages as the result of acts or omissions in rendering the emergency care. This section shall not be construed to grant immunity from civil damage to any person whose conduct in rendering emergency care is grossly negligent.”
- California Business & Professions Code Section 3503.5 applies to physician’s assistants and states that “a person licensed under this chapter [physician’s assistant] who in good faith renders emergency care at the scene of an emergency that occurs outside both the place and course of that person’s employment shall not be liable for any civil damage as a result of any acts or omissions by that person in rendering the emergency care. This section shall not be construed to grant immunity from civil damages to any person whose conduct in rendering emergency care is grossly negligent. In addition to the immunity specified in subdivision (a), the provisions of Article 17 (commencing with Section 2395) of Chapter 5 shall apply to a person licensed under this chapter when acting pursuant to delegated authority from an approved supervising physician.”

9.8 Governor’s Standby Orders

During a healthcare surge, individuals providing healthcare services in an Alternate Care Site may be unable to fully adhere to statutes, regulations and professional standards of practice relating to patient rights and professional ethics. Under the Emergency Services Act, the Governor may suspend those regulatory requirements perceived to be an obstacle to an effective emergency response effort. The suspension would be implemented through an executive standby order of the Governor.

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. All standby orders 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 the Office of Emergency Services, 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.

Below are two recommendations for standby orders for inclusion in a Governor's Declaration of Emergency to facilitate timely and appropriate regulatory assistance for the operation of an Alternate Care Site during a healthcare surge:

- Clarification of Governmental Agents (Contractors) Providing Services within an Alternate Care Site as Disaster Service Workers
- Expansion of Scope of Practice

The Clarification of Governmental Agents (Contractors) Providing Services within an Alternate Care Site as Disaster Service Workers Standby Order specifically deems contractors working in an Alternate Care Site at the request of the government as Disaster Service Workers. It is intended to provide immunities from liability for volunteers at an Alternate Care Site. The standby order has been drafted as a recommendation for use by the Governor and must be approved by the Governor before effective for use.

Text of Standby Order for Clarification of Governmental Agents (Contractors) Providing Services within an Alternate Care Site as Disaster Service Workers:

In the event a local governmental jurisdiction is required to activate an Alternate Care Site to provide or arrange to provide treatment of disaster related victims when existing facilities are overloaded and cannot accommodate the patient load, all persons providing services at the Alternate Care Site 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.

The following standby order for use by the Governor is intended to address the likely need for increasing the number of paid healthcare professionals 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 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 to the healthcare provider, this order will link the action of the 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 licensed healthcare professionals to the extent possible under current law, the liability protections

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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, and without willful misconduct.
- Patient protection: to protect patients when receiving healthcare from licensed healthcare professionals that are inconsistent with their training, experience or abilities.
- The need to balance local decision making with State authority.

Text of the Standby Order for Expansion of 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 hospital, shall direct healthcare providers under their authority to mitigate the medical needs caused by the emergency. (Note: this standby order will be filled in from a comprehensive list of licensed healthcare workers based on the needs of the emergency).

***Instructions**

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

- Acupuncturists
- Associate Clinical Social Worker
- Audiologists
- Clinical Nurse Specialists
- Licensed Clinical Social Worker
- Licensed Educational Psychologist
- Marriage and Family Therapist
- Marriage and Family Therapist Intern
- Occupational Therapists
- Optometrists
- Osteopaths
- Nurse Practitioners

- Pharmacists
- Pharmacist Interns and Pharmacy Technicians
- Physical Therapists
- Physician Assistants
- Physicians
- Podiatrists
- Psychiatric Technician
- Psychologists
- Registered Dental Assistant
- Registered Dental Assistant in Extended Functions
- Registered Dental Hygienist
- Registered Dental Hygienist in Alternative Practice
- Registered Dental Hygienist in Extended Functions
- Registered Dispensing Opticians
- Registered Nurse Anesthetists
- Registered Nurses
- Registered Veterinary Technicians
- Respiratory Care Practitioners
- Speech-Language Pathologists
- Veterinarians
- Vocational Nurses

10. Supplies, Pharmaceuticals and Equipment

The Alternate Care Site Planning Team should consider that operations of an Alternate Care Site will depend on the availability of limited resources. The Alternate Care Site Planning Team should take an all-hazards approach and plan to be as self-sufficient as possible with respect to supplies, pharmaceuticals and equipment, recognizing that each Alternate Care Site may need to sustain operations for an extended period of time to treat patients.

The disaster scenario and the anticipated surge of patients into the healthcare system care will impact the supplies, pharmaceuticals and equipment which will be needed at an Alternate Care Site. As stated above, activation of Alternate Care Sites will be a last resort. This section assumes that resources stockpiled by existing healthcare facilities will be utilized by the facilities and unavailable for use by the Alternate Care Site. Therefore, in planning resource needs, the Alternate Care Planning Team should estimate the number of patients to be cared for by the Alternate Care Site based on the severity of various events and the anticipated impact to the healthcare delivery system, including supplies, pharmaceuticals and equipment.

10.1 Maximizing Sustainability

Effective planning for sustainability at an Alternate Care Site will help to maximize the use of limited resources. Alternate Care Sites should use the recommendations provided in this section as a guide to determining the types and quantities of supplies, pharmaceuticals, and equipment to acquire prior to and during a catastrophic event and the methods to obtain these resources (e.g., vendor managed inventory, Memorandum of Understanding, local stockpiles). The governmental entity authorizing and managing the Alternate Care Site should plan to have adequate supplies and equipment to be self-sufficient for three-seven days and have pharmaceuticals on hand for at least the first 72 hours. Initially, this may come from pooling existing supply stock from the local community. Maximizing sustainability will require the identification of needed resources for operating an Alternate Care Site, developing a comprehensive inventory of existing resources, determining the resources gaps and developing procurement strategies to acquire needed resources.

In planning for the operation of an Alternate Care Site, the Alternate Care Site Planning Team should consider three categories of resources: pharmaceuticals, supplies and equipment and personal protective equipment for Alternate Care Site staff.

10.1.1 Pharmaceuticals

Determining Pharmaceutical Needs

It is recommended that the Alternate Care Site Planning Team involve key stakeholders in the planning process for pharmaceutical stockpiling and distribution. The goal should be to include healthcare personnel who are familiar with pharmaceutical requirements for patient treatment, the methodology for selection and the acquisition process. Key stakeholder involvement should include the following types of professionals:

- Clinical Pharmacists
- Disaster Coordinators
- Emergency Department Directors
- Emergency Department Physicians
- Respiratory Therapists
- Pulmonologists
- Critical Care Director
- Infectious Disease Physicians
- Poison Control Specialists
- Drug Information Specialists
- Radiologists
- Radiation Safety Officers
- Hospital Administrators
- Pediatric Specialist (Pediatric Critical Care / Emergency Medicine Physicians)
- Vendors and Distributors

The disaster scenario and the anticipated surge of patients into the healthcare system will impact the types of pharmaceuticals needed at an Alternate Care Site. Two types of pharmaceuticals should be considered: general pharmaceuticals that are commonly needed during emergency situations (e.g., saline solution) and pharmaceuticals specific to the type of the event that caused the healthcare surge (e.g., ciprofloxacin for a biological event).

Pharmaceuticals that should be considered for all event types include:

1. Sterile IV solutions (e.g., normal saline)
2. Pain medications
3. Antibiotics
4. Anti-hypertensive
5. Respiratory drugs, including corticosteroids
6. Biologicals, including insulin and vaccines

Event-specific pharmaceuticals include:

1. Antibiotics and antidotes for biological agents

2. Antidotes for chemical agents
3. Antidotes for radiological agents
4. Drugs for treating acute radiation syndrome
5. Vaccines

The Alternate Care Site Planning Team should consider that clinical resources used in everyday patient care may be needed in larger supplies during a healthcare surge. For example, intravenous fluids, such as saline solution, will be in high demand during a healthcare surge. The Planning Team should consider the potential volume of patients who may require intravenous fluids for a 72-hour period. Dehydration may result post-disaster due to diarrhea from a lack of clean drinking water and sanitary facilities and would increase the need for these products. The Planning Team should also consider the potential volume of patients who may require oral hydration during the post-disaster period.

Pharmaceuticals that are specific to the pediatric population must be included in the planning for a healthcare surge. In the specific tool 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/aboutemsa/emsa184.pdf>

The Alternate Care Site Planning Team should consider that pharmaceutical substitutions may be required because of availability (e.g. ciprofloxacin vs. levofloxacin and tobramycin vs. gentamicin).

Although developed for hospital pharmaceutical planning, the following *Alternate Care Site Inventory Based Pharmaceuticals by General Classification List* is a tool that the Alternate Care Site Planning Team can use when determining the pharmaceutical needs for an Alternate Care Site. Using inputs such as doses required and the days of therapy required, the tool can be used to calculate the number of patients to be treated, the doses required and the packages of pharmaceuticals to be stocked. This tool also distinguishes potential pharmaceuticals needed by the following types of events:

- Biological events
- Chemical events
- Radiological events

The Alternate Care Site Inventory Based Pharmaceuticals by General Classifications List is shown below. The list can also be found in the Government-Authorized Alternate Care Site Operational Tools Manual on pages 29-35.

Critical Pharmaceuticals That May Be Needed During a Surge													
Sample Pharmaceutical Suggested During a Surge	Strength	Route of Administration	Package Size	Wholesaler Item #	Average	Potential	Employees	Total	Doses	Days of	Total	#	Alternate
					Daily Census	Surge Patients							
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	20MIU	Injectable											
Rifampin	300mg	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
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											
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											

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
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											
Magnesium Sulfate	N/A	Oral											
Magnesium Oxide	N/A	Oral											
Penicillamine	125mg/ 250 ml	Oral											
Potassium Iodide	130mg	Oral											
Prussian Blue	500mg	Oral											
Sodium Iodide	130mg	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
Trisodium Calcium Diethylenetriamin epentaacetate	1g	Injectable											
Trisodium Zinc Diethylenetriamin epentaacetate	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											
Ondansetron HCL	2mg / ml	Injectable											
Pegfilgrastim	6mg	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
Trimethoprim/ Sulfamethoxazole	160mg / 800mg	Oral											
Trimethoprim/ Sulfamethoxazole	16mg/ml/ 80mg/ml	Injectable											
Vaccines													
Tetanus Toxoid	N/A	Injectable											

After determining the specific pharmaceuticals needed by the Alternate Care Site, the quantity of pharmaceuticals to have available locally for use in the Alternate Care Site needs to be determined. This analysis should incorporate the number of potential patients, the number of employees and family members who will need prophylaxis, and the daily dosage. The Alternate Care Site should plan on having at least 72 hours worth of the identified pharmaceuticals on hand to be able to maintain self-sufficiency before the supply is replenished.

Inventorying Existing Resources

Before procuring resources, the Alternate Care Site Planning Team should determine what resources would be available for use in the Alternate Care Site and document their location in the community.

The following tool provides a mechanism to track purchased pharmaceuticals.

The Alternate Care Site Critical Pharmaceuticals Locations Tracking Tool is shown below. The tool can also be found in the Government-Authorized Alternate Care Site Operational Tools Manual on pages 17-20.

Standards and Guidelines for Healthcare Surge During Emergencies Critical Pharmaceuticals Locations												
Sample Pharmaceuticals Suggested During a Surge	Strength	Route of Administration	Projected Need	Location #1		Location #2		Location #3		Quantity Available in Operational Area		
				Quantity	Physical Location	Contact	Quantity	Physical Location	Contact		Quantity	Physical Location
Antidotes for Biological Agents												
Activated charcoal 50 g slurry	N/A	Oral										
Clofofour	75mg /ml	Injectable										
Ciprofloxacin	400mg	Injectable										
Ciprofloxacin	500mg	Oral										
Clindamycin	600mg	Injectable										
Doxycycline Hydrate	100mg	Injectable										
Doxycycline Hydrate	100mg	Oral										
Gentamicin Sulfate	10mg /ml	Injectable										
Gentamicin Sulfate	40mg /ml	Injectable										
Penicillin GK	20MU	Injectable										
Ritampin	300mg	Oral										
Streptomycin Sulfate	400mg / ml	Injectable										
Antidotes for Chemical Agents												
Amyl Nitrite 0.3 ml. Crushable ampul	N/A	Inhaled										
Atropine Sulfate prefilled syringe	1mg / 10ml	Injectable										
Atropine Sulfate multidosage vial	8mg / 20ml	Injectable										
Calcium Chloride	10mg /10ml	Injectable										
Calcium Gluconate 10%	10mg / 100ml	Injectable										
Diazepam	5mg / ml	Injectable										
Dimenaciprol	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										

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

Inventory Management – Pharmaceuticals

The inventory must be managed to be effective when used. There must be a process to monitor expiration dates and storage dates, as well as a process for rotating stock from a cache into the general inventory to minimize pharmaceuticals that may expire. When receiving pharmaceuticals from stockpiles, caches and other existing healthcare facilities, it is important to verify that the pharmaceuticals are current.

Receiving Pharmaceuticals at Alternate Care Sites

As noted in Business and Professions Code Section 4059.5(a), pharmaceuticals may be ordered by a licensed pharmacy and delivered to the licensed premises, and must be signed for by a pharmacist.¹⁶ The Alternate Care Site Planning Team is encouraged to work with the Board of Pharmacy to approve the identified pharmaceutical storage sites and to discuss licensing of the Alternate Care Sites for receipt of pharmaceuticals prior to an emergency. This would help minimize potential delays in receiving pharmaceuticals at to Alternate Care Sites in the event of a healthcare surge situation.

Off-Label Drug Use

During a catastrophic emergency there is the possibility that the indicated medication for a diagnosis is unavailable. There may be other medications that have demonstrated effectiveness in the initial stages of evaluation and research, but have not yet been granted federal Food and Drug Administration approval for a particular diagnosis. For example, many medications that are federal Food and Drug Administration - approved for antiarrhythmic use are also effective for treating hypertension. Some of the agents that are federal Food and Drug Administration - approved for depression also demonstrate effectiveness in treating pain.

There is no statutory or regulatory prohibition against off-label use of a drug by a physician. Consequently, pharmacists may dispense pharmaceuticals for off-label purposes without being out of compliance.

Out-of-State Pharmaceuticals

Non-resident pharmacies or wholesalers that are not licensed in California but that are licensed in good standing in another state are encouraged to ship medications to pharmacies, health professionals or other wholesalers in California.

10.1.2 Supplies and Equipment

The stockpiling of supplies and medical equipment will be critical for Alternate Care Sites to function during a disaster. Key stakeholders must be included in the planning process, with the goal to involve healthcare personnel familiar with the healthcare supply and equipment needs as well as procurement strategies. The list below gives examples of key stakeholders to include:

- Materials Manager/Procurement
- Disaster Coordinator
- Emergency Department Director
- Respiratory Therapists
- Facilities/Logistics
- Medical-Surge Coordinator
- Critical Care Coordinator
- Pediatric Specialists (Pediatric Critical Care/Emergency Medicine Physicians)
- Vendors and distributors

Alternate Care Site-Specific Tool for Supplies and Equipment Planning

In determining the supplies and equipment needed for each Alternate Care Site, planners should take an all-hazards approach. The following tool provides a list of the supplies and equipment in the State caches maintained by CDPH which were purchased for the operation of Alternate Care Sites. Designed in collaboration with a team of medical experts, each cache is equipped to treat patients impacted by various disaster scenarios. The intent of these caches is to provide support for 50 patients over a period of 10-14 days (actual support may vary based on event).

Careful consideration should be given to which items are stockpiled and the rotation of perishable items. The State cache includes vendor rotation of items, vendor stored and maintained equipment, and State storage of items. To maximize the life-span of the supplies and equipment, storage should be in a temperature controlled environment. Vendor managed inventory should be considered particularly for perishable items.

The Alternate Care Site Supplies and Equipment List is shown below. The list can also be found in the Government-Authorized Alternate Care Site Operational Tools Manual on pages 78-91.

Alternate Care Site Supplies and Equipment List

The supplies and equipment in the State Alternate Care Site Cache are packaged according to nine categories:

1. IV Fluids
2. Bandages and Wound Management
3. Airway Intervention and Management
4. Immobilization
5. Patient Bedding, Gowns, Cots, Misc.
6. Healthcare Provider Personal Protective Equipment (PPE)
7. Exam Supplies
8. General Supplies
9. Defibrillators and Associated Supplies

The Alternate Care Site Cache content list has five columns:

1. **Item number:** The number assigned to the supply or piece of equipment in the cache.
2. **Group:** the number identifying which category the item is from (See the nine categories above).
3. **Item Description:** A description of the supply or equipment.
4. **Units:** Identifies how the items are packed (e.g., individually, box)
5. **Number:** The number of items in the cache.

Alternate Care Site Supplies and Equipment List

Alternate Care Site Cache (updated April 11, 2007)

Item #	Group (see below)	Item Description	Units	#
IV Fluids				
1	1	Alcohol Pad, Isopropyl, Sterile, 2" x 2"		
2	1	Arm Board, Padded, Long (Size = 3" x 18")		
3	1	Band-Aid (Coverlet Patches), 1-1/2" X 2"		
4	1	Catheter, (IV), 14G x 2" (LATEX FREE), Model = Medex Jelco #4048. NO SUBS		
5	1	Catheter, (IV), 16G x 1 1/4", Gray (Safety Tip) (LATEX FREE), Model = Medex Jelco #4072. NO SUBS		
6	1	Catheter, (IV), 18G x 1 1/4", Green (Safety Tip) (LATEX FREE), Model = Medex Jelco #4065. NO SUBS		
7	1	Catheter, (IV), 20G x 1 1/4", Pink (Safety Tip) (LATEX FREE), Model = Medex Jelco #4066. NO SUBS		
8	1	Catheter, (IV), 22G x 1", Blue (Safety Tip) (LATEX FREE), Model = Medex Jelco #4050. NO SUBS		
9	1	Catheter, (IV), 24G x 1", Yellow (Safety Tip) (LATEX FREE), Model = Medex Jelco #4063. NO SUBS		
10	1	IV Administration Set, 78", w/clamp, Vented (15 Drop) Macro drip (LATEX FREE), Model = Amsino #AA3101, NO SUBS		
11	1	IV Administration Set, 78", w/clamp, Vented (60 Drop) Microdrip (LATEX FREE), Model = Amsino #608306, NO SUBS		
12	1	IV Fluid Bags, Normal Saline 100 ml, Model = Baxter #629122A, NO SUBS		
13	1	IV Fluid Bags, Normal Saline 1000 ml, Model = Baxter #2B1324X, NO SUBS		

Note: The list above is a **partial** listing of the Alternate Care Site Cache Supplies and Equipment. The full list can be found in the Government-Authorized Alternate Care Site Operational Tools Manual.

The Use of Supplies and Equipment Beyond the Manufacturer's Recommended Use

During a catastrophic emergency, there is the possibility that medical supplies and equipment may be used in a different manner than their intended use, which brings into consideration liability and reimbursement. For example, an adult intubation kit is used on a pediatric patient.

The Federal Food, Drug and Cosmetic Act, Chapter V, Subchapter E, Section 564 [21 USC 360bbb-3] - Authorization for Medical Products for Use in Emergencies, states that the Secretary of the U.S. Department of Health and Human Services may authorize the introduction into interstate commerce, during the effective period of a declaration of emergency, of a drug, device, or biological product for "emergency use".

Inventory Management – Supplies and Equipment

Inventory management should include procedures to maintain supplies and equipment that have an expiration date or require ongoing maintenance. For example, batteries must be replaced periodically and equipment that may be impacted by the environment, such as ventilator seals, needs to be maintained. Obsolescence must also be considered because supplies and equipment may become outdated due to technological advances or changes in ordering patterns. Therefore, the Alternate Care Site Planning Team should assign personnel to check the supplies and equipment during the set up of an ACS and once supplies and equipment are received to make sure they remain usable. Personnel may not be knowledgeable on the use of equipment that is obsolete and that lack of knowledge can put a patient's life in danger. To help ensure that personnel can use the equipment stored, "Just-In-Time" training documents for the clinical resources should be placed in the storage area once the Alternate Care Site is established.

Supplies and equipment for pediatric patients must also be planned for. In the tool for this section, the pediatric population is referenced, but to find more detailed information on the emergency care of the pediatric population, refer to http://www.emsa.ca.gov/def_comm/vii032807_a.asp.

10.1.3 Personal Protective Equipment

The primary users of personal protective equipment will be the staff who require protection during an emergency. This includes proper equipment and training to sustain an all-hazard event response. Alternate Care Sites may be in the position of being first receivers of patients, similar to other healthcare facilities. This section will concentrate on the first receiver component of personal protective equipment. The Occupational Safety and Health Administration provides guidelines that many facilities currently use. Under California Occupational Safety and Health Administration Labor Code 6401, every employer must furnish protective equipment, use safety devices and safeguards and provide training to staff. Employers are required by the Occupational Safety and Health Administration to use personal protective equipment to limit employee exposure to hazards, and employers must determine if

personal protective equipment should be used for the protection of the employees. An Alternate Care Site can use these recommendations as a guide to understanding what personal protective equipment may be required during a healthcare surge.

Personal protective equipment must be matched to the environmental conditions at the Alternate Care Site to provide the proper level of protection. Below are some considerations when determining the type of personal protective equipment required for event-specific situation.

Natural Disaster/Biological Event:

- This is an infection control/epidemiology issue (e.g., pandemic influenza outbreak) that requires universal precautions
- Respiratory protection may be required, depending on the situation (e.g., N-95/N-100)
- Infection control practices should be followed

First Receiver Operations (Chemical, Radiological, Nuclear, Explosive/ CBRNE)

- This type of operation involves receiving individuals from an incident with the release of hazardous substances.
- Alternate Care Site planners should use the 1995 Occupational Safety and Health Administration manual, “Best Practices for Hospital-Based First Receivers,” as a guide for handling these types of catastrophic emergencies. Training, personnel and storage are addressed in detail in this manual.

Guidance on the Selection and Acquisition of Personal Protective Equipment

- Equipment selection should be site specific, depending on the volume and acuity of patients expected.
- The Alternate Care Site Planning Team must determine where Alternate Care Site supplies and equipment will be stored once acquired.

Considerations Related to Managing/Storing Personal Protective Equipment

- Equipment must be current for appropriate use – Alternate Care Site employees should check personal protective equipment to ensure it is not outdated prior to using.
- Personal protective equipment requires a large amount of space and an Alternate Care Site may not have adequate storage areas to stock personal protective equipment.
- Personal protective equipment is not made to fit all body types.
- Alternate Care Site employees must be able to anticipate specific personal protective equipment needs at the Alternate Care Site.
- Personal protective equipment materials must be durable to be effective (e.g., strength of materials).
- Personal protective equipment can have an effect on heat stress.
- Numerous layers of personal protective equipment may be needed for adequate protection.
- Some personal protective equipment requires personnel to be in certain physical condition to safely utilize the equipment (e.g. personnel with asthma may not be able to wear a respirator).

- Multiple types of personal protective equipment are used and staff may not be cross-trained on the many brands of equipment that may be brought to an Alternate Care Site.
- Some equipment must be stored in a temperature controlled space as they are sensitive to exposure to heat and cold (e.g., batteries, plastic, and rubber).

Training Recommendations

- The Alternate Care Site will need to rely on Just-in-Time training for many of the personnel using personal protective equipment. For more information on training in the use of personal protective equipment, refer to the Occupational Safety and Health Administration website at: <http://www.osha.gov/SLTC/personalprotectiveequipment/index.html>

10.1.4 Communication

Communication and information technology capabilities for the operations of an Alternate Care Site are essential during a healthcare surge. Planners should include communication and information technology systems that are easy to set up and allow for communication between Alternate Care Sites and the Unified Command. Additionally, communication systems should link hospitals, law enforcement, and suppliers. Core communication and information technology equipment may be inaccessible due to damage, resulting in a lack of communication and information technology capabilities during a healthcare surge. It is recommended that the Alternate Care Site Planning Team prepare for the worst case scenario and consider the following methods for internal and external Alternate Care Site communications and information technology support:

- Runners
- Portable/hand-held radios
- Disaster radios
- Portable Public Address System
- Telephone
- Cell phones/Bull Horn
- Fax system
- Televisions
- Hand-held devices
- Laptops

10.2 Procurement of Resources Prior to an Event

Once a determination has been made regarding the type and amount of pharmaceuticals, supplies and equipment needed to procure prior to a catastrophic event for use in an Alternate Care Site, the Alternate Care Site Planning team should consider methods to acquire these resources or insure they are available for use at the time an Alternate Care Site is activated.

Memoranda of Understanding with wholesalers and retailers can be proactively set-up with manufacturers, wholesalers, and retailers in order to procure resources (including vendor-managed inventory).

10.2.1 Contract Considerations

The Alternate Care Site Planning Team should decide which items or services will be purchased and stored by local government and which will be vendor managed. The team should establish ongoing relationships with vendors to manage daily supply levels in case an Alternate Care Site is activated.

National equipment and supply vendors provide a range of services for supplying, storing and distributing equipment. Regional vendors may only offer specialized services. Some contracting arrangements can be made in advance on a “contingency” basis so that contracts can be implemented rapidly when an emergency occurs. In the pre-planning stages, it is possible to develop contracts, purchase orders, vendor relationships and inventory reallocation plans. If the entire equipment and supply process is to be arranged under a comprehensive service contract, during the facility assessment, the Alternate Care Site Planning Team should include a representative of the selected contractor who will be responsible for much of the time-sensitive ramp-up during the week prior to opening. Using an existing contract at a major medical center as the contractual “vehicle” would promote even faster procurement.¹⁷

Vendor-Managed Contract Considerations

An Alternate Care Site may rely on vendors for maintenance of their supplies and equipment once it is set up. As a result, the vendors or suppliers who manage supplies, pharmaceuticals and equipment need to be considered to ensure proper maintenance during storage. The maintenance of such storage items may need to be serviced by multiple vendors. This group may play a large role in ensuring that materials work correctly during a healthcare surge.

Key considerations when evaluating requirements with outside vendors:

- Understand the process for the rotation of stock and inventory (control management).
- Understand the “days-on-hand” inventory of the vendors. This may guide the Alternate Care Site determination on what quantity of supplies, pharmaceuticals and equipment to order at one time.
- Clarify the process for the delivery of material to the Alternate Care Site; pre-identifying Alternate Care Sites where possible.
- Identify any “disaster clauses” within the contract and understand the requirements of the vendor.
- Understand the options of how and where the supplies, pharmaceuticals and equipment will be delivered during a healthcare surge.
- Identify the vendor lead time of critical supplies, pharmaceuticals and equipment.

- Understand the rotation stock and inventory (control management) agreement.
- Identify payment terms under a healthcare surge catastrophic emergency.
- Understand the turnover inventory of the vendors.

10.3 Acquiring Additional Resources through the SEMS Process

Even with local planning, an Alternate Care Site is likely to require resources beyond those on hand when the Alternate Care Site is activated. Additional resources must be requested through the SEMS/NIMS process. Requests for resources will be made through the Alternate Care Site Command to the Unified Command of the jurisdiction. Resource requests should be as specific as possible to ensure resource needs are met. See SEMS overview in Foundational Knowledge, Section 3.9: Standardized Emergency Management System.

The following are examples of State and federal resources that will be utilized to fill resource requests received through the SEMS process. Planners should be aware that during statewide events, resources will be used to fill requests for multiple areas and some requests will be delayed or unable to be filled.

State Available Resources:

- *N-95 respirators*: CDPH has 50.9 million N-95 respirators that were purchased for protection of healthcare workers at healthcare facilities and Alternate Care Sites. These respirators will be stored regionally.
- *Ventilators*: CDPH has 2400 ventilators maintained for deployment.
- *Alternate Care Supplies*: CDPH has supplies and equipment for 21,000 Alternate Care Site beds. Each all-hazard cache includes supplies and equipment for 50 patients for a seven to ten day period. Alternate Care Site caches will be stored regionally.
- *Mobile Field Hospitals*: The Emergency Medical Services Authority has three two-hundred bed mobile field hospitals. Each mobile field hospital has 200 beds and is fully equipped to provide full hospital care including laboratory, surgical, and isolation capacity. Mobile field hospitals will be stored in Northern, Central, and Southern California.

State/Federal Resources:

- *Antivirals*: Through a federal cost-sharing program, CDPH maintains 3.76 million courses of antivirals, comprised of 90% Tamiflu and 10% Relenza. The federal government maintains an additional 5.3 million courses for California. Together these courses will provide for treatment of approximately 25% of California's population.
- *Strategic National Stockpile*: The federal Strategic National Stockpile has 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 and would be delivered by CDPH to Local Health Departments.

- **CHEMPACK:** The Centers for Disease Control and Prevention provides a sustainable nerve agent antidote cache that increases the capability to respond quickly to a nerve agent event such as a terrorist attack. California has 230 CHEMPACK pharmaceutical caches that contain enough medication (atropine injection, pralidoxime injection and diazepam injection) to treat approximately 100,000 persons exposed to nerve agents and acute poisoning from certain type of pesticides. The caches are stored in acute care hospitals, local public health agency facilities, emergency medical services locations and fire stations throughout the State. Approximately 90 percent of the State is within one hour response time of CHEMPACK assets.

10.4 Storage Considerations

During a healthcare surge, supplies, pharmaceuticals and equipment need to be immediately accessible. This section addresses stockpiling caches off-site and storage on-site at an Alternate Care Site.

Space is a very important consideration in determining storage locations. Many Alternate Care Sites have inadequate space to house equipment and supplies so planners must prioritize what will be included in the on-site storage space as well as identifying where other resources will be stored.

Environmental Management

Environmental management of storage space for pharmaceuticals and supplies/equipment is critical. The chemical nature of pharmaceuticals puts them at risk of premature deterioration which may impact the efficacy of the drug and safety of the patient. Many pharmaceuticals are affected by temperature and have specific storage requirements such as “controlled room temperature” or “refrigeration.” There must be a process to monitor the environment of pharmaceuticals to meet the United States Pharmacopeia. Supplies and equipment items are also impacted by temperature, as significant variations can affect the durability and quality of the material. For example, some personal protective equipment must be stored at specific temperatures. In planning storage for an Alternate Care Site, the Alternate Care Site Planning Team should ensure that manufacturers' storage guidelines are met.

Transport

Transportation must be considered in planning how supplies and equipment will be moved from a storage site, cache or stockpile to the Alternate Care Site. A transportation plan should be in place to designate the primary mode of transport and alternate back-up options. This plan should consider the possibility that roads and facilities may be inaccessible.

Pharmaceutical Storage Consideration Checklist

This tool serves as a checklist to address the vital areas that need to be considered specifically in storing pharmaceuticals at an Alternate Care Site.

The Alternate Care Site Pharmaceutical Storage Consideration Checklist is shown below. The checklist can also be found in the Government-Authorized Alternate Care Site Operational Tools Manual on pages 55-56.

Alternate Care Site Pharmaceutical Storage Consideration Checklist

Whether in preparation for a healthcare surge or during a surge, there are many considerations that need to be addressed so that pharmaceuticals can be accessed and used immediately. The following checklist includes considerations for pharmaceutical storage at an alternate care site across six major categories including:

- Inventory management
- Environmental management
- Security
- Caches
- Licensing
- Ease of access

Inventory Management

- A process for monitoring the expiration dates.
- A process for rotating stock from the cache into the general inventory to minimize outdates, if applicable.
- A process for returning unused stock to vendors for replacement or credit, if applicable.
- A process for local repackaging of pharmaceuticals if they come in bulk containers.
- A process for properly labeling repacked pharmaceuticals.

Environmental Management

- A process for monitoring the environment to meet United States Pharmacopeia (USP) standards, e.g., temperature, humidity, pests.
- A process for maintaining adequate room temperature ranges between 68° and 77° F, the range required for most medications, as specified in Strategic National Stockpile guidelines.
- A process to ensure that the manufacturer's storage guidelines are met.

Security

- A process for ensuring the security of the pharmaceuticals (e.g., locks, security personnel).
- 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 ensuring security locks on pharmaceuticals are in place.
- 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 an Alternate Care Site

- A process for ensuring the security of the 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.

Licensing

- A process to consider any licensing needs, e.g., Board of Pharmacy, depending on the location of the cache.
- A process to consider the location of the cache and if it is licensed to receive a delivery of pharmaceuticals.

Ease of Access

- A process for staging the layout of pharmaceuticals to ensure ease of access, e.g., what is needed in the first 24 hours.

Supplies and Equipment Storage Consideration Checklist

This tool serves as a checklist to address the vital areas that need to be considered for storing supplies and equipment at an Alternate Care Site.

The Alternate Care Site Supplies and Equipment Storage Consideration Checklist is shown below. The checklist can also be found in the Government-Authorized Alternate Care Site Operational Tools Manual on pages 92-93.

Alternate Care Site Supplies and Equipment Storage Consideration Checklist

Whether in preparation for a healthcare surge or during a surge, there are many considerations that need to be addressed so that supplies and equipment can be accessed and used immediately. The following checklist includes considerations for supplies and equipment storage at an Alternate Care Site across six major categories including:

- 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 (AEDs)
- 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

- A process for monitoring personal protective equipment (e.g., temperature)

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 an Alternate Care Site

- 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)

10.5 Staging and Deployment

This section examines the most efficient ways for an Alternate Care Site to stage supplies, pharmaceuticals and equipment pre-surge and during a surge. It also addresses the impact of regulatory issues on distribution.

Staging Considerations

Most Alternate Care Sites will have limited storage capacity, particularly in close proximity to their designated disaster triage and treatment areas. Further, because disaster supplies are not routinely used, they are often relegated to the least convenient available space, sometimes in off-site warehouses. This can result in delays in care, as Alternate Care Sites retrieve their supplies from various storage locations.

As a reference, hospitals often organize their disaster supplies similar to other hospital materials — each item is stored with like items in the same location, e.g., cots are stored with cots, powered air purifying respirators are stored with powered air purifying respirator hoods, medical supplies are stored with medical supplies, etc., and items are often in different locations. This is an efficient means of monitoring and replenishing inventory under routine operating procedures; however, it may not be optimal in disaster response.

One option the Alternate Care Site Planning Team may wish to consider is to identify a small storage area near the identified Alternate Care Sites. This area can be used for the “first push” of the supplies likely needed in the first moments of a crisis. For example, a small collection of cots, linens, gowns, and medical supplies could be gathered here. If space allows, it is suggested that a tent, lights and generator be added if additional space is needed to sort through supplies and equipment. If environmental conditions are adequate, pharmaceutical supplies might be included. As the event evolves and additional supplies are needed, the more remote storage areas can be tapped to replenish or supplement the first push of supplies. Plans to retrieve the additional supplies should be activated as their first set is deployed.

If space is sufficient, the “first-push” supplies may be packaged in a cart or trailer to make deployment more rapid. Consideration should be given to the path of travel between the storage site and the destination to ensure that the chosen cart or trailer will successfully clear all obstacles. Further, a detailed inventory should accompany the first push of supplies, indicating “what” and “how many” of each item is immediately available, and where additional supplies are located so that they can be acquired by staff who may not know how the supplies are organized and stored.¹⁸

Staging Recommendation Checklist

This tool serves as a checklist to identify key considerations when staging resources. This tool is useful for the set up of resources at Alternate Care Site and caches/warehouses.

The Alternate Care Site Staging Recommendations Checklist is shown below. The checklist can also be found in the Government-Authorized Alternate Care Site Operational Tools Manual on the 76-77.

Alternate Care Site Staging Recommendations Checklist

The following checklist identifies considerations the Alternate Care Site Planning Team should assess when setting up their materials in planning for and during a healthcare surge:

- A process for determining what items will be needed first (concept of last in, first out).
- Do not place one type of material all in one place (e.g., cots all in one area).
- A plan for how the materials will be moved (e.g., deployable cart).
- 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).
- Space is often a limiting factor at an Alternate Care Site. Consider alternate sites to stage supplies, pharmaceuticals and equipment (e.g., off-site warehouses).
- Pushcarts can be used for moving materials efficiently.
- Pushcarts need to be labeled with all materials and expiration dates.
- Plans should consider ownership of staging areas (State versus local) and who is responsible for identifying points of distribution.
- Pharmaceutical caches should be stored in secure containers that can be easily transported (e.g., plastic totes with tear away locks).
- Medical supplies without expiration dates should be kept separate from medical supplies that have expiration dates.
- Supplies, pharmaceuticals and equipment must be covered for protection from the elements to reduce spoilage and the need to repackage materials.

11. Patient Management

When an Alternate Care Site is activated, the staff will need to provide patient care in a manner that will save as many lives as possible. Planners and Alternate Care Site staff should become familiar with statutes and regulations that govern patient management activities. The following discussion identifies several specific patient management topics that local government and local health departments should consider.

Authority for Patient Care in Emergency Situations

Authority for patient healthcare management during an emergency is vested in the licensed or certified healthcare professional at the scene of the emergency who is most medically qualified specific to the provision of rendering emergency medical care. If no licensed or certified healthcare professional is available, the authority of patient healthcare management is vested in the most appropriate medically qualified public safety agency representative who has responded to the scene of the emergency. Health and Safety Code Section 1798.6 authorizes counties to establish a unified command structure for patient management at the scene of an emergency within the county and specifies the composition of a committee for that purpose.

Patient Restraints

Certain circumstances at an Alternate Care Site could warrant the use of patient restraints for the safety of the patient, other patients and staff. Welfare and Institutions Code Section 5150 authorizes peace officers, members of the attending staff of an evaluation facility designated by a county, designated members of a mobile crisis team, and other county-designated professional persons, upon probable cause, to take a mentally disordered person into custody for 72-hour treatment and evaluation.

Guidance on policy and procedures associated with patient restraints can be obtained from the San Diego County Division of Emergency Medical Services - Policy Procedure Protocol (page 48), July 2002. The document can be accessed via:

<http://www2.sdcounty.ca.gov/hhsa/documents/EMS-TreatmentProt2004 Rev 6 30 04 Part3.pdf>

Prioritization and Management of Patients: Liability Protection

Alternate Care Site staff may encounter patients who do not require emergency medical care. Health and Safety Code Section 1317 provides liability protection for a health facility, health facility employees, a physician, a dentist, a clinical psychologist and a podiatrist for refusing to render emergency care if, based on a determination and exercising reasonable care, the person is not suffering from an emergency medical condition, or the health facility does not have the appropriate facilities or qualified personnel available to render those services.

12. Security Services

Safety and security are the most important operational planning requirements of an Alternate Care Site. Without proper safety and security measures at an Alternate Care Site, the lives of patients and personnel could be in jeopardy. Therefore, it is recommended that an Alternate Care Site be open to the public ONLY if, at a minimum, one armed guard is present at the time of opening.

Security resources may be scarce during a healthcare surge and the Alternate Care Site Planning Team should pre-plan for heightened security in a disaster state. A security process should be set up to:

- Ensure the security of existing inventory and caches by using personnel
- Control access into and within the Alternate Care Site
- Identify and track patients, staff and visitors
- Work with local authorities prior to a healthcare surge to address heightened security needs and private security entities.

12.1 Establishing a Security System at an Alternate Care Site

Security needs of an Alternate Care Site may require more personnel than a traditional healthcare facility, given the number of individuals affected by a catastrophic disaster and the public's lack of familiarity with an Alternate Care Site. These security needs include the general safety of patients, staff and visitors, and protection of pharmaceuticals and other assets. However, typical measures to achieve security are likely more complex for an Alternate Care Site than a traditional healthcare facility, for the following reasons:¹⁹

- Because this is a temporary facility, the facility itself and security procedures will be unfamiliar and not yet routine to the security staff. Therefore, protocols will be more difficult to establish and maintain and unusual events will be more difficult to identify.
- Alternate Care Site personnel will not be known to security staff or to one another, making it more difficult to identify unauthorized persons.
- Mechanical and electronic security controls (such as electronic keyed doors) which are already in a facility are not likely to be quickly configured for the Alternate Care Site structure and may not be of optimal design and function for the use of the facility as an Alternate Care Site.
- All personnel, patients and visitors will be under heightened stress due to the catastrophic event that necessitated opening the Alternate Care Site.

During an infectious agent or communicable disease epidemic scenario, there are significant additional security concerns and risks beyond those mentioned above. If the Alternate Care Site is to serve as an isolation/quarantine facility for infectious patients, there could be a strong

“not-in-my-backyard” reaction from the community surrounding the surge facility, due to fear of the infectious agent. This could cause community members to try to prevent the facility from opening and receiving patients, and might lead to disruption of facility operations. If there is widespread perceived risk from the infectious agent, and if vaccinations and medical prevention and treatment are in short supply, there could be aggressive attempts to obtain or steal medications from the surge facility. These are serious and real security risks, and they will be difficult to manage under the conditions of a quickly opened temporary surge facility. The following additional measures should be considered:

- Provide security for incoming and outgoing vehicles (for roadways between site perimeter and major corridors through the community), in particular those transporting infected patients.
- Control access to the grounds.
- Heighten access control into and around the building.
- Implement more stringent identification and tracking of patients, staff and visitors.

It is recommended that a comprehensive security management plan and action protocols for any planned government-authorized Alternate Care Site be developed by the Alternate Care Site Planning Team with advice from security experts. The following are considerations as the Alternate Care Site Planning Team develops security plans and protocols:

Access Control

Control of access to the site and building can be achieved through security personnel; physical barriers such as fencing; alarms; and mechanical and electronic devices such as locks, card reader systems on doors and security cameras where available. There is a strong interplay between these security methods. As an example, if doorways cannot be locked or secured with electronic card readers, additional security staff will be needed at each doorway.

Controlling Site Access

An Alternate Care Site should have access to at least two roadways to ensure continued access to the Alternate Care Site in the event that one roadway became blocked or inaccessible. Access roadways should connect directly to the Alternate Care Site property and allow for easy set up of traffic stop points to limit access and check personnel identification or vehicles if needed during surge use. In particularly difficult security situations, all but one roadway could be blocked with Jersey knees or other barriers, and traffic access could be limited to one checkpoint using physical traffic barriers plus security staff. Facility access roadways must also be wide enough to create zigzag pathways to prevent a hostile vehicle from approaching the facility at high-enough speeds to cause damage. For an Alternate Care Site with large, open land areas and no fencing or other barriers, the Alternate Care Site Planning Team should consider the installation of physical barriers as well as a plan for additional security staff to control access onto the site.

Traffic Control

Depending on the situation, individuals are likely to arrive at the Alternate Care Site by private autos accompanied by quickly escalating numbers of family and friends. At some point, the media may also arrive and request special parking locations for their outside interviews and “live shots.” The gravity of the situation may warrant inspecting all of these vehicles as they enter the Alternate Care Site’s immediate environment, which would require additional personnel and the equipment needed to do the inspection.

Controlling Building Access

Controlling the movement of individuals into, throughout and out of the Alternate Care Site during an emergency is essential to the safety of patients and staff and the security of critical supplies, equipment and utilities. The Alternate Care Site security personnel, in conjunction with the Alternate Care Site Director, may determine the type of access and movement to be allowed for staff, patients, visitors, emergency volunteers, vendors, maintenance and repair workers, utility suppliers, and other individuals when emergency measures are initiated.

The exterior windows, doors and other structural components of the Alternate Care Site building should be in place with no breach in the building envelope allowing building access other than in normal doorway entrances. Locks on doors and windows should be in place and functional. A limited number of building entranceways should be established. Exterior doorways should be controlled with locks and, where possible, electronic card readers. If electronic card readers are not available, security experts estimate that a minimum of three to four security personnel would be needed per shift to control building access and monitor the building. Additional security staff will be needed for very large sites. If doorways could not be secured via use of such technology, additional security personnel would be needed to control these doorways.

Identification of Patients, Staff and Visitors

Comprehensive identification efforts will be needed and security experts recommend issuance of staff identification badges, use of security personnel for identification and tracking or limitation of visitors. This identification and tracking would be conducted in concert with other access control measures as described above.

Monitoring and Prevention

Regular patrols by security personnel will be needed to continually identify and de-escalate potential security problems. In an infectious agent or communicable disease epidemic scenario, significant monitoring efforts will be needed because the security risks are much greater.

Security Communications

Effective execution of security protocols will require that on-site security personnel be able to communicate with one another and be able to call in additional outside emergency personnel if needed.

Security Staffing

In operating an Alternate Care Site, at least four to six security staff per shift would be needed, and perhaps more at a larger facility. This includes three to four staff for building access control and security, and one to two staff for site access control and security. This level of staffing assumes that reasonable levels of physical barriers are in place. If this is not the case, additional staffing will be needed. For example, an additional security staff person would be needed at each entrance door that could not be locked or otherwise secured.

In an infectious agent or communicable disease epidemic scenario, a higher level of staffing will be needed because security risks are greater. Approximately eight to twelve security staff would be needed, four to six for building access control and security, and another four to six for site access control and security. If controls cannot be put in place to limit the number of access points, a higher level of staffing would be needed, including two to four additional security staff per shift to patrol and secure the site perimeter.

Sources of Security Staff

Depending on what else is happening in the community, all law enforcement staff may be fully utilized in conducting their regular duties and will only be available to respond to active security or civil unrest situations. A possible option for security staff would be to contract with a private security firm. Some of these firms specialize in the types of emergencies that would necessitate opening a healthcare surge facility; the Alternate Care Site Planning Team should consider setting up a contract in advance with a security firm.

Security contracts should specify the following:

- Number of security personnel needed and in what timeframe (It should be readily feasible to get up to ten security personnel from a private firm within 24 hours.)
- Security protocols to be followed and exact parameters of responsibility
- Level of training needed
- Gear and equipment specifications
- Number of personnel who need to be armed
- Chain of command guidance

The firm under contract should specify how (and how quickly) personnel will be made available given the needs of their permanent client list, and the Alternate Care Site Planning Team should assess if they can truly deliver the needed staff.

It may be possible to hire officers from the local community police department in the town where the Alternate Care Site is located to serve as paid police details. This cannot be set up in advance or guaranteed.

Security personnel may also be called in from public police or military entities such as local police, National Guard, military police or security members of federal Disaster Medical Assistance Teams (DMATs) (only under a federal emergency). Personnel from these

organizations cannot be arranged for in advance, but can be called in response to an existing emergency situation.

In an infectious agent or communicable disease epidemic scenario it may be more difficult to obtain security personnel because many may not want to serve at an isolation/quarantine facility. Armed security staff may be needed under this scenario if civil unrest threatens to disrupt facility operations. Security staff might also need protective gear against the infectious agent, such as respirators, for which medical screening, training and fit testing are required. Private security firms and/or their staff will likely be unwilling to serve at the isolation/quarantine surge facility. Local police officers might have the necessary skills and training and are likely to be fitted with respirators under Department of Homeland Security preparedness efforts (at a minimum, powered air-purifying respirator or air-purifying respirator fitted with High Efficiency Particulate Air (HEPA) cartridges are recommended) but may be unwilling to serve at the isolation/quarantine surge facility.

Restricting Access

Decisions on how to restrict access must be made early in the event by Command staff. If access is to be restricted, this decision should be immediately implemented. Announcing the security restrictions to the staff and public should be immediate, followed by assigned personnel re-routing pedestrian and vehicular traffic and doors being locked, either manually or electronically. Locked doors should be monitored to ensure no compromise occurs. 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 for rapid deployment.

It is crucial to involve life-safety engineers in planning and response to ensure adequate egress in the event of a fire or other internal emergency.

Heightened surveillance procedures may need to be implemented, including inspecting suspect packages; closer scrutiny of personnel at checkpoints, including verification that each individual, including staff, is wearing a proper identification badge; and assigning properly protected personnel at patient arrival points, including decontamination, if needed. Certain areas such as the emergency department, pharmacy, and the Alternate Care Site Command should receive enhanced security support. Steps may need to include restricting staff entry into certain areas because of security concerns or unsafe conditions.

12.2 Facility Lock-Down

Alternate Care Sites may be required to lock-down facilities during a mass medical emergency. The primary goal in a lock-down situation is to isolate and control access to the Alternate Care Site facility while caring for the safety of the patients, visitors, staff and property. The following tool provides procedures and guidance on when the need to lock-down an Alternate Care Site

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.

The Alternate Care Site Lock-Down Policy & Procedure Sample is shown below. The tool can also be found in the Government-Authorized Alternate Care Site Operational Tools Manual on pages 36-40.

Alternate Care Site Lockdown Policy and Procedures SAMPLE

I. PURPOSE

The purpose of the lockdown policy and procedures is to provide guidance when the need to lockdown an Alternate Care Site 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 Alternate Care Site 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 Alternate Care Site facility, whenever possible.

C. STAFF

All Alternate Care Site clinical and non-clinical staff members will separate themselves, if at all possible, from any involvement in a civil disturbance.

IV. PROCEDURES

A. GENERAL – CIVIL DISTURBANCE

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.

1. 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 Alternate Care Site Command.

2. Upon becoming aware of a civil disturbance situation, the facility administrator or senior administrative person in the Alternate Care Site facility will be notified immediately.

B. MASS CONTAMINATION

1. Contaminated individuals/equipment entering the Alternate Care Site facility building may require the closure of all or part of the facility.
2. In a mass contamination situation, only individuals or equipment 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 Alternate Care Site Director, if available, based on information provided by security and other staff members.
2. Announcement/Notification
 - a. Upon specific guidance from the Alternate Care Site Director or designee, the operator will announce the civil disturbance three times via available communication system. The proper announcement is:
<<Code Name for Lockdown>> “Nature and Location of Disturbance”
Repeat the statement every 15 minutes for the first hour, or as often as the Alternate Care Site Director instructs.
 - b. When directed by the Alternate Care Site Director, the operator will contact the appropriate law enforcement office and request immediate assistance.
 - c. When so directed by the Alternate Care Site Director or the senior administrative individual in the facility, the All Clear will be announced of the public address system as follows:
<<Code Name for Lockdown>>, Location, ALL CLEAR” (three times)
3. Upon announcement of lockdown, the Command Center and other designated portions of the Command System organization will be activated. This will normally include as a minimum, a portion of the Planning Section.

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 Alternate Care Site Director, or designee.
2. In the case of a mass contamination situation, the Infection Control Coordinator or designated clinical staff member will assess the situation and recommend appropriate action.
3. If required, security augmentation will be initiated through recall of off duty security, by 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 reenter the building.

E. COMMAND CENTER OPERATIONS

1. All information from local law enforcement, fire department and other sources will be provided to the Command Center.
2. Actions to be taken will be based on the evaluation of this information.
3. The Alternate Care Site Director will determine what information will be disseminated to facility staff.
4. In the case of mass contamination, the decontamination procedures will be initiated.
5. In the event the disturbance is in one of the area's prisons and/or jails and the Alternate Care Site 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.
6. In the event of an extended disturbance causing all or part of the staff to remain in the facility, provisions will be made for housing and feeding these individuals.

F. ALTERNATE CARE SITE OPERATIONS

1. Patients, visitors, and staff will be moved from the immediate area of the disturbance if at all possible.
2. In patient care areas, access will be limited to staff and others authorized by the Alternate Care Site Director to be in those areas.
3. Based on guidance provided by the Alternate Care Site Director, visiting hours may be reduced or eliminated and any visitors will be strictly controlled.
4. Staff will be informed to avoid the area and to not involve themselves in the disturbance.

G. POST CRISIS MANAGEMENT

After cancellation of the lockdown, 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 CHECKSHEET

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.

- _____ Personnel 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, if possible, in any manner with the civil disturbance.
- _____ Isolate the situation by locking all exterior doors to the unit and closing all ground-floor windows.
- _____ Do not allow any entry or exit from other than through controlled entry point(s) which should be controlled by security.
- _____ Only individuals KNOWN to be free of contamination will be allowed to enter the building in a mass contamination event.
- _____ If exiting the building, request an escort to and from the parking lot areas.
- _____ Allow law enforcement to quell the civil disturbance.

Source: This policy and procedure sample was adapted from CODE CD - Lock-Down for Scripps Hospital, San Diego.

13. Environmental Services

Environmental engineering at an Alternate Care Site requires careful planning. Prior to opening an Alternate Care Site, general environmental controls should be in place before patient care begins. The several hundred page *Guidelines for Environmental Infection Control in Healthcare Facilities* by the Centers for Disease Control and Prevention is specifically aimed at environmental controls that decrease patient illness from common infections, and can be used as guidance for the environmental service requirements at an Alternate Care Site. The Alternate Care Site Planning Team should consider environmental services staff and/or contractors for the following functions:²⁰

- Clean the facility, including fumigation for pest control, to bring it to sanitary standards before admitting patients
- Maintain sanitary water, air and other environment throughout the course of operation of the Alternate Care Site
- Launder bedding and other cloth goods
- Dispose of hazardous materials under strict Environmental Protection Agency guidelines
- Dispose of medical and other waste (solid and liquid)

The Alternate Care Site Planning Team may choose to pre-establish executable contracts for disaster remediation and pest control, general waste management, hazardous waste disposal and laundry services. Environmental services contracts should include specific language around the following tasks:

- General cleaning of surfaces and walls within patient areas, including wet/dry methods, timing to repetition, appropriate materials and detergents/disinfectants
- Pest control
- Mitigation of the use of mists, aerosols and fumigants in patient areas and cleaning methods that disturb and distribute dust into patient areas
- Cleaning areas with immuno-compromised patients
- Cleaning spills of bodily fluids
- Special care of carpeting and other cloth furnishings

The following environmental services supplies and equipment will need to be procured as part of the planning initiative:

- Environmental Protection Agency-certified detergents, disinfectants and chemical sterilants (including tuberculoids and germicides)
- Disposable mops, cleaning cloths, sponges and other cleaning apparatus
- Floor buffer/polisher and carpet shampooer
- Sweeping apparatus (note: recommendations from the Environmental Protection Agency suggest minimizing the use of such tools because they may disturb and distribute dust into the air – use wet mops whenever possible)

- Industrial-strength vacuum with High Efficiency Particulate Air (HEPA) filter (and replacement)
- Containers and labels for hazardous waste
- General waste containers
- Cleaning carts and cleaning material storage shelving

Environmental Service Staff

An environmental crew should be the first staff at the Alternate Care Site, as soon as the Local Health Department has authorized its preparation for use. This disaster remediation team, noting the specific instructions based on the facility assessment, will be responsible for cleaning a facility that has not had a medical grade cleaning and bringing it to sanitary standards appropriate for patients. Cleaners will maintain the Alternate Care Site and keep general orderliness and cleanliness during the preparation period while many people enter and exit the Site. As patients are discharged and the Alternate Care Site is prepared for closure, cleaning staff may be reduced. A core staff should remain to shut down the facility and return it to a safe closure state.

14. Hazardous Waste Management

This section provides the Alternate Care Site Planning Team with an overview of the current standards and regulations applicable to hazardous waste management as well as offering a resource for information.

The Occupational Safety and Health Administration does not require that Alternate Care Site facilities receive accident victims, but if the patient is part of an emergency involving hazardous substances and personnel are needed to decontaminate that individual, Hazardous Waste Operations and Emergency Response would apply (Occupational Safety and Health Administration, 1992).

The role of facility personnel in the safe decontamination of individuals has been further clarified in the Occupational Safety and Health Administration publication "*Best Practices for Hospital-Based First Receivers of Victims from Mass Casualty Incidents Involving the Release of Hazardous Substances*," released in December 2004. In this document, Occupational Safety and Health Administration outlines the minimal level of personal protective equipment recommended for staff decontaminating individuals at a non-contaminated medical facility.

This document can be accessed at:

http://www.osha.gov/dts/osta/bestpractices/html/hospital_firstreceivers.html.

Alternate Care Site decontamination programs should include procedures for runoff containment and management in the decontamination plan. The United States Environmental Protection Agency, in implementing the Emergency Planning Community Right to Know Act, has stated that it will not pursue enforcement actions for environmental consequences of necessary and appropriate actions, such as decontamination, during the phase of an emergency response where an imminent threat to human health and life is present. However, once this phase passes, every attempt should be made to contain the runoff and dispose of it properly. The federal Environmental Protection Agency website has extensive guidelines for hazardous waste storage, disposal, transportation and treatment. The guidance can be accessed at: <http://www.epa.gov/epaoswer/osw/hazwaste.htm>.

Key aspects to consider in the development of the standard operating procedure for decontamination include event recognition, activation, management, primary triage, patient registry and collection of personal property, decontamination, secondary triage, logistics for treatment, public information, and post-incident actions. Alternate Care Site decontamination training programs should follow National Fire Protection Association Standard 473, Professional Competence of Emergency Medical Service Personnel Responding to a Hazardous Materials Incident. The Alternate Care Site Planning Team may consider involving the local emergency medical services agency in development of standard operating procedures.

Emergency first responders at the site of the release are covered under the Occupational Safety and Health Administration's Hazardous Waste Operations and Emergency Response Standard (HAZWOPER), or by the parallel California Occupational Safety and Health Administration State Plan standards, 8 CCR 5192(e).

14.1 Medical Waste Management

The regulations for medical waste management under normal circumstances can be found in California's Medical Waste Management Act (Health and Safety Code, Division 104, Part 14, commencing with Section 117600). Although these regulations apply to hospitals under normal operations, they can be used as guidelines by the Alternate Care Site Planning Team to develop waste management protocols that address the challenges associated with the increased volume of medical waste.

Considerations in developing protocols for waste management include but are not limited to:

1. Greater quantities of materials suitable for containing biological agents or infectious organisms will be needed. These materials are to include, but not be limited to:
 - a. Biohazard labeled bags
 - b. Sharps containers
 - c. Liquid-handling containers
 - d. All other associated supplies materials
2. Each Alternate Care Site should list the supplies with supporting information that shows:
 - a. The quantity normally on hand.
 - b. An estimate of how long these supplies will last for an inpatient population level determined by the facility.
3. If the existing inventory of materials or usage rate compromises patient care or waste containment needs, the Alternate Care Site should contact the Unified Command in their jurisdiction and request the materials needed.

In planning the waste storage component of medical waste management, the Alternate Care Site Planning Team is encouraged to consider the following options:

1. An Alternate Care Site may consult with medical waste disposal vendors for details of the vendor's ability to provide continued waste disposal services during a catastrophic emergency.
2. An Alternate Care Site may consult with county government for protocols for storage of medical waste during a catastrophic incident.

3. Medical waste may need to be stored under refrigeration (<32°F) to limit nuisance conditions. If the Alternate Care Site has exhausted its refrigeration resources, it should request assistance from the appropriate designee under SEMS.
4. Separation of medical waste from the solid waste stream is to be maintained.
5. Combined waste streams are to be handled as medical waste.
6. Chemical and radiological wastes must be separated and segregated from medical waste in order to avoid dual contamination.
7. Waste stored on the premises of the Alternate Care Site must be secure to prevent access by unauthorized persons and to prevent accidental spread of contamination.
8. The designated storage area for medical waste must display the appropriate “bio-hazard” symbols.
9. Refrigerated storage areas need to be located away from external air intakes or be maintained with negative airflow.

15. Mass Fatality Management

Each California county has a Sheriff-Coroner, Coroner, or Medical Examiner to manage fatalities. These local government officials rely on the State's mutual aid system to meet their resource needs in events that overwhelm their response capacity. The mutual aid system for these officials is described in the statewide Coroners Mutual Aid Plan. Recognizing that this plan is not a complete, statewide fatality management plan, the Office of Emergency Services has established the California State Mass Fatality Management Planning Committee. This committee has drafted a Mass Fatality Management Planning Concept of Operations as a first step in developing a broader plan to address all the topics for management of mass fatalities during catastrophic events. In addition to the Coroners Mutual Aid Plan, California has established procedures for recording deaths in mass casualty events.

The Alternate Care Site Planning Team should develop scenario based estimates of the number of expected fatalities that might occur in their jurisdiction. Using that information, counties need to plan for refrigerated storage capacity and body bags for deaths occurring in healthcare facilities within their jurisdiction. Using the estimated number of fatalities, the Alternate Care Site Planning Team should plan for expanded refrigerated storage capacity and body bags for deaths occurring in within the Alternate Care Site.

Members of the Alternate Care Site Planning Team should work with local government in planning for temporary morgue sites within the jurisdiction including locations such as:

- Armories
- Schools with gymnasiums (without wooden floors)
- Airport hangers
- Warehouses
- Reception halls
- County fair grounds

Considerations for temporary morgue site:

- Proximity to disaster site
- Electricity
- Refrigeration
- Hot and cold running water
- Restrooms
- Adequate office space
- Ventilation
- Large open area of sufficient size to accommodate the number of dead to be cared for
- Area for securing valuables
- Parking
- Secure from public

Once potential sites are selected, the Alternate Care Site should develop a plan for transporting bodies to the morgue sites.

For additional information on temporary morgues, the Minnesota Department of Health, Disaster Mortuary Emergency Response Team (D-MERT) Plan (<http://www.health.state.mn.us/terrorism.html>) provides detailed guidance on setting up temporary morgues.

16. Considerations for Staff Training

Training for Alternate Care Site operations requires pre-event training as well as on-site/just-in-time training. The following training topics offer suggestions on the type of training the Alternate Care Site Planning Team should consider. The Alternate Care Site Planning Team should develop a matrix to show which staff should attend each type of training and then develop a system to track training attended by staff.

16.1 Pre-Event Training

Below is a list of training topics to be considered for pre-event training:

- SEMS/NIMS
- Alternate Care Site Command System, adapted from Hospital Incident Command System, to include job action sheets
- Alternate Care Site setup training in the form of drills/table top exercises
- Concepts of catastrophic care for clinical staff, (e.g. Doing the greatest good for the greatest number of people)
- Alternate Care Site operational training, including inventory management, infection control and personal protective equipment, security and safety, and equipment training
- Orientation training, including process flow for inside and outside the facility and communication protocols
- Bedside point-of-care laboratory testing
- Volunteer training

16.2 On-Site/Just-in-Time Training

On-site and/or just-in-time training may be required to provide orientation to Alternate Care Site operations and procedures. It is assumed that licensed medical staff have sufficient emergency medical training. Examples of needed just-in-time training include:

- Patient tracking
- Report procedures, check in procedures, credentialing
- Personal protective equipment, medical evaluation and testing, infection control, FIT testing
- Logistics and operational training

17. Administration

Planning for the administrative support functions for staff and patient care in an Alternate Care Site is an essential component of the operations of an Alternate Care Site. This section discusses key administrative tasks including patient tracking, patient registration, patient valuables tracking, medical records, document storage, disease reporting, and worker's compensation benefits for Alternate Care Site staff.

17.1 Patient Tracking

The following section provides recommendations for a paper-based patient tracking mechanism to be used by an Alternate Care Site during a healthcare surge. Suggestions are provided for inter-facility tracking and intra-facility tracking.

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

- *Collect minimum necessary data:* Given that an unanticipated disaster may severely limit the capability of healthcare providers 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 or disaster incident number.
- *Patient tracking is a priority:* Tracking persons seeking treatment at healthcare system entry points (e.g. hospitals, Alternate Care Sites, and emergency medical system) during a healthcare surge is a high priority.
- *Paper-based tracking is an essential contingency:* Although significant efforts are under way to develop robust electronic patient tracking systems for disaster and emergency purposes, manual back-up processes should be maintained in case of system failures. Paper-based processes reduce compatibility issues when sharing data.

Disaster Incident Number

A disaster incident number is a unique identifier used to track patients during healthcare surge. It is recommended that the county Office of Emergency Services or Local Health Department serve as the central source responsible for creating and disseminating disaster incident numbers to public and private healthcare facilities, Alternate Care Sites and emergency medical services. Having a single entity responsible for creating disaster incident numbers is essential to avoiding duplication.

The procedure below provides an example of the process and documentation that could be instituted at the Alternate Care Site for the purpose of tracking a patient during healthcare surge.

The Alternate Care Site Disaster Incident Number Policy and Label is shown below. The tool can also be found in the Government-Authorized Alternate Care Site Operational Tools Manual on pages 21-23.

Alternate Care Site Disaster Incident Number Policy and Label

Policies and procedures for use are listed below:

1. Disaster incident number would be a unique patient identifier that would follow the patient during a healthcare surge from the point of entry into the healthcare system through discharge.
2. The disaster incident number would comprise 2 specific elements of identification:
 - a. The first 2 digits would be the California county code where that patient entered the system. County codes are 1 to 58. Those counties that have a single-digit county code would place a 0 in front of the first digit.
 - b. The second set of numbers would be a number from 1 to 9,999,999, which would be used to specifically identify each patient within that county.
 - c. Example: 01-0000025
3. The disaster incident number could be assigned at any of the following entry points and/or locations:
 - a. Hospital - To be assigned at registration.
 - b. Alternate Care Site /field treatment centers/shelters - To be assigned at registration.
 - c. Emergency Medical Services (field crew) - To be assigned upon pick up.
4. The disaster incident number Label includes the following elements to be completed by the person performing the intake for that patient. At all entry points, the goal is to fill out as much information as possible at the time the disaster incident number is initiated. The disaster incident number label includes the following elements to be completed by the person performing the intake for the patient. When the local Emergency Medical Services Agency initiates the disaster incident number, condition, gender and destination are key data elements.
 - a. First Name - Patient's first name
 - b. Last Name - Patient's last name
 - c. Street Address - Patient's home address
 - d. City - Patient's city of residence
 - e. SSN - Patient's Social Security number
 - f. Telephone - Patient's home phone
 - g. Cell - Patient's cell phone
 - h. Destination – Place to which the patient is being triaged
 - i. Condition (Minor compromise, Major compromise, Not compromised, Shelter only)
 - j. Facility Name
5. The disaster incident number form may include a bar code that would represent the number for that form.

6. Ideally, the Disaster Incident Number should replace the triage number on the triage tag. Alternatively, the triage tags can be modified to include space for a Disaster Incident Number label.

Sample Disaster Incident Number Label

First Name:	Multiple copies of these stickers provided to follow the patient as he / she moves
Last Name:	
DIN:	BAR CODE and Disaster Incident Number
Street Address:	
City:	BAR CODE and Disaster Incident Number
SSN:	
Tel:	BAR CODE and Disaster Incident Number
Cell:	
Destination:	BAR CODE and Disaster Incident Number
Facility Name:	
Condition (indicate condition with check mark):	
Minor compromise: []	Not compromised: []
Major compromise: []	Shelter only: []

Patient Tracking Form²¹

This procedure is an example of the type of process and form that could be instituted at an Alternate Care Site for the purpose of tracking patients as they are transferred to other facilities. Additionally, this form could serve as a tool to report Alternate Care Site census and bed capacity to the local incident command.

The Alternate Care Site Patient Tracking Form is shown below. The form can also be found in the Government-Authorized Alternate Care Site Operational Tools Manual on pages 47-49.

PURPOSE: Track individuals seeking medical attention within an Alternate Care Site and disposition of those transferred to hospitals during a healthcare surge

INSTRUCTIONS:

Print legibly and enter complete information.

1. **INCIDENT NAME** The incident name should clearly identify the cause of the surge requiring the operation of an Alternate Care Site (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 time 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 Alternate Care Site Director, 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. **TRIAGE AREAS (IMMEDIATE, DELAYED, EXPECTANT, MINOR, MORGUE)** 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 location and time of diagnostic procedures, time patient was sent to surgery, disposition of patient and time of disposition.
 - a. **LAST NAME** Record patient's last name
 - b. **FIRST NAME** Record patient's first name
 - c. **DIN** Disaster identification number is the unique identifier assigned to that patient for the surge
 - d. **MR #/Triage #** Medical record (MR) number and/or triage number assigned to that patient at the hospital
 - e. **SEX** Record "M" for male and "F" for female
 - f. **DOB/AGE** Date of birth for that patient. Use the international standard date notation. If available and/or time permits, age should be recorded as well.
 - g. **TIME IN** Record the time the patient was received at the hospital using the international

- g. **TIME IN** Record the time the patient was received at the hospital using the international standard time notation.
- h. **AREA TRIAGED TO** The area or zone a patient is triaged to
- i. **DISPOSITION** The specific area, hospital or location the patient is being transferred or discharged to
- j. **TIME OUT** Record the time of patient transfer or discharge using the international standard date notation.

5. **AUTHORIZATION SIGN OFF**

6. **CLINICAL PROVIDER**

7. **SUBMITTED BY** Use proper name to identify who verified the information and submitted the form.

8. **AREA ASSIGNED TO** Indicate the 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. **ALTERNATE CARE SITE NAME** Record the hospital name. Use when transmitting the form outside of the treating hospital.

11. **PHONE** Record the Alternate Care Site phone number.

12. **FAX** Record the Alternate Care Site fax number.

WHEN TO COMPLETE Hourly and at end of each operational period, upon arrival of the first patient and until the disposition of the last.

ALTERNATE CARE SITE PATIENT TRACKING FORM

1. INCIDENT NAME: _____ 2. DATE/TIME PREPARED: _____ 3. OPERATIONAL PERIOD DATE/TIME: _____

4. TRIAGE AREAS IMMEDIATE, DELAYED, EXPECTANT, MINOR, MORGUE

MR # / Triage #	Disaster Incident Number	Last Name	First Name	Sex	DOB/ Age	Time In	Area Triage to or Ambulance Unit	Disposition	Time Out

5. AUTHORIZATION SIGN OFF: _____ 6. CLINICAL PROVIDER: _____

7. SUBMITTED BY: _____ 8. AREA ASSIGNED TO: _____ 9. DATE/TIME SUBMITTED: _____

10. ALTERNATE CARE SITE NAME: _____ 11. PHONE: _____ 12. FAX: _____

17.2 Patient Registration

During a healthcare surge, it is reasonable to expect that most staff resources in an Alternate Care Site will be devoted to patient care. Additionally, specific administrative functions may need to be modified due to limited technology at the Alternate Care Site or the staff's inability to collect personal data or insurance related information from the patient. Surge planning should include developing a modified registration form to use during surge conditions. Recommended data sets and sample registration tools are included below to guide the planning process.

A. Required Data Elements for Billing through Federal Emergency Management Agency

Reimbursement for operation of Alternate Care Sites will be based on time and materials. Documentation on the number and types of patients treated may be required as justification for time and material charges. Minimum data elements include:

- Patient name
- Permanent and/or temporary displacement address
- Telephone number
- Disaster-related medical conditions or pre-existing condition flare up
- Specific services rendered
- Cause of injury or illness
- Date and time
- Location of treatment
- Provider
- Provider license number
- Medi-Cal/Medicare ID number
- Provider signature
- Documentation of care to specify moment of care or stabilization
- Indicate whether treatment for medical stabilization or regular medical care

B. Sample Alternate Care Site Patient Registration Form

Procedures must be established for conducting patient registration within an Alternate Care Site. The following Patient Registration Form sample, adapted for use by an Alternate Care Site, provides suggestions related to minimum data elements that should be considered for collection during patient registration.

The Alternate Care Site Patient Registration Form is shown below. The form can also be found in the Government-Authorized Alternate Care Site Operational Tools Manual on pages 43-44.

Alternate Care Site Patient Registration Form	
Patient name:	Patient guardian:
Social security #:	Date:
Date of birth:	Time:
Telephone #:	
Permanent and/or temporary displacement address:	
Disaster-related medical condition: <input type="checkbox"/> or Pre-existing condition flare up: <input type="checkbox"/>	
Comments:	
Cause of injury or illness:	
Specific services rendered:	
Documentation of care to specify moment of care or stabilization:	
Location of treatment:	
Treatment for medical stabilization: <input type="checkbox"/> or Treatment for regular medical care: <input type="checkbox"/>	
Comments:	
Primary care provider:	
Provider:	Provider license #: Medi-Cal/Medicare ID #:
Provider signature: _____	

C. Sample Patient Registration Log

The Alternate Care Site Patient Registration Log may be used to log all patients registered at an Alternate Care Site. It includes fields for medical record number, disaster incident number, last name, and first name.

The Alternate Care Site Patient Registration Log is shown below. The log can also be found in the Government-Authorized Alternate Care Site Operational Tools Manual on pages 45-46.

#	Medical Record #	Disaster Incident #	Last Name	First Name
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				

D. Sample Paper-Based Patient Registration Face Sheets

A registration face sheet enables staff to collect critical patient demographic data as well health related information regarding the patient's medical condition. In the event that staff have limited access to technology to maintain an automated registration process, paper-based patient registration face sheets should be made available. Registration staff will manually complete pre-numbered (if available) face sheets. The Patient Registration Face Sheet will allow staff to more effectively monitor, track and locate patients coming into the Alternate Care Site for treatment as well as assist in collecting patient contact information in the event notification to a family member is required during the course of the stay.

A sample Alternate Care Site Paper-Based Patient Registration Face Sheet is shown below. The form can also be found in the Government-Authorized Alternate Care Site Operational Tools Manual on pages 41-42.

Alternate Care Site Paper-Based Patient Registration Face Sheet

Patient Information:

Name: _____ DIN: _____ DOB: _____ SSN: _____ Sex: Male Female
 Mailing Address: _____ Zip: _____ City: _____ County: _____
 Home Phone: _____ Cell/Message Phone: _____
 Marital Status: Single Married Widow Divorced Separated
 Name of Spouse: _____ Maiden Name: _____
 Race/Ethnicity: _____ Primary Language: _____ Translator Required? Yes No
 Employer Name: _____ Employers Phone Number: _____
 Employer Address if Work Comp related: _____ Occupation: _____

Accident/Injury/Condition Information:

Type of accident: _____ Date of Accident/Injury: _____ Time: _____
 Condition: _____
 Location: _____
 Is there legal action involved? Attorney or Insurance name: _____
 Phone _____ Address _____
 Policy ID#: _____ Claim#: _____ Adjuster: _____
 Is there a police report? Was there another car involved? Who was at fault? _____
 If other involved do you have there Insurance information? _____

Guarantor information (Person responsible for bill, co-pay, deductible, SOC etc.)

Name: _____ DOB: _____ SSN: _____
 Address: _____ Zip: _____ City: _____
 Home Phone Number: _____ Work Phone Number: _____
 Employer Address: _____ Occupation: _____

Emergency Contact:

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

Insurance Information: (Copy of Insurance Card and Identification Required)

Name of insurance Coverage: _____ Policy#: _____ Group# _____
 Is this a HMO plan? Yes NO. If yes name the Medical group: _____
 Primary Care Physician _____ Co-pay \$ _____

Subscriber Information:

Name _____ Relation _____ DOB _____ SSN _____
 Last Name, First Name
 Employer _____ Employer's Work Phone _____

Transferring Facility: _____ **Referring Physician:** _____

FOR EMPLOYEE USE ONLY:

If the patient has "No" Insurance was the POE Letter Provided Yes No
 Is the patient under 21 or over 65 years of age? Yes No
 Is the patient legally disabled? Yes No
 Is the patient pregnant? Yes No
 Does the patient have children under the age of 21 residing in the home? Yes No
 Forms Completed: T & C NOPP MCARE MRL & ADDENDUM Insurance Letter DFR EAAF ITI
 Eligibility Verified: Active Inactive Financial Counselor Referral: Yes No
 Runner _____ Follow Up _____

Adapted from UC Davis Health System

17.3 Medical Record and Records Retention

17.3.1 Paper-Based Medical Records

While care is being provided at the Alternate Care Site, a medical records system must be maintained. Experts recommend a paper-based medical records system for the Alternate Care Site, rather than trying to establish an electronic medical record system, for several reasons. First, any electronic medical record system would probably not be interoperable with the systems at the hospitals from which the patients originate (and possibly to which they return). As a result, patient movement would not be facilitated by an electronic system. A paper record can travel back and forth from one facility to another and, if necessary, can be entered into an electronic format at a sending/receiving hospital (just as normally occurs when patients move between hospitals that do not use electronic records systems). Second, electronic systems require hardware, software, technicians, and clinical personnel who are trained in that particular system. The equipment will most likely not be available on short notice, and staff coming from many other settings will not be familiar with the selected system. Finally, the effort does not appear warranted because the Alternate Care Site may be in operation for only a few weeks. For all of these reasons, reliance on a paper-based medical record will simplify the administrative burdens.

17.3.2 Short Form Medical Record

The sample short form medical record below is an example of the type of medical record that could be initiated for a patient during provision of care in an Alternate Care Site. The short form medical record should be used to capture pertinent assessment, diagnosis and treatment information. The recommended sets of medical record data elements that can be considered as accepted documentation during healthcare surge are included in the form.

The Alternate Care Site Short Form Medical Record is shown below. The form can also be found in the Government-Authorized Alternate Care Site Operational Tools Manual on pages 73-75.

Alternate Care Site Short Form Medical Record

Instructions:

This document should be completed for individuals seeking medical attention.

Demographic

Patient Demographic Information - Include patient name, date of birth, parent/guardian, disaster incident number and/or medical record number, known allergies, and primary physician.

History

- Chief Complaint - Enter patient's primary complaint upon presenting for care
- Significant Medical History - Enter notes on patient's medical history
- Glasgow Coma Scale - Enter score for each area
- Field Triage Category - Enter category
- Site Triage Category - Enter category
- Pupil Size - Enter pupil size
- Reactive - Circle yes/no
- Pain - Circle patient's level of pain
- Temp - Indicate patient's temperature
- Pulse - Indicate patient's pulse
- Respiration - Enter patient's rate of respiration
- Blood Pressure - Enter patient's systolic and diastolic blood pressure
- Intake - Enter patient fluid intake
- Output - Enter patient fluid output
- Special Dietary Needs - Enter patient's special dietary needs
- Medications - Indicate medications the patient is currently taking including name, dose, route and time
- Last Menstrual Period - Indicate last period
- Pregnancy Status - Indicate status

Physical Exam

- Physical Exam - This section should be used to capture comments relative to the assessment of the patient's cardiovascular, pulmonary and other body systems.

Re-Assessment

- This section is to be completed as a secondary assessment prior to a procedure. It includes a place for a set of vital signs and any lab results.

Procedure/Disposition

- This section of the form includes space to document the following:
 - Pre and post procedure diagnosis
 - Procedure performed
 - Findings
 - Condition of the patient post procedure
 - A check box to indicate if discharge instructions were provided in printed form and/or verbally
 - Dietary restrictions
 - Activity restrictions
 - Discharge medications
 - Follow-up visit information
 - Condition on discharge/Transferred to
 - Date, time and physician's signature authorizing discharge
 - Time admitted
 - Physician order notes/Other notes

Alternate Care Site Short Form Medical Record

Demographic	Patient Name: _____ DOB/Age: _____ Parent / Guardian: _____ Primary Physician: _____ DIN: _____ MRN: _____ Allergies: _____ <input type="checkbox"/> NKA																																																	
History	Chief Complaint: _____ Significant Medical History: _____ Last Menstrual Period: _____ Pregnancy Status: _____ <table border="1" style="display:inline-table; border-collapse: collapse;"> <tr><th colspan="2">Glasgow Coma Scale</th></tr> <tr><td>Eye</td><td> </td></tr> <tr><td>Motor</td><td> </td></tr> <tr><td>Verbal</td><td> </td></tr> <tr><td>Total</td><td> </td></tr> </table> Field Triage Category: _____ Site Triage Category: _____ Pupil Size L: _____ Reactive: <input type="checkbox"/> Yes <input type="checkbox"/> No Pupil Size R: _____ Reactive: <input type="checkbox"/> Yes <input type="checkbox"/> No Circle pain (Adult): 0 (no pain) 1 2 3 4 5 6 7 8 9 10 (worst pain) Circle pain ¹ (Child/Other) <table style="display:inline-table; text-align:center;"> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>0 NO HURT</td> <td>1 HURTS LITTLE BIT</td> <td>2 HURTS LITTLE MORE</td> <td>3 HURTS EVEN MORE</td> <td>4 HURTS WHOLE LOT</td> <td>5 HURTS WORST</td> </tr> </table>		Glasgow Coma Scale		Eye		Motor		Verbal		Total								0 NO HURT	1 HURTS LITTLE BIT	2 HURTS LITTLE MORE	3 HURTS EVEN MORE	4 HURTS WHOLE LOT	5 HURTS WORST																										
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Medications																																																		
Name	Route	Dose	Time Frequency																																															
Physical Exam	Physician initials: _____ Nurse initials: _____ Other initials: _____ Cardiovascular: _____ Pulmonary: _____ Neurological: _____ Other Significant Findings: _____ Physician initials: _____																																																	
Re-Assessment	Date: _____ Time: _____ System Review: Temp: _____ Pulse: _____ Respiration: _____ Blood Pressure: _____ Lab Results: _____ X-ray Results: _____ Physician initials: _____ Nurse initials: _____ Other initials: _____																																																	
Procedure / Disposition	Pre-Procedure DX: _____ Post-Procedure DX: _____ Procedure: _____ Findings: _____ Condition of Patient Post Procedure: <input type="checkbox"/> Critical <input type="checkbox"/> Guarded <input type="checkbox"/> Stable Discharge Instructions (YES/NO): Written _____ Verbal _____ Diet: <input type="checkbox"/> Regular <input type="checkbox"/> Soft <input type="checkbox"/> Liquid <input type="checkbox"/> Other: _____ Activities: <input type="checkbox"/> No Restrictions <input type="checkbox"/> Restrictions as Follows: _____ Discharge Medications: _____ Follow-Up Visit: When _____ NA: _____ Condition at discharge: ___ Critical ___ Guarded ___ Stable ___ Fair ___ Deceased ___ Temp ___ Pulse ___ Respiration ___ Blood Pressure Discharge: <input type="checkbox"/> Home <input type="checkbox"/> Shelter <input type="checkbox"/> ACS <input type="checkbox"/> SNF <input type="checkbox"/> Deceased Date: _____ <input type="checkbox"/> Transfer: _____ <input type="checkbox"/> Other: _____ Time: _____ Admitted: <input type="checkbox"/> Time admitted: _____ Physician order: _____ Notes: _____ Physician initials: _____ Nurse initials: _____ Other initials: _____																																																	

Wong, DL, Hockenberry-Eaton M, Wilson D, Winkelstein ML, Schwartz P: *Wong's Essentials of Pediatric Nursing*, ed. 6, St. Louis, 2001, p.1301.

17.3.3 Document Storage

Operation of an Alternate Care Site will include the need to create and store medical records. Ownership of the medical records after the Alternate Care Site has closed must be determined. Although current regulations require that a hospital maintain a copy of medical records for several years after discharge, this will not be possible at the Alternate Care Site after it is closed. There are several options for records control: 1) Local health department retains all records; 2) If operations are contracted out, the contractor retains copies of all records; or 3) Patient retains all records.

The Alternate Care Site Planning Team should evaluate these options to determine which is most feasible for their facility during a healthcare surge. Security and privacy issues should be considered under each option.

17.4 Alternate Care Site Administrative and Disease Reporting Requirements

An Alternate Care Site will not be subject to the disease and administrative reporting requirements of healthcare facilities, but should make reasonable efforts to mitigate any adverse health effects on the population from diseases by reporting occurrences of any unusual disease or outbreaks of diseases during a healthcare surge. For example, an Alternate Care Site would need to report clusters or unusual presentations of disease. These may be an unusual syndrome or appearance of pulmonary complications due to pandemic, or it may be an outbreak of diarrhea in the community, febrile rash illness, or unusual skin infections. The Alternate Care Site Planning Team should determine the process for reporting these requirements and develop tools to foster efficient reporting. Disease reporting should include, at a minimum, the numbers of cases, severity and deaths.

17.5 Health Insurance Portability and Accountability Act Compliance during Healthcare Surge

The Health Insurance Portability and Accountability Act (HIPAA) applies only to defined covered entities which include health plans, healthcare clearinghouses, and healthcare providers who transmit any health information in electronic form in connection with a transaction as defined under the act. Under this definition, Alternate Care Sites are not covered entities and would not be covered under HIPAA.

17.6 California State Privacy Law

Although an Alternate Care Site would not be subject to HIPAA, it would be covered by other state and local privacy laws. California State law pertaining to the privacy of information is expected to remain effective during a healthcare surge. Alternate Care Sites should take reasonable steps to ensure the privacy of identity and health information. A list of relevant privacy statutes and additional information on California State privacy laws can be found in the Reference Manual, Section 12: California State Privacy Laws Pertaining to Government-Authorized Alternate Care Sites

17.7 Patient Valuables Tracking

The patient valuable tracking system at an Alternate Care Site will be difficult and time consuming. Patients should be advised to not bring valuables with them to the Alternate Care Site. However, the Alternate Care Site Planning Team should recognize that patients will be admitted to the Alternate Care Site with valuables and should establish a plan for assuring the security of their valuables. The Alternate Care Site Planning Team should identify a secure area for storage of patient valuables and may want to develop procedures for discharging valuables to family members, ensuring that the release is fully documented. The Alternate Care Site Planning Team may also want to consider having patients sign a waiver that the Alternate Care Site is not responsible for lost valuables.

Sample Procedure for Patient Valuables Tracking²²

This policy and sample tracking form provides an example of the type of process and documentation that could be implemented at an Alternate Care Site 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	<p>A. The Alternate Care Site 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.</p> <p>B. Patient or patient representative 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 as follows: 1) 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. 2) The facility maintains a reasonable secure space for keeping small-size valuables and will not assume responsibility for the</p>

	loss or damage of these items.
DEFINITIONS	<p>A. Personal valuables include but are not limited to cash, checks, wallet contents, coin purse, keys, pocket knives, watches, hearing aids, miscellaneous papers, jewelry, personal electronic devices.</p> <p>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.</p>

Inventoried Valuables

During the admitting process, a designated staff member should advise the patient that valuables such as jewelry, credit cards and cash (more than \$20), will not be properly secured in the Alternate Care Site. Patients should be strongly encouraged to arrange with family members or others to secure their valuables.

The Alternate Care Site Patient Valuables Deposit Form is shown below. The form can also be found in the Government-Authorized Alternate Care Site Operational Tools Manual on pages 52-54.

Alternate Care Site Patient Valuables Deposit Form

Instructions

In the event a patient must store valuables with the Alternate Care Site for safekeeping, a designated Alternate Care Site staff should inventory the valuables and complete a patient valuables deposit form in the presence of the patient. The disaster incident number should be included on the patient valuables deposit form. The Alternate Care Site staff should:

1. Inventory and document valuables on the form.
2. Describe jewelry generically:
 - “Yellow metal” is used to describe gold.
 - “White metal” is used to describe silver.
 - Precious and semi-precious stones should be described by color and not by the type of stone.

An example—A man’s gold Timex watch with 5 diamonds would be described as “Man’s yellow metal watch with 5 clear stones, Timex.”

3. Conduct the inventory in the presence of the patient. If the patient is not able to sign the form or observe the inventorying of valuables, a friend or family member may do so. If a friend or family member is not present, another Alternate Care Site staff member must witness the process.

4. List credit cards individually by account number.
5. Document personal blank checks, including the total number of blank checks.
6. Record currency by denomination and also the total amount. Large amounts of currency being held (more than \$1,000) should be reported to Alternate Care Site security administration. Alternate Care Site security administration should determine whether further security precautions should be taken.
7. Record “none” if no currency is deposited. The space for currency should not be left blank.
8. Visually assess the patient for valuables, such as jewelry, rings, necklaces, earrings, etc., and encourage the patient to include all items in the inventory.
9. Have a witnessing Alternate Care Site staff member verify the inventory and document its accuracy by signing the patient valuables deposit form. This should be performed prior to placing the valuables into a patient valuables envelope.
10. Write the control number from the patient valuables envelope on the patient valuables deposit form.
11. Have the patient, family member or friend sign the patient valuables deposit form. If they are not available or able to sign, note in the signature slot that the patient is unable to sign.
12. Place the valuables into the patient valuables envelope, along with the original copy of the patient valuables deposit form, and seal it in the presence of the patient and the witnessing Alternate Care Site staff member.
13. Provide a second copy of the patient valuables deposit form to the patient and include the third copy in the patient’s chart.
14. Complete a patient valuables control log that is kept near the storage place for patient valuables (i.e., a safe) and have a witnessing Alternate Care Site staff member initial the log.
15. Deposit the envelope in a secured container in the presence of a witnessing Alternate Care Site staff member.

IMPORTANT!		ALTERNATE CARE SITE NAME	
RECORD VALUABLES PAK NUMBER			
PATIENT NAME		ADDRESS	
		CITY, ST ZIP CODE	
		PHONE NUMBER	
MEDICAL RECORD #	DISASTER INCIDENT #	PATIENT'S VALUABLES DEPOSIT	
RECEIVED BY	DELIVERED TO	CURRENT COUNT	CREDIT CARDS/CHECKS
		X \$100=	
RECEIVED FROM PATIENT OR REPRESENTATIVE		X 50=	
I leave the following items of personal property in the care, control and custody of the Alternate Care Site and I acknowledge that the items shown here have been put in a container, sealed and marked with my name, and that this has been done in my presence.		X 20=	
SIGNATURE OF DEPOSITOR		X 10=	
		X 5=	
		X 2=	
		X 1=	
DATE DEPOSITED		WITNESSED BY	Total Currency \$
RETURNED TO PATIENT OR REPRESENTATIVE		Total Coin \$	
I hereby acknowledge that all personal property deposited with the Alternate Care Site on the above mentioned date has been returned to me.			
SIGNATURE OF DEPOSITOR		Total Deposit \$	
DATE RECEIVED		WITNESSED BY	OTHER VALUABLES
		COMPLETED BY	DATE

Patient Valuables Envelope

Valuables should be stored in an envelope, ideally, a plastic, tamper-proof envelope. If one is unavailable, consider using a large manila envelope.

- The envelopes should be consecutively numbered for auditing and control purposes, if possible.
- A designated manager should ensure that patient-valuables envelopes are available to the triage, emergency department and admitting areas. The amount should be consistent with operational needs.
- Surplus envelopes should be securely stored.

follow-up visit for the purpose of observation, is considered first-aid even though provided by a physician or registered professional personnel.”

An injury is further defined in California Labor Code Section 3208.05 as “a reaction to or a side effect arising from healthcare provided by an employer to a healthcare worker, which healthcare is intended to prevent the development or manifestation of any blood borne disease, illness, syndrome, or condition recognized as occupationally incurred by California Occupational Safety and Health Administration, the Federal Centers for Disease Control, or other appropriate governmental entities. Such preventive healthcare, and any disability indemnity or other benefits required as a result of the preventive healthcare provided by the employer, shall be compensable under the workers’ compensation system. For purposes of this section, “healthcare worker” includes any person who is an employee of a provider of healthcare as defined in subdivision (d) of Section 56.05 of the Civil Code, and who is exposed to human blood or other bodily fluids contaminated with blood in the course of employment, including, but not limited to, a registered nurse, a licensed vocational nurse, a certified nurse aide, clinical laboratory technologist, dental hygienist, physician, janitor and housekeeping worker. “Healthcare worker” does not include an employee who provides employee health services for an employer primarily engaged in a business other than providing healthcare.”

California Labor Code Section 5402 requires the employer to authorize medical care within one day of receipt of a claim form and reimburse for all medical treatment in accordance with the American College of Occupational and Environmental Medicine’s guidelines or utilization schedules adopted by the state Division of Workers’ Compensation administrative director. Until the claim is accepted or denied, liability for medical treatment is limited to \$10,000.

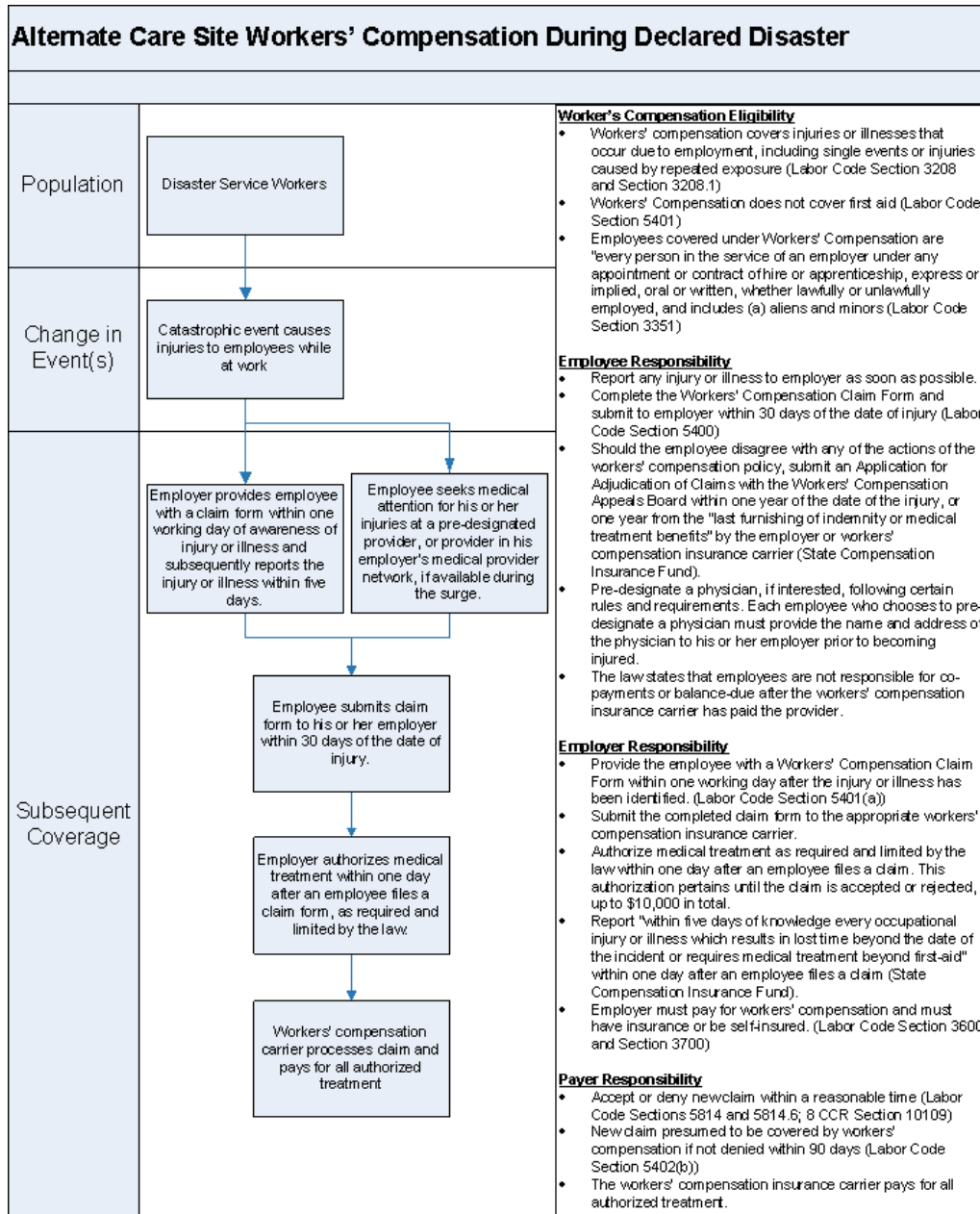
Registered Disaster Service Workers volunteers may file a claim for injuries sustained while engaged in the following activities: “Performing disaster service, including travel to and from the incident site, when called to duty during an emergency or disaster, or while participating in a search and rescue operation...Participating in an authorized and documented, planned disaster training activity or disaster exercise.” Coverage for these activities does not include travel to and from the training site. Unregistered volunteer workers not impressed into service may not file a claim if injured during a training activity or disaster exercise.

Staff at an Alternate Care Site may be injured at work and workers’ compensation is an important mechanism with which Alternate Care Site management should be familiar. Existing healthcare facilities have specific policies and procedures for reporting injuries sustained at work which may be used as samples for Alternate Care Site planning around this issue.

The process flows that begin on the next page depict how workers’ compensation may play a role during a healthcare surge for Disaster Service Workers. For additional information on how worker’s compensation may play a role as a payer of healthcare services for those injured at work during a healthcare surge, refer to the State of California Division of Workers’ Compensation website, which includes up-to-date information on how to file a workers’


compensation claim, how to request a qualified medical evaluation and other information. This website can be accessed at <http://www.dir.ca.gov/dwc/>.

The Alternate Care Site Workers' Compensation Process Flow and the State of California Workers' Compensation Claim Form for Disaster Service Workers is shown below. The tools can also be found in the Government-Authorized Alternate Care Site Operational Tools Manual on pages 97-99.



State of California Workers' Compensation Claim Form (DWC1)

A copy of the DWC1 form can be obtained at: www.dir.state.ca.us/dwc/DWCForm1.pdf

<p>State of California Department of Industrial Relations DIVISION OF WORKERS' COMPENSATION</p>		<p style="text-align: right;">Estado de California Departamento de Relaciones Industriales DIVISION DE COMPENSACIÓN AL TRABAJADOR</p> <p style="text-align: center;">PETITION DEL EMPLEADO PARA DE COMPENSACIÓN DEL TRABAJADOR (DWC 1)</p>
<p>WORKERS' COMPENSATION CLAIM FORM (DWC 1)</p>		
<p>Employee: Complete the "Employee" section and give the form to your employer. Keep a copy and mark it "Employee's Temporary Receipt" until you receive the signed and dated copy from your employer. You may call the Division of Workers' Compensation and hear recorded information at (800) 736-7401. An explanation of workers' compensation benefits is included as the cover sheet of this form.</p> <p>You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them.</p>		
<p>Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.</p>		
<p>Toda aquella persona que a propósito haga o cause que se produzca cualquier declaración o representación material falsa o fraudulenta con el fin de obtener o negar beneficios o pagos de compensación a trabajadores lesionados es culpable de un crimen mayor "felonía".</p>		
<p>Employee—complete this section and see note above Empleado—complete esta sección y note la notación arriba.</p>		
<p>1. Name. <i>Nombre.</i> _____ Today's Date. <i>Fecha de Hoy.</i> _____</p> <p>2. Home Address. <i>Dirección Residencial.</i> _____</p> <p>3. City. <i>Ciudad.</i> _____ State. <i>Estado.</i> _____ Zip. <i>Código Postal.</i> _____</p> <p>4. Date of Injury. <i>Fecha de la lesión (accidente).</i> _____ Time of Injury. <i>Hora en que ocurrió.</i> _____ a.m. _____ p.m.</p> <p>5. Address and description of where injury happened. <i>Dirección/lugar dónde ocurrió el accidente.</i> _____</p> <p>6. Describe injury and part of body affected. <i>Describe la lesión y parte del cuerpo afectada.</i> _____</p> <p>7. Social Security Number. <i>Número de Seguro Social del Empleado.</i> _____</p> <p>8. Signature of employee. <i>Firma del empleado.</i> _____</p>		
<p>Employer—complete this section and see note below. Empleador—complete esta sección y note la notación abajo.</p>		
<p>9. Name of employer. <i>Nombre del empleador.</i> _____</p> <p>10. Address. <i>Dirección.</i> _____</p> <p>11. Date employer first knew of injury. <i>Fecha en que el empleador supo por primera vez de la lesión o accidente.</i> _____</p> <p>12. Date claim form was provided to employee. <i>Fecha en que se le entregó al empleado la petición.</i> _____</p> <p>13. Date employer received claim form. <i>Fecha en que el empleado devolvió la petición al empleador.</i> _____</p> <p>14. Name and address of insurance carrier or adjusting agency. <i>Nombre y dirección de la compañía de seguros o agencia administradora de seguros.</i> _____</p> <p>15. Insurance Policy Number. <i>El número de la póliza de Seguro.</i> _____</p> <p>16. Signature of employer representative. <i>Firma del representante del empleador.</i> _____</p> <p>17. Title. <i>Título.</i> _____ 18. Telephone. <i>Teléfono.</i> _____</p>		
<p>Employer: You are required to date this form and provide copies to your insurer or claims administrator and to the employee, dependent or representative who filed the claim within <u>one working day</u> of receipt of the form from the employee.</p> <p>SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY</p> <p><input type="checkbox"/> Employer copy/Copia del Empleador <input type="checkbox"/> Employee copy/Copia del Empleado <input type="checkbox"/> Claims Administrator/Administrador de Reclamos <input type="checkbox"/> Temporary Receipt/Recibo del Empleado</p> <p>7/1/04 Rev.</p>		<p>Empleador: Se requiere que Ud. feche esta forma y que provéa copias a su compañía de seguros, administrador de reclamos, o dependiente/representante de reclamos y al empleado que hayan presentado esta petición dentro del plazo de <u>un día hábil</u> desde el momento de haber sido recibida la forma del empleado.</p> <p>EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD</p>

18. Reimbursement

Government–authorized Alternate Care Sites will be reimbursed through local, State, and federal resources. Third Party Payers, including commercial health plans, are not required to reimburse for healthcare services delivered through Alternative Care Sites. The Office of Emergency Services will assist local jurisdictions with reimbursement from both State and federal emergency funds for those healthcare services which are delivered at Alternative Care Sites. State funds under the California Disaster Assistance Act may be available as well as Federal Emergency Management Agency funds.

18.1 Federal Emergency Management Agency Public Assistance for Alternate Care Sites During a Healthcare Surge

Funds that are available from the Federal Emergency Management Agency are awarded at a baseline of 75 percent federal with a 25 percent state/local cost share. Under catastrophic events, the Federal Emergency Management Agency has sometimes paid up to 90 percent of the costs. The Federal Emergency Management Agency has traditionally focused on property casualty losses due to a disaster. However, as a result of temporary but substantial population displacement during the Hurricane Katrina disaster period and the severe acute respiratory syndrome (SARS) pandemic, Federal Emergency Management Agency funds have been appropriated for payment of medical stabilization services during a disaster. Recently the Federal Emergency Management Agency issued Disaster Assistance Policy # 9523.17 on Emergency Assistance for Human Influenza Pandemic, which recognizes that a Pandemic Flu scenario may require a different kind of local, State and federal response.

Given the rapidly infectious and deadly nature of human influenza, federal resource response for an outbreak is different from other disaster relief undertakings, and as such, a separate policy was developed to address this potential situation. One of the differences between a pandemic and most other emergencies is that a pandemic may last much longer than most public emergencies, and may include “waves” of influenza activity separated by months, affecting the ability of interstate mutual aid to respond and reducing the numbers of healthcare workers and first responders available to work. Additionally, resources in many locations could be limited, depending on the severity and spread of an influenza pandemic.

The Federal Emergency Management Agency Disaster Assistance Policy # 9523.17 on Emergency Assistance for Human Influenza Pandemic lists a series of emergency protective measures that may be eligible for reimbursement to State and local governments and certain private nonprofit organizations under the Public Assistance Grant. The measures most applicable to an Alternate Care Site are italicized below. For the full text of this Disaster Assistance Policy, see the Reference Manual, Section 7.24: Federal Emergency Management Agency's Emergency Assistance for Human Influenza Pandemic.

- Activation of State or local emergency operations center to coordinate and direct the response to the event
- Purchase and distribution of food, water, ice, medicine and other consumable supplies
- Management, control and reduction of immediate threats to public health and safety
- *Movement of supplies and persons*
- *Security forces, barricades and fencing, and warning devices*
- *Emergency medical care (non-deferrable medical treatment of disaster individuals in a shelter or temporary medical facility and related medical facility services and supplies, including emergency medical transport, X-rays, laboratory and pathology services, and machine diagnostics tests for a period determined by the Federal Emergency Management Agency coordinating officers)*
- *Temporary medical facilities (for treatment of individuals affected by disaster when existing facilities are overloaded and cannot accommodate the patient load)*
- Congregate sheltering (for individuals affected by disaster when existing facilities are overloaded and cannot accommodate the patient load)
- Communication of health and safety information to the public
- Technical assistance to State and local governments on disaster management and control
- *Search and rescue to locate and recover members of the population requiring assistance and to locate and recover human remains*
- Storage and internment of unidentified human remains
- *Mass mortuary services*
- Recovery and disposal of animal carcasses (except if another federal authority funds the activity — e.g., United States Department of Agricultural, Animal, Plant and Health Inspection Services provides for removal and disposal of livestock)
- Coordination with emergency support functions; coordination among emergency support functions 3, 5, 6, 8, 9, 11 and 14 will be required

19. Alternate Care Site Activation

Upon declaration of healthcare surge in a local health jurisdiction the establishment of Alternate Care Site may need to be considered. To prepare for a successful Alternate Care Site opening, the following should be considered for activation:²³

- Coordinate with each team member to ensure that the Alternate Care Site can be fully operational within 72 hours of the determination to activate
- Activate set-up process
- Ensure that at the time of opening, there is at a minimum: one armed guard, one physician and one nurse regardless of the size of the facility.
- Contact Alternate Care Site Director and operations chief
- Contact administrative staff
- Assemble all applicable contracts for services and staff
- Contact and mobilize staff for security, environmental, administrative, clinical and pharmaceutical services
- Contact vendors for supplies, pharmaceuticals and equipment to ensure smooth delivery
- Act as liaison between vendors and government-authorized Alternate Care Site
- Assist with troubleshooting or procuring additional assistance/resources as needed

19.1 Facility Assessment

A thorough facility assessment should be conducted to ensure the structural integrity of the facility. It is recommended that a facility vulnerability assessment report be completed at the initial stages of activating an Alternate Care Site. When ramping up for a healthcare surge, the Alternate Care Site facility should be checked to ensure the following:

- Functionality of utilities: electrical power, ventilation, heating, air conditioning, water and plumbing systems
- Functionality of a Heating, Ventilation and Air Conditioning (HVAC) system
- All areas that will not be used are partitioned off
- Functionality of telephone and other communications systems
- Functionality of backup power, if available
- Proper space needed for patient care: this may involve contacting an identified moving company to conduct move out of desks, etc.
- Efforts need to be made to make the Alternate Care Site as clean and sterile as possible.
- Availability of fire extinguishers
- Functionality of a supplemental morgue system

The Alternate Care Site Facility Damage Report (Limited Assessment) is shown below. The report can also be found in the Government-Authorized Alternate Care Site Operational Tools Manual on pages 24-25.

Alternate Care Site 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: _____

#	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 Alternate Care Site 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 Licensing and Certification District Office will ask the Alternate Care Site to describe its plan for resolving the issue. If facility is preparing to evacuate, the Licensing and Certification District Office will obtain patient list and evacuation destination(s) and complete a facility transfer summary. A summary report will then be sent to CDPH’s disaster preparedness coordinator and/or field branch chief.

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

The Alternate Care Site Facility On-Site Damage/Operability Report (Comprehensive Assessment) is shown below. The report can also be found in the Government-Authorized Alternate Care Site Operational Tools Manual on pages 26-28.

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

Alternate Care Site Facility Name: _____
 Date of Visit: _____

Address: _____ Evaluator Names: _____

City: _____

Overall Damage Assessment*:
 GREEN YELLOW RED

AVAILABLE VACANT BEDS MALE _____ FEMALE _____

PATIENT EVACUATION ORDERED BY: _____ TITLE _____

TYPE OF EVACUATION: TOTAL PARTIAL

BUILDING	YES	NO		COMMUNICATIONS	YES	NO
PARTIAL COLLAPSE			ELEVATORS OPERATIONAL (IF APPLICABLE)	EXTERNAL		
TOTAL COLLAPSE				INTERNAL		
PHOTOS TAKEN				ELEVATORS OPERATIONAL (IF APPLICABLE)		

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		
LINEN		
OTHER SUPPLIES		

STAFF AVAILABILITY	YES	NO
ADMINISTRATION		
NURSING		
DIETARY		
HOUSEKEEPING		

EVALUATOR COMMENTS AND DIAGRAM (IF NECESSARY):

Recommend Referral To: _____

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

*Green: Habitable, minor or no damage,

Yellow: Damage which represents some degree of threat to occupants

Red: Not habitable, significant threat to life safety

20. Alternate Care Site Closure

Once all patients can be safely discharged or transported back to existing facilities for continued care and there are no ongoing healthcare surge capacity needs, the Alternate Care Site can be closed. The Local Health Department and Alternate Care Site operations personnel will use professional judgment to determine when to shut down an Alternate Care Site and oversee shut-down activities. Shut-down of an Alternate Care Site will require removal of equipment and termination of ongoing contracts or arrangements. Shut-down should be expedited so that the facility can quickly be returned to the control of the existing owners and returned to its usual function.

Action checklist items for Alternate Care Site closure should include, but not be limited to, the following:

- Alternate Care Site Team Leader or designee checks in periodically with each team member to ensure initiation and completion of shutdown activities in that member's area of focus.
- Alternate Care Site Team Leader or designee assists with problem troubleshooting or procuring additional assistance or resources as needed.
- Alternate Care Site Team Leader or designee conducts a site walkthrough with the facility owner when shutdown activities are completed to ensure that removal of equipment and supplies, cleaning and other surge closure activities have been completed to the owner's satisfaction.
- Alternate Care Site Team Leader or designee performs medical record documentation storage procedures

21. 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/emshq/>
- ² Depending upon the jurisdiction, the designated official may be the director of emergency services, the director or medical director of the local emergency medical services agency, or medical health operational area coordinator. A description of these officials is provided later in this document.
- ³ Hassol A, Zane R. *Reopening Shuttered Hospitals to Expand Surge Capacity*. Prepared by Abt Associates Inc. under IDSRN Task Order No. 8. AHRQ Publication No. 06-0029. Rockville, MD: Agency for Healthcare Research and Quality. February, 2006.
- ⁴ Depending upon the jurisdiction, the designated official may be the director of emergency services, the director or medical director of the local emergency medical services agency, or medical health operational area coordinator. A description of these officials is provided later in this document.
- ⁵ Government Code Section 8607(a)(1) ; 19 CCR 2401; 19 CCR 2402(l); and 19 CCR 2405.
- ⁶ "National Incident Management System," United States Department of Homeland Security, March 1, 2004.
- ⁷ Adapted from Medical Board of California, Division of Licensing, Standard of Care for California Licensed Midwives. *Midwifery Standards of Care* (September 15, 2005). http://www.mbc.ca.gov/MW_Standards.pdf
- ⁸ 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_Medical_Subpanel.pdf
- ⁹ Expanded 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, Sections 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.
- ¹⁰ Business and Professions Code Section 4062(b).
- ¹¹ Business and Professions Code Section 4051.
- ¹² Business and Professions Code Section 900; Business and Professions Code Section 4005(b); Business and Professions Code Section 4062.
- ¹³ Business and Professions Code Section 4062(a)
- ¹⁴ "National Incident Management System," United States Department of Homeland Security, March 1, 2004.
- ¹⁵ Emergency Services Act, 19 CCR 2570.2
- ¹⁶ Business and Professions Code Section 4059.5 (a)
- ¹⁷ Hassol A, Zane R. *Reopening Shuttered Hospitals to Expand Surge Capacity*. Prepared by Abt Associates Inc. under IDSRN Task Order No. 8. AHRQ Publication No. 06-0029. Rockville, MD: Agency for Healthcare Research and Quality. February, 2006.
- ¹⁸ James Lenthall. Director, Safety/Security & Emergency Management, Saddleback Memorial Medical Centers.
- ¹⁹ AHRQ. Publication No. 07-0001, *Mass Medical Care with Scarce Resources. A Community Planning Guide*. February 2007.
- ²⁰ Hassol A, Zane R. *Reopening Shuttered Hospitals to Expand Surge Capacity*. Prepared by Abt Associates Inc. under IDSRN Task Order No. 8. AHRQ Publication No. 06-0029. Rockville, MD: Agency for Healthcare Research and Quality. February, 2006.
- ²¹ Adapted from HICS Form 260, Patient Evaluation Tracking Form, <http://www.emsa.ca.gov/hics/hics.asp>
- ²² Adapted from Tenet Health Systems, Business Office Procedure Manual, 2003.
- ²³ Hassol A, Zane R. *Reopening Shuttered Hospitals to Expand Surge Capacity: Surge Tool Kit and Facility Checklist*. Prepared by Abt Associates Inc. under IDSRN Task Order No. 8. AHRQ Publication No. 06-0029. Rockville, MD: Agency for Healthcare Research and Quality. February, 2006.