

Annex 12: Public Health & Operational Area (OA) Surge Plan

Updated: May 2018

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References:

Institute of Medicine (IOM) Crisis Standards of Care: A Toolkit for Indicators and Triggers, 2013

IOM Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response, 2012

California Department of Public Health, Standards and Guidelines for Healthcare Surge, 2007

California Public Health and Medical Emergency Operations Manual (EOM) 2011

I. Purpose:

The **purpose** of this function-specific plan is to describe how Public Health and Coalition partners participate in a shared response during a Tuolumne County Operational Area (OA) healthcare system surge event.

Background:

An important focus for the Public Health facilitated Health Care & Safety Coalition (HCSC) is developing plans and practicing events to prepare for medical surge. This surge of patients/clients/residents or victims could occur in response to multiple triggers, such as a natural disaster, a multi-vehicle and multi-victim accident or an emerging disease.

It is important to clarify that health care systems are frequently operating at or above capacity during day-to-day operations. Emergency Departments are often crowded with admitted patients awaiting inpatient beds. Emergency Medical Services (EMS) system resources are often challenged by overwhelming demand for services. Health care surge is **not** typical emergency department overcrowding or the result of a local multi-casualty incident that may stress nearby facilities but have little to no impact on the **overall** health care delivery system. The definition of healthcare surge states there is a marked increase of services needed that overwhelm the entire healthcare system.

During healthcare surge, the EMS system will conduct field operations to save lives, triage and transport patients. Hospitals are likely to care for the most severely injured or ill during a surge event and will take actions to free up bed capacity to treat those in greatest need. Other health care facilities will increase or maintain capacity to the extent possible and thereby reduce pressure on acute care facilities.

II. Definitions:

- A. Crisis Standards of Care A substantial change in usual healthcare operations and the level of care it is possible to deliver, which is made necessary by a pervasive (e.g., pandemic influenza) or catastrophic (e.g., earthquake, hurricane) disaster. This change in the level of care delivered is justified by specific circumstances and is formally declared by a state government, in recognition that crisis operations will be in effect for a sustained period. The formal declaration that crisis standards of care are in operation enables specific legal/regulatory powers and protections for healthcare providers in the necessary tasks of allocating and using scarce medical resources and implementing alternate care facility operations. (IOM 2009)

- B. Government Authorized Alternate Care Site (ACS) A location that is not currently providing healthcare services and will be converted to enable the provision of healthcare services to support, at a minimum, outpatient and/or inpatient care required after a declared catastrophic emergency. These specific sites are not part of the expansion of an existing healthcare facility (i.e., extensions of the general acute care hospitals), but rather are designated under the authority of the local health officer of designee when the delivery system is unable to accommodate the existing or anticipated patient volume. See attachment, Checklist for Opening a Government Authorized Alternative Care Site.

- C. Healthcare Surge 2007, CDPH Standards and Guidelines for 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

Public Health Surge Indicators and Triggers

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|--------------------------------------|--|
| Healthcare Surge | 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 provides, resources and/or emergency medical services. |
| D. Immediate Bed Availability (IBA) | IBA is the concept whereby coalition partners provide an appropriate level of care to non-disaster and disaster-related patients during declared disasters with public health implications, by availing 20% of staffed hospital beds to higher acuity patients within four hours of a disaster and identifying and providing the appropriate care for lower-acuity patients. |
| E. Population Based Care | During a catastrophic emergency event “clinicians will need to balance the obligation to save the greatest possible number of lives against that of the obligation to care for each single patient.” Those rendering care must be informed of surge status in their community so that they can adjust their practices accordingly. |
| F. Surge Capability | The ability to manage patients requiring unusual or very specialized medical evaluation and care. Requirements span the range of specialized medical and public health services (expertise, information, procedures, equipment, or personnel) that are not normally available at the location where they are needed. It also includes patient problems that require special intervention to protect medical providers, other patients, and the integrity of the healthcare organization. |
| G. Surge Capacity | The ability to evaluate and care for a markedly increased volume of patients—one that challenges or exceeds normal operating capacity. Requirements may extend beyond direct patient care to include other medical tasks, such as extensive laboratory studies or epidemiologic investigations. |
| H. Surge Plan – Health Care Facility | Health Care Facility expansion can occur two ways: 1) expand existing healthcare facilities to increase capacity for patient care, or 2) establish temporary healthcare facilities to provide care in non-healthcare locations, such as a government authorized care site (ACS). |
| I. Trigger | A decision point along the continuum of care (initiates action). |

III. Surge Concept of Operations

- A. When a disaster leads to health care surge, facilities and EMS providers activate their Disaster Plans to manage the actual or anticipated health care needs of patients.
- B. When multiple agencies (e.g., public health, EMS, fire) are involved in an emergency response *and Unified Command has been established*, the Health Officer or Emergency Medical Services Agency will participate. This establishes the MHOAC (Medical Health Operational Area Coordinator) functions during the event. The MHOAC represents the Health Care and Safety Coalition within the command structure.
- C. The MHOAC utilizes the color-coded descriptors to designate the status of the health care system and progression of surge in Tuolumne County during the event.

Public Health Surge Indicators and Triggers

- GREEN:** Local system is operational and in usual day-to-day status. No assistance required.
- YELLOW:** Most healthcare assets within the local jurisdiction are experiencing a surge and are able to manage the situation within their organizational frameworks. No assistance required.
- ORANGE:** The health care assets in the local jurisdiction require the participation of additional health care assets within the jurisdiction to contain the situation.
- RED:** Local jurisdiction is not capable of meeting the demand for care, and assistance from outside the local jurisdiction/Operational Area is required.
- BLACK:** Local jurisdiction not capable of meeting the demand for care, and significant assistance from outside the local jurisdiction/Operational Area is required.

Table 1: Local Surge Emergency

Local Surge Emergency						Regional Level Surge	Statewide Surge Level
Surge Level	Green	Yellow	Orange	Red	Black		
Enabling Authorities	Regulation/ Accrediting Agency Waiver	Regulation/ Accrediting Agency Waiver	Regulation/ Accrediting Agency Waiver & Local Emergency Declaration	Local Emergency Declaration	Local Emergency Declaration	State of Emergency Declaration	Federal Emergency Declaration

Source: EOM, page 133

Table 2: Contacts

Office	Telephone
Health Officer and/or Medical Health Operational Area Coordinator (MHOAC) Tuolumne County Public Health 20111 Cedar Rd N Sonora, CA 95370	Office hours: 209-533-7401 After hours: 209-533-8055
CDPH Licensing and Certification Sacramento District Office (Tuolumne County)	916-263-5800 or 800-554-0354 Fax: 916-263-5840
CDPH Duty Officer	916-328-3605 CDPHDutyOfficer@cdph.ca.gov
California State Warning Center (CSWC) Note: Hazardous materials spills or releases must be reported immediately to the CSWC	916-845-8911 Warning.center@ops.calema.ca.gov

IV. Implementing Crisis Standards of Care as a Response to Surge

- A. Public Health is an essential partner when implementing Crisis Standards of Care.
1. Catastrophic care moves from individual-based care to population-based. The standard of care will focus on saving the maximum number of lives possible.
 2. Under current state statute and regulations, a move to population-based healthcare response must be preceded by a declaration of a health and medical emergency. The declaration of a local health and medical emergency is issued by the Health Officer and the Board of Supervisors.
 3. Executive Standby Orders are issued by the Governor following his/her issuance of a declaration of emergency. Based on the event and impact to the delivery system, these temporary changes to statutes and regulations may affect hospitals, long-term care facilities, community care clinics, public health departments and other primary and secondary care providers, resources and/or emergency medical services. Federal waivers and temporary suspension may also occur.

Public Health and Operational Area Surge

- B. The local health official and local government determines the scope of the medical and health emergency and facilitates communication to the local healthcare delivery system with the region, state and federal government. This includes changes to the standard of care, or initiating Crisis Standards of Care permitted by regulatory and legal authorities.
- C. The following attachments include both triggers and tactics for the progression of surge from contingency (unusual) to crisis standards of care:

V. Implementing Patient Tracking

- A. The operational area patient tracking process is an integral aspect of Capability 6: Information Sharing. Two needed functions in patient tracking are:
 - 1) The access to relevant and aggregate patient tracking data from EMS and Healthcare organizations, and the capacity to,
 - 2) Integrate the aggregate patient tracking data into the local, state and/or Federal incident common operating picture.
- B. The HAVBED program utilized by the Tuolumne County Emergency Medical Services Agency (EMSA) is integrated with the Federal tracking system. Tuolumne County TCEMSA manages this program through Region IV.
- C. Patient Tracking may be required for an MCI, natural disaster or contagious epidemic (pandemic). Tuolumne County patient tracking includes the following steps to improve data collection and reporting.
 - 1) Healthcare organizations are asked to associate the triage tag from an MCI event for reporting.
 - a. If patient is transferred from one healthcare organization to another, perhaps for a change in necessary level of care, the triage tag is to be sent along with the patient.
 - b. If patient is discharged from care and is not moving to another facility, the last facility to care for the patient is to keep the triage tag. LEMSA will then collect the tags from each facility.
 - 2) For an event where the triage tag is not used, an event name or code will be distributed. For example, during the 2009 H1N1 event, specific codes and waivers were issued by the Health and Human Services (Centers for Medicare/Medicaid Services) agency.
 - 3) Reporting by paper or electronic reporting is acceptable ([see attached sample form](#)).
 - 4) Patient event specific tracking will be initiated by the MHOAC or County Office of Emergency Services.
 - 5) A person and/or department will be identified to receive and assemble the information.
 - 6) All information is protected and secure and limited to those with authority/permissions to use the information during an incident. ([see attached flow chart](#))

The facility may choose to limit the information and/or request the patient permission which is addressed by the following codes: *California Civil Code § 56.10 and California Health and Safety Code § 123100-123149.5 (15) Basic information, including the patient's name, city of residence, age, sex, and general condition, may be disclosed to a state-recognized or federally recognized disaster relief organization for the purpose of responding to disaster welfare inquiries. Code of Federal Regulations, § 164.510(b)(4) Uses and disclosures for disaster relief purposes. A covered entity may use or disclose protected health information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating with such entities the uses or disclosures permitted by paragraph (b)(1)(ii) of this section. The requirements in paragraphs (b)(2), (b)(3), or (b)(5) of this section apply to such uses and disclosures to the extent that the covered entity, in the exercise of professional judgment, determines that the requirements do not interfere with the ability to respond to the emergency circumstances.*

V. Attachments

Triggers and Tactics Public Health

Public Health and Operational Area Surge

Triggers and Tactics Emergency Medical Services Agency

Triggers and Tactics Hospital

Triggers and Tactics Clinic

Triggers and Tactics Skilled Nursing Facility

Triggers and Tactics Behavioral Health

Checklist for Opening a Government Authorized Alternate Care Site

Patient Tracking Flow Chart

Sample Data Collection, Patient Tracking Form

Public Health Triggers and Tactics

No Notice	Slow Onset (Pandemic)
<i>(Depending on event, triggers and tactics from either no notice or slow onset are combined in response)</i>	
CONTINGENCY	
Unusual Event (beyond capacity of day to day operations)	
<p>Triggers:</p> <ol style="list-style-type: none"> 1. Disruption of services 2. Impacted persons taken to multiple health care organizations 3. Unable to locate or track all patients impacted by incident 4. Disruption of roads 5. Inadequate EMS resources 6. Emergency medical services (EMS) reporting evacuations of long-term care (LTC) and similar facilities 7. Multiple healthcare facilities have infrastructure damage 8. Disruption medical supply chain; anticipate shortages 9. Substantial loss of 911 or other communications 10. Numbers of persons are missing adding to pressure families are putting on 911 and other systems to find them 11. Emergency management has initiated shelters 12. Capacity exceeded despite surge capacity plan activation 	<p>Triggers:</p> <ol style="list-style-type: none"> 1. Increasing outbreaks in more than one jurisdiction 2. Fatality storage capacity has been exceeded 3. Public information hotlines needed 5. Interruption or contamination of water supply or utilities 6. Increasing absenteeism among public health staff; increased demand for staffing for community-based interventions, etc. 7. Community-based interventions required (e.g., vaccine, countermeasure distribution, “flu centers”) 8. Decrease availability of critical medical resources anticipated 9. Requests for health care coalition coordination of supplies Health care organizations and/or medical 10. Statewide indication of high transmission in congregate setting
<p>Tactics:</p> <ol style="list-style-type: none"> 1. Implement patient tracking system 2. Support requests from health care organizations through health care coalition 3. Prioritize key public health activities to support critical jurisdictional needs and health care organization service delivery 4. Local public information officials work with media on health-related risk communication strategies 5. Implement family reunification systems (EOC) 6. Modify EMS transport protocols (statewide) and suspend specific staffing and other response requirements 7. Local EOCs work with regional to identify and prioritize transport resources 8. Identify cross-trained personnel to support services linked to incident 9. Plan to support response with volunteer health professionals (Emergency System for Advance Registration of Volunteer Health Professionals [DHV], Medical Reserve Corps [MRC], coalition, etc.) 10. Work with health care coalition to distribute regional resources, including obtaining resources from health care coalitions that are not impacted by the incident 11. State Emergency Support Function- (ESF-) 8 will identify possible waivers, including the reuse of equipment and supplies within health care organizations – inform coalition partners. 12. Initiate process to request SNS 	<p>Tactics:</p> <ol style="list-style-type: none"> 1. Allocate scarce resources to maintain public safety functions (civil order maintenance) 2. Initiate coordinated risk communication strategies (JOC) 3. Use government purchasing powers to support critical medical supplies 4. Maintain communications with federal SNS program 5. Disperse state public health guidelines on allocation of resources 6. State public health investigates modifications to laws, regulations, etc., for dealing with decedents. <u>Local public health</u> assesses cultural barriers to modifications. 7. Executive order or governor’s declaration to eliminate congregate gatherings 8. Quarantine orders implemented as indicated

Public Health Triggers and Tactics

No Notice <i>(Depending on event, triggers and tactics from either no notice or slow onset are combined in response)</i>	Slow Onset (Pandemic)
CRISIS	
Disaster Event indicating population based care or CSC (crisis standards of care) <i>Preceded by a Declaration of an (Local) Emergency</i>	
Note: Implies pertinent <u>contingency</u> triggers and tactics have been initiated either previous or simultaneous in response to event	
<p>Triggers:</p> <ol style="list-style-type: none"> Local emergency management needing shelters, including functional needs. (American Red Cross or other nongovernmental organization establishing multiple sheltering operations.) Health care organization capacity is overwhelmed based on casualty counts and impact on health care infrastructure Local EOCs and state emergency operation center are fully activated statewide to respond to catastrophic incident Widespread loss of utilities Widespread loss of critical communications (cellular, Internet, public safety radio, etc.) Incident unfolding with health care coalitions communicating more than 20% of facilities with significant infrastructure damage Hospitals have inadequate space for victims Requests to modify EMS transport protocols Local infrastructure damage will prevent mutual aid in a timely manner Requests for alternate care sites for inpatient to overflow Personnel availability impacted widely by access, family obligations, injury/direct effects Multiple organizations requesting medical staff support and inadequate availability of volunteers (DHV, etc) Specialty consultation unavailable to hospitals boarding burn, pediatric, or other patients due to demands or communication issues at referral centers (unable to transfer) Critical medical supplies are unavailable 	<p>Triggers:</p> <ol style="list-style-type: none"> With disaster plans implemented, fatality processing demand exceeds available resources and threat of civil unrest or decomposition is real Healthcare organizations have implemented all strategies and seek alternate care sites for inpatients Unable to fulfill critical mission (eg., support alternate care sites) with appropriate staff Forced quarantine is required to prevent spread of dangerous pathogen, public gathering is prohibited Have exceeded thresholds for critical resources and maximum critical care capacity Shortages of critical equipment, drugs, or vaccine present significant risk to persons who cannot receive them National guidance on rationing distributed
<p>Tactic</p> <ol style="list-style-type: none"> Establish a patient tracking system and allow access by nongovernmental and other organizations as required to facilitate family reunification Risk communications to community Identify needs of health care organizations in collaboration Identify staff, including volunteers, to assist with public health issues in shelters, including those targeted to functional needs Plan to support response with volunteer health professionals and modify services based on skills available Ensure skilled staff have support from non-specialized staff Limit services to those related to life/safety issues only Facilitate out-of-area specialty consultation as able Local health care organizations work with their health care coalition to distribute regional resources, including obtaining resources from health care coalitions that are not impacted by the incident State Emergency Support Function- (ESF-) 8 should identify possible waivers, including the reuse of equipment and supplies within health care organizations and modified transport plans Initiate process to request SNS 	<p>Tactics:</p> <ol style="list-style-type: none"> Coordinate risk communication strategies Activation of all available mortuary resources, including response teams and expanded cremation and processing operations Consider transfer of decedents to other locations for processing if required Focus allocation of scarce resources to maintaining public safety function Maintain communications with federal SNS program Eliminate all nonessential functions to support local and state response to the incident Reallocate any health professionals whose training allows them a more active role to support health care organizations Assist if needed in coordination of health volunteers to support public health and medical functions identified Triage personnel resources to services of most benefit (community vaccination, etc.) Use just-in-time recruiting and training as required to fulfill missions Obtain regulatory relief as required to facilitate facility crisis responses (e.g., who may administer vaccinations) Implementation of governmental waivers to establish alternate care sites Distribute and instruct on state crisis guidelines

EMS Surge Indicators and Triggers

No Notice	Slow Onset
<i>(Depending on event, triggers and tactics from either no notice or slow onset are combined in response)</i>	
CONTINGENCY – Unusual Event (beyond capacity of day to day operations)	
Triggers: <ol style="list-style-type: none"> 1. Increased patient encounters 2. Report of natural or manmade disaster with multiple injuries. (Evacuation routes crowded, roads or bridges collapsed.) 3. Hospital activating their EOC. EDs requested additional medical staff or are on diversion (>20-30%) 4. Public unable to access timely care 	Triggers: <ol style="list-style-type: none"> 1. Staff at risk for infection 2. More than 10% of staff off sick 3. Implement mitigation measures to protect staff 4. Available PPE is less than what is needed 5. The use of medical supplies, medications, vaccines and antidotes begins to exceed their replacement 6. Trend by the public to not comply with emergency directives (mitigation strategies)
Tactics: <ol style="list-style-type: none"> 1. Notify Control Facility, EMSA Medical Director, MHOAC 2. Activate mutual aid (local and if needed region) 3. Mutual Aid requests 4. Prioritize dispatch calls 5. Batched transport 6. Activate patient tracking log, associate to triage tag and potential request for electronic information sharing 	Tactics: <ol style="list-style-type: none"> 1. Coordinate with local healthcare coalition 2. Activate protocols that advise patients with minor injuries/illnesses to use their own transportation 3. Conservation of supplies 4. Change shift length 5. Activate alternative care sites and support with EMS as possible
CRISIS – Disaster Event indicating population based care or CSC (crisis standards of care)	
<i>Preceded by a Declaration of an (Local) Emergency</i>	
Note: Implies pertinent contingency triggers and tactics have been initiated either previous or simultaneous in response to event	
Triggers: <ol style="list-style-type: none"> 1. No available ground ambulances 2. Mutual aid for additional vehicles exhausted. 3. Mutual aid staffing resources exhausted 	Triggers: <ol style="list-style-type: none"> 1. Unable to sustain staffing 2. Overwhelmed by numbers seeking care
Tactics: <ol style="list-style-type: none"> 1. Direct dispatch to decline response without threat to life, direct EMS to decline transport without significant injury or illness 2. Mandatory use of disaster triage guidelines 3. Limit resuscitation to witnessed cardiac arrest 4. Secure federal, state, regional and local staffing resources/assets 5. Provide security for EMS crews 6. Activate crisis standards of care 7. Establish casualty collection points 8. Use treat and release protocols 	Tactics: <ol style="list-style-type: none"> 1. Reduce staffing requirements (ALS/BLS) 2. Provide medications to “at-risk” populations 3. Determine alternate vendors 4. Reduce staffing for ambulances to one 5. Use of non-EMS dispatch and non-transport protocols

Hospital Surge Indicators and Triggers

No Notice	Slow Onset
<i>(Depending on event, triggers and tactics from either no notice or slow onset are combined in response)</i>	
CONTINGENCY – Unusual Event (beyond capacity of day to day operations)	
Triggers: <ol style="list-style-type: none"> 1. Damage to infrastructure, transportation, and/or utilities and communications 2. Increased hospital census <ol style="list-style-type: none"> a. >____(hrs) ED boarding time 3. EMR/EHR downtime 4. Telephone or internet systems failures 5. Normal staff to patient ratios exceeded 6. Anticipate shortage in medical supplies 7. Usual transfer facilities on diversion and unable to accept patients 8. EMR/EMR Downtime 	Triggers: <ol style="list-style-type: none"> 1. Inpatient census exceeds conventional beds 2. Predict ventilator or other specific resource shortage 3. Medication/vaccine supply limited 4. Consumption rates of PPE unsustainable 5. Vendor shortages impact ability to provide normal resources 6. School closures require opening of staff day care 7. ____% of staff ill
Tactics: <ol style="list-style-type: none"> 1. Implement Surge strategies, such as cancelling electives and reassigning supervisory staff to patient care. 2. Curtail nonessential services and reassign staff 3. Earlier Discharges 4. Consider limited EOC 	Tactics: <ol style="list-style-type: none"> 1. Coordinate with local healthcare coalition 2. Expand outpatient capacity 3. Divert patients (separate infectious from non-infectious) 3. Obtain supplies from coalition stockpiles (including federal and state resources) 4. Repurpose, reuse or adapt equipment and supplies 5. Change documentation responsibilities 6. Consider opening childcare for staff
CRISIS – Disaster Event indicating population based care or CSC (crisis standards of care)	
<i>Preceded by a Declaration of an (Local) Emergency</i>	
Note: Implies pertinent contingency triggers and tactics have been initiated either previous or simultaneous in response to event	
Triggers: <ol style="list-style-type: none"> 1. Damage affecting critical systems 2. Unable to increase staff to patient ratios or broaden supervisory responsibilities 3. Lack of qualified staff for specific cases – especially those with high life-safety impact, such as ICU, Emergency, Surgery 4. Escalating and sustained demand on ED/outpatient despite implementing contingency strategies 	Triggers: <ol style="list-style-type: none"> 1. Contingency beds maximized 2. Contingency adaptations inadequate 3. Inadequate ventilators or other life sustaining technology 4. Inadequate supplies of medications or supplies (PPE) that cannot be conserved or substituted 5.
Tactics: <ol style="list-style-type: none"> 1. Active EOC and notify MHOAC and CDPH L&C 2. Change staff to patient ratios 3. Convert non patient care space to patient care 4. Reverse triage stable patients to these areas. 5. Change documentation strategies 6. Triage access to life-saving resources 7. Evacuate to other facilities 8. Activate (participate) in local healthcare coalition shared respond plans 	Tactics: <ol style="list-style-type: none"> 1. Obtain supplies from coalition stockpiles (including federal and state resources) 2. Establish nontraditional alternate care locations (coordinate with government-regulatory authorities) 3. Recruit and coordinate from volunteer organizations 4. Consider remote (tele-health) capacity 5. Restrict medication to select indicators 6. Restrict PPE to high-risk exposures 7. Follow State and Federal regulatory temporary adjustment to statutes, investigate CMS waivers, coding and batch billing (and other insurers)

Clinic (Outpatient) Surge Indicators and Triggers

No Notice	Slow Onset
(Depending on event, triggers and tactics from either no notice or slow onset are combined in response)	
CONTINGENCY Unusual Event (beyond capacity of day to day operations)	
Triggers: Damage to infrastructure, transportation, and/or utilities and communications Sole reliance on paper records (downtime may be long term) Multiple healthcare agencies/facilities have been damaged and/or need evacuation MHOAC or CAHAN alerts that a medical and health emergency has occurred Supply chain interruption	Triggers: Increasing requests for service Increasing staff absenteeism Alerts received from TCHD-CDPH – CAHAN regarding prevention and guidance on disease management Supply shortages Pharmacy's having difficulty filling prescriptions Hospitals are at capacity and either diverting or cancelling electives to accommodate surge.
Tactics: Activate alternate methods of communication Initiate downtime procedures and adjust documentation guidelines. Contact CDPH L&C with situation report Evaluate ability to send staff to a scene of emergency or integrate emergency appointments into schedule. Assess staffing, supplies and schedule needs for augmentation, reuse, and repurposing.	Tactics: Consider group appointments, such as all members of the same family with the same complaint Consolidate services or strategize to increase capacity, such as extend hours, calling in retired staff or volunteers Maintain contact with local emergency response agencies, such as Office of Emergency Services (OES) and local Public Health and MHOAC (Medical Health Operational Area Coordinator) Institute preventative strategies as directed Track and report
CRISIS Disaster Event indicating population based care or CSC (Crisis Standards of Care) <i>Preceded by a Declaration of an (Local) Emergency</i> Note: Implies pertinent <u>contingency</u> triggers and tactics <i>have been initiated</i> either previous or simultaneous in response to event	
Triggers: Absence of patient care records. Alternate care sites beyond capacity Clinics damaged or unable to increase capacity Critical shortage of sanitation and food Transportation, utilities and communications severely damaged	Triggers: Mass Fatalities 30% of staff are sick Transportation, communications, technology interrupted Absence of medical records Facility damaged Critical shortage of staff (providers) Rationing of supplies
Tactics: Initiate Incident Command System and lines of authority Coordinate with local healthcare coalition and MHOAC Reassign staff (example: billers become registration) Request (healthcare) volunteers and/or supplies Initiate triage and follow scope of practice and crisis standards of care as distributed by the state or federal government. Investigate CMS waivers and coding for billing adjustments	Tactics: Initiate Crisis Standards of Care as directed by the State and local Health Officer Follow recommendations on rationing equipment (and or recycle) Notify CDPH L&C if utilizing alternate space or site for patient care

Skilled Nursing Facility Surge Indicators and Triggers

No Notice	Slow Onset
<i>(Depending on event, triggers and tactics from either no notice or slow onset are combined in response)</i>	
CONTINGENCY	
Unusual Event (beyond capacity of day to day operations)	
<p>Triggers:</p> <ul style="list-style-type: none"> Damage to infrastructure, transportation, and/or utilities and communications Sole reliance on paper records (downtime may be long term) Multiple healthcare agencies/facilities have been damaged and/or need evacuation MHOAC or CAHAN alerts that a medical and health emergency has occurred Supply chain interruption 	<p>Triggers:</p> <ul style="list-style-type: none"> Increasing resident (same) disease-illness Hospital full with increasing wait times in the ED prior admission Increasing staff absenteeism Travel restrictions, closing of schools Alerts received from TCHD-CDPH – CAHAN regarding prevention and guidance on disease management Supply shortages Pharmacy's having difficulty filling prescriptions Hospitals are at capacity and either diverting or cancelling electives to accommodate surge.
<p>Tactics:</p> <ul style="list-style-type: none"> Activate alternate methods of communication Initiate downtime procedures and adjust documentation guidelines. Contact CDPH L&C with situation report Evaluate capacity for emergency admission (hospital bed decompression) Assess staffing, supplies and schedule needs for augmentation, reuse, and repurposing. Consider limited Incident Command System (ICS) initiation 	<p>Tactics:</p> <ul style="list-style-type: none"> Adjust services to increase patient care staff (reassign staff). Call in staff or volunteers Consider provisions for family to augment care Maintain contact with local emergency response agencies, such as Office of Emergency Services (OES) and local Public Health and MHOAC (Medical Health Operational Area Coordinator) Institute preventative and treatment strategies as directed Track and report
CRISIS	
Disaster Event indicating population based care or CSC (crisis standards of care)	
<i>Preceded by a Declaration of an (Local) Emergency</i>	
Note: Implies pertinent contingency triggers and tactics have been initiated either previous or simultaneous in response to event	
<p>Triggers:</p> <ul style="list-style-type: none"> Critical shortage of sanitation and foot Transportation severely interrupted Unable to transfer sick patients 	<p>Triggers:</p> <ul style="list-style-type: none"> Mass fatalities Critical shortage of staff and unable to support patient needs Critical shortage of supplies and/or medications
<p>Tactics:</p> <ul style="list-style-type: none"> Initiate ICS Notify CDPH L&C Follow Crisis Standards of Care guidelines as determined by the State and/or Federal, such as ratios, scope of practice and CMS waivers Adjust documentation Family provides care to the patient 	<p>Tactics:</p> <ul style="list-style-type: none"> Convert space Ration supplies Triage patients

Behavioral Health Surge Indicators and Triggers

BEHAVIORAL HEALTH

No Notice	Slow Onset
<i>(Depending on event, triggers and tactics from either no notice or slow onset are combined in response)</i>	
CONTINGENCY	
Unusual Event (beyond capacity of day to day operations)	
Triggers: Facility has damage Loss of usual transportation, utilities and communications Loss of electronic records Multiple casualties and victims in the county Staff are also victims Hospital bed decompression results in BH patients being discharged early Psychiatric inpatient facilities exceed capacity	Triggers: Increasing requests for evaluations Increased staff absenteeism Increased stress in health care workers (responders) Inadequate supplies of supplies, equipment and/or medications
Tactics: Expand early intervention strategies Implement alternative methods to maintain contact with staff and/or clients Expand temporary workforce Adjust documentation methods and guidelines Evaluate reassignment of space and staff Consider limited ICS (Incident Command System) Maintain communications with local responders (MHOAC, OES)	Tactics: Mobilize stress management team Monitor EOC needs and resources (supply and demand) Create alternative care – site – services Update mutual aid strategies Coordinate guidelines on alternative medications, dangers of self-dosing and resources for help/detox Coordinate response for a coordinate public-private response Develop and initiate risk communication strategies specific to the situation
CRISIS	
Disaster Event indicating population based care or CSC (crisis standards of care)	
<i>Preceded by a Declaration of an (Local) Emergency</i>	
Note: Implies pertinent contingency triggers and tactics have been initiated either previous or simultaneous in response to event	
Triggers: Facility damaged and must treat injured and/or evacuate Hospital triage results in reduction of BH patient admits Increased number of BH patients maintained in the ED Very heavy use of service Lack of supplies, equipment or medications (supply interruption) Psychiatric facilities exceed capacity	Triggers: Unable to meet requests for service, assessments and management
Tactics: Implement mutual aid Recommend Triage and dosing strategies to address critical shortages Evaluate out of area, out of State transfers	Tactics: Increased monitoring of medication supply Seek to expand temporary employment Access and use volunteers Reassign staff and or space Activate mutual aid

Checklist for Opening a Government Authorized Alternate Care Site

See CDPH Standards and Guidelines for Healthcare Surge During Emergencies, Volume II: Government-Authorized Care Sites

Topic	Key Points	
Definition	A location that is not currently providing healthcare services and will be converted to enable the provision of healthcare service to support, at a minimum, inpatient &/or outpatient care required after a declared catastrophic emergency . These sites are NOT expansion of an existing health care facility, but rather are designated under the authority of the local government.	
Level of Care	<p>The level of care at an Alternate Care Site (ACS) will differ from that provided by the existing healthcare facilities, because that care will be driven by resource availability.</p> <ul style="list-style-type: none"> • A government authorized ACS will be established only when anticipated that all other healthcare resources are exhausted. • The objective is to manage patient load until the local healthcare system can manage the demands of patients • The design considers three basic criteria; patient type, level of care, facility type. 	
Authority	<p>The California Emergency Services Act recognizes the role of the State and its political subdivisions to mitigate effects of an emergency.</p> <p>California Government Code Section 8550-8551: Under this authority local governments can contract with local public and private entities to establish and operate a government authorized Alternate Care Sites.</p> <p>California Government Code Section 8565-8574: Local Health Departments are responsible for planning and coordinating, other government entities may play a significant or primary role in setup and operation.</p>	
Patient Type (Determine)	<p>Inpatient/Outpatient: <i>Provision of inpatient & outpatient care with general care requirements.</i></p> <p>Critical: <i>Facilities treat patients with complex and/or critical care requirements. Keep this level in hospitals.</i></p> <p>Supportive: <i>Facilities provide palliative care requirements or conditions with maintenance needs.</i></p>	
Facility Selection (Considerations)	<ul style="list-style-type: none"> ✓ Close proximity to a hospital for transferring patients and sharing resources (lab, pharmacy, radiology) ✓ Sufficient number and types of existing communications ✓ Adequate parking, loading and unloading ramps ✓ Utilities, back-up generator highly desirable, ventilation heating, air conditioning, water, plumbing ✓ Men and women's restrooms and shower function for patients ✓ Kitchen facilities (separated from patient care areas) ✓ Refrigeration and storage for medical supplies and food ✓ Waste removal ✓ Area for hand-washing stations ✓ Staff support / rest break / shower areas ✓ Adequate staging areas for supplies and storage 	<ul style="list-style-type: none"> ✓ Fire protection ✓ Security, limited number of entrances (access control) and exits including wheelchair – gurney access ✓ Centralized medical command ✓ Rooms for registration and family waiting area ✓ Triage-focused areas for patients requiring various levels of care ✓ Oxygen supply and cylinder refill capability ✓ Mortuary support ✓ Sufficient square footage to provide space for patient cots or mats and space for work areas for healthcare providers, ancillary workers and support staff.
Level of Care	Supplies: <i>Tuolumne County maintains some supplies, including a State ACS Cache. Supplies needed include: (See list page 79, Alternate Care Site Cache, Updated April, 2007)</i>	
	<ul style="list-style-type: none"> ✓ IV fluids and administration supplies ✓ Bandages and Wound Management ✓ Airway Intervention and Management ✓ Immobilization ✓ Patient Bedding, Gowns, Cots, Misc. 	<ul style="list-style-type: none"> ✓ Healthcare Provider Personal Protective Equipment ✓ Exam Supplies ✓ General Supplies ✓ Defibrillators and Associated Supplies.
	Staffing: <i>Various staffing classifications and hours needed are available, page 62, Alternate Care Site Sample Estimated Staffing Levels for Healthcare Surge. A shortened list includes:</i>	
	<p>Command Staff, assign roles as needed</p> <ul style="list-style-type: none"> ✓ Chief Medical Officer (responsible for care 24/7) ✓ Physician – each physician, assuming 10-15 minutes per patient could see 48-72 patients over 12 hours ✓ PA/NP – Could supplement MD coverage ✓ Nursing Director (responsible for care 24/7) ✓ RN Supervisor – 1 / shift ✓ RN – could go as high as 1:40 with adequate LVN, nurse aide and ancillary staff coverage, highly dependent upon patient acuity (LVN-NA-MA) <p>Dependent upon level of patient acuity</p> <ul style="list-style-type: none"> ✓ Dietitian ✓ Discharge Planner ✓ EKG Tech 	<p>Dependent upon level of patient acuity</p> <ul style="list-style-type: none"> ✓ Laboratory Tech and/or Phlebotomist ✓ Laboratory Tech ✓ Medical Records ✓ Pharmacist or Pharmacy Tech ✓ Respiratory Therapist ✓ Radiology Technician ✓ Administrative Support ✓ Central Supply ✓ Biomed ✓ Housekeeping ✓ Security ✓ Transport ✓ Volunteers
	Documentation: <i>Implement forms, as needed, located in Manual, such as:</i>	

Checklist for Opening a Government Authorized Alternate Care Site

See CDPH Standards and Guidelines for Healthcare Surge During Emergencies, Volume II: Government-Authorized Care Sites

	<ul style="list-style-type: none"> ✓ ACS Patient Registration Form, pg. 44 ✓ ACS Patient Registration Log, pg. 46 ✓ ACS Patient Tracking Form, pg. 49 ✓ ACS Pharmaceutical Storage Checklist, pg. 56 ✓ Inventory based Pharmaceuticals by General Classification Table, pg 31 ✓ ACS Critical Pharmaceutical Locations tracking tool, pg.17 ✓ ACS Short Form Medical Record, pg 75 	<ul style="list-style-type: none"> ✓ ACS Volunteer Application (Support Staff). pg 95 ✓ State of California Workers' Compensation Claim Form for Disaster Service Workers, pg. 99 ✓ Lock-Down Checklist, pg 40 ✓ ACS Valuables Control Log, pg. 51 ✓ ACS Valuables Deposit Form, pg. 52 ✓ ACS Tracking Form for Dependent Care, pg 71
Volunteers	<p>See HEPReP Annex 10. Volunteer Management and Assimilation Checklist for additional detail. Sources of medical volunteers are listed on page 101. These include:</p> <ul style="list-style-type: none"> American Red Cross Disaster Services (ARC)– Local Sierra chapter California Medical Assistance Team (CalMAT) –Three 120 person CalMATs have been created under State control. Community Emergency Response Teams (CERT) Disaster Medical Assistance Team (DMAT) usually sponsored by a major medical center, i.e., Stanford Medical Center Disaster Service Worker- public employees California Disaster Healthcare Volunteers (DHV) – both local and regional or state Medical Reserve Corps (MRC) – organized medical and public health professionals. Stanislaus County maintains an MRC. 	

Patient Tracking Flowchart

CAPABILITY 6: Information Sharing

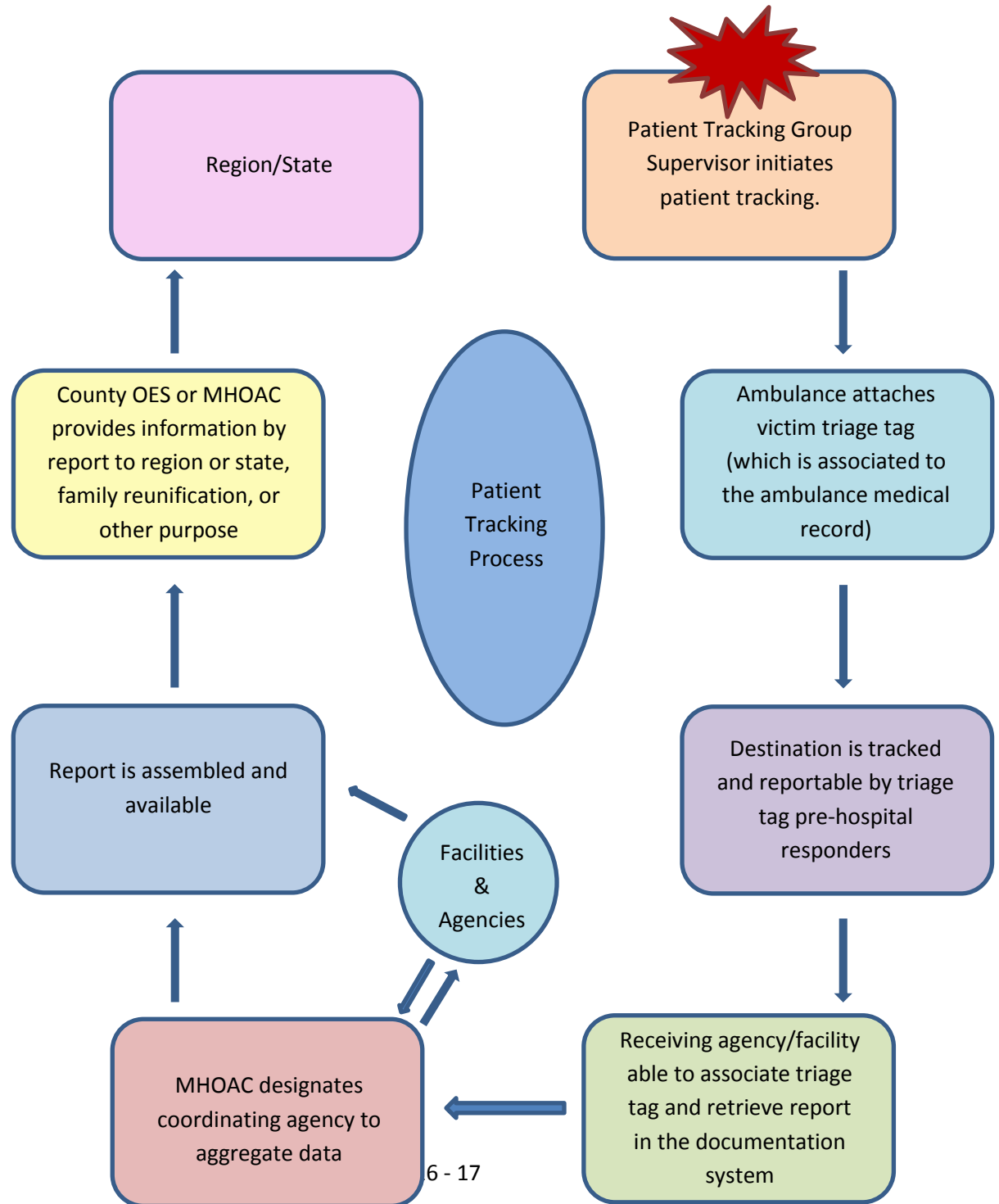
Provide healthcare situational awareness that contributes to the incident common operating picture.

The State and Health Care Coalitions, in coordination with EMS and healthcare organizations, should have or do have access to a patient tracking system. The system should have the ability to:

- 1) Track patient from entry into the healthcare system (EMS or facility level) *through discharge*
- 2) Integrate (aggregate) data into the local, state, and Federal incident common operating picture

California Civil Code § 56.10 (15)

Basic information, including the patient’s name, city of residence, age, sex, and general condition, may be disclosed to a state-recognized or federally recognized disaster relief organization for the purpose of responding to disaster welfare inquiries.



Tuolumne County Health Care & Safety Coalition

Preparing for Health and Medical Emergencies

PATIENT TRACKING FORM

Name of Incident:

Date:

Facility:

Person completing:

Return this form to Incident Command

Fax:

Email:

Admitted
Discharged
Transfer
Deceased

Triage Tag #	Last Name	First Name	DOB	Disposition (If transferred add location in "comments"
Comments:				
Comments:				
Comments:				
Comments:				
Comments:				
Comments:				
Comments:				

California Civil Code § 56.10 (15) Basic information, including the patient's name, city of residence, age, sex, and general condition, may be disclosed to a state-recognized or federally recognized disaster relief organization for the purpose of responding to disaster welfare inquiries.