

# Template 7.1. Core Functions of Hospital Facilities and Providers in the Implementation of CSC Plans

## *Hospital Facilities*

### Function 1. Alerting

#### Task 1

Health care facility is able to receive and manage alerts from emergency medical services (EMS), public safety, hospital partners, the department of public health (Health Alert Network), and the National Weather Service.

#### Task 2

Health care facility emergency response plan provides the triggers and process for incident command to activate the CSC plan and indicators (if applicable) to prompt consideration of activation.

#### Notes and Resources

Triggers and indicators are consistent with regional and state plans as applicable.

### Function 2. Notification

#### Task 1

Institution is able to alert staff within and external to the facility, including

- EMS and coalition/partner health care facilities;
- medical, administrative, and support staff;
- clinical care committee members; and
- technical experts, including those in toxicology, radiation safety, infectious disease, critical care, emergency medicine, trauma surgery, blood banking, dialysis, pediatrics, burn surgery, and mental health (those institutions without in-house expertise should identify other sources for consultation)

Notification mechanisms account for redundancy in case a disaster affects usual means of contact/consultation).

#### Task 2

Expectations of staff, including technical experts and those staffing the clinical care team, are understood prior to an incident, and appropriate activation/notification policies are in place.

#### Notes and Resources

Institution tests notification systems at least annually and ensures that up-to-date contact information is available.

## Function 3. Command

### Task 1

Hospital incident command system (HICS) (or other national incident management system [NIMS]) and community-compliant system is in place. Includes

- understanding where technical specialists, the clinical care committee, and the triage team fit into the incident management structure;
- training and exercising with key staff, including those on the clinical care committee and potential triage team members;
- command staff being trained and exercised (at least table-top) in activation of the full continuum of care, including use of crisis spaces and staffing;
- command staff understanding incident action planning and use of the planning section during longer-term events; and
- appropriate resources (job aids) being available to guide capacity expansion.

### Notes and Resources

See Appendix B for a sample hospital CSC plan.

See Table 7.2 in Chapter 7 for a sample surge capacity template.

## Function 4. Control

### Task 1

Command staff understand interfaces for resource requests and acquisition (as well as any existing plans for resource triage/allocation) with:

- Local public health and emergency management,
- Local/regional hospital coalitions, and
- State resources (usually via local emergency management and/or state public health).

### Task 2

Command and other appropriate staff understand transfer and diversion policies in the area and their function during a disaster.

### Task 3

Command staff understand the process for sheltering, relocation, and evacuation in response to threats to the facility.

### Task 4

Command staff understand options for security/access controls and community law enforcement support during a disaster.

### Task 5

Facility plan reflects a phased expansion of surge capacity/capabilities for conventional, contingency, and crisis situations.

### Task 6

Command staff understand the process for rapid facility and incident

### Notes and Resources

See Appendixes B, C, and D.

assessment in the immediate aftermath of an incident to gain situational awareness.

### **Task 7**

Command staff understand the state public health department authorities and resource allocation/policy/plans for an epidemic or other public health crisis, including how the health care facility interfaces with local and state public health (this affects facility isolation, personal protective equipment, quarantine, vaccination, countermeasures, and other actions taken to contain an outbreak).

## **Function 5. Communications**

### **Task 1**

Facility has policies and procedures in place for sharing situational information with staff, patients, and other facilities and agencies within the region.

### **Task 2**

Facility has redundant ability to communicate with:

- local EMS,
- the local emergency operations center,
- the local/regional health and medical multiagency coordination center (as applicable), and
- other hospitals/facilities in the area.

### **Task 3**

Facility has around-the-clock capability to receive health alerts and other local, state, and federal health communications and a process for rapidly analyzing those communications, and developing or modifying policy accordingly.

## **Function 6. Coordination**

### **Task 1**

Command staff understand the interface between the institution and local public health, emergency management, and local/regional hospital coalitions, as well as any multiagency coordination constructs.

### **Task 2**

Facility understands the function of the state disaster medical advisory committee and any regional medical coordination center or regional disaster medical advisory committees, as well as the means by which information is received from or communicated to these bodies.

### **Task 3**

If the facility is part of a health care system, plans document the responsibilities of the facility vs. the corporate response structure and the process by which corporate policy and other region- or community-developed policies and processes are integrated.

#### **Task 4**

If facility has a limited patient population (Department of Veterans Affairs [VA] hospital, children’s hospital, military hospital, rehabilitation hospital), there is guidance/a plan for how that facility will contribute to the response when an incident affects either its usual target population or other groups disproportionately.

### **Function 7. Public Information**

#### **Task 1**

Facility has a process in place to ensure the development of appropriate risk communications in conjunction with coalitions and/or public agencies, as well as facility-specific means of dissemination (website, calling programs, e-mail, social media).

#### **Task 2**

Facility coordinates information with other agencies and facilities and participates in joint information system (JIS) and joint information center (JIC) activities when implemented by the jurisdiction, state, or coalition. This includes the ability to reach key cultural groups served by the facility.

### **Function 8. Operations**

#### **Conventional Care**

##### **Task 1**

Command and unit staff are aware of actions to be taken to maximize the availability of staffed beds, including canceling elective admissions/surgeries and invoking early patient discharge (“surge discharge”) or movement.

#### **Contingency Care**

##### **Task 1**

Command and unit staff are aware of how to implement institutional plans for supply substitution, conservation, and adaptation; staff responsibility extension; and patient care area repurposing (e.g., opening pre- and post-anesthesia care units for general patient care).

#### **Crisis Care**

##### **Task 1**

This task is the same as Task 1 for contingency care, but options are expanded to include

- reuse and reallocation of supplies,
- changes in staff roles,
- use of cot-based care, and
- resource allocation and triage decisions and interface with the triage team (if activated).

Standards for patient care are adjusted according to circumstances (e.g., changed thresholds for intensive care unit or floor admission).

#### **Notes and Resources**

See Appendix B.

See Appendix C.

## **Medical Care Branch, Clinical Care Committee, and Triage Team**

### **Task 1**

Facility has planned for crisis care by convening potential members of an institutional clinical care committee and triage team (for tertiary triage of inpatients, not for no-notice incidents) to identify specific risks to the facility and specific resources at risk.

### **Task 2**

Facility emergency operations plan includes a crisis care annex that details the use of the clinical care committee and triage team, including

- membership,
- activation,
- roles and responsibilities,
- considerations prior to implementing triage strategies,
- documentation of decisions (medical records as well as incident documentation),
- the triage process and possible decision tools to be used (including the ability to incorporate incidents or community-specific modifications),
- an appeals process for triage decisions, and
- anticipated clinical and administrative strategies.

## **Mental Health**

### **Task 1**

Facility has non-mental health personnel trained in basic psychological first aid and psychological triage and assigns a role to mental health operations within its incident command system.

### **Task 2**

CSC-specific coping information/resources are provided to patients, family members, and staff, including CSC-specific “neighbor-to-neighbor, family-to-family” psychological first aid.

### **Task 3**

Facility has a plan for triage-driven management of psychological casualties, including participation in local/regional plans for mental health incident management.

### **Task 4**

Facility participates in the development of risk communications that include a behavioral component related to “coping with CSC” for patients, their families, and health care workers.

### **Task 5**

Facility has a personal resilience plan for health care workers that includes triage and referral to a continuum of evidence-based care.

### **Task 6**

Facility participates in a local gap analysis and develops an action plan to build key local disaster mental health and spiritual care capacities.

See Appendix B.

The mental health section of Chapter 4 provides more detailed discussion and examples.

### Task 7

Facility has a plan to engage community faith-based and other support providers, as well as key cultural groups within the community, during crisis care operations to expand mental health care capacity, particularly in times of resource triage.

## Palliative Care

### Task 1

Facility has planned for adequate symptomatic management (analgesia, antiemetics, anxiolytics) for all patients (including those that will not receive other treatment modalities).

### Task 2

Palliative care, including palliative care principles, triage tools, and any facility-specific procedures, is addressed in the emergency operations plan.

### Task 3

Palliative care training (including just-in-time training) is developed and provided according to the facility plan.

Palliative care may be addressed in the CSC/scarce resources annex or elsewhere in the facility emergency operations plan.

The palliative care section of Chapter 4 provides a more detailed discussion.

## Function 9. Logistics

### Supplies

#### Task 1

In conjunction with the clinical care committee, emergency management committee identifies key potential scarce resources based on different types of incidents and, to the extent possible, stockpiles or identifies alternative sources for these supplies.

#### Task 2

For highly vulnerable supplies, facility identifies strategies for appropriate substitution, conservation, adaptation, reuse, and reallocation.

#### Task 3

For local or state cached supplies (such as a local pharmaceutical cache) or Strategic National Stockpile (SNS) supplies, facility understands the process for requesting, receiving, and distributing these supplies.

### Space

#### Task 1

Facility examines available beds, beds in storage, cots, beds for lease, and other potential sources and develops a plan for maximizing available patient care space and converting non-patient care areas to patient care as necessary.

### Staffing

#### Task 1

Call-back criteria and policies are in place and include maintenance of current and accurate employee contact information,

### Notes and Resources

For an example, see the Minnesota Department of Health's *Strategies for Scarce Resource Situations*.

### **Task 2**

Facility assesses number of staff available for selected large-scale events, including those that limit access to the facility or result in provider illness. Consideration is given to the need for extended staffing requirements or for holding back adequate staff for future operational periods.

### **Task 3**

Facility plans for on-site accommodation of staff and family members as appropriate.

## **Special Challenges**

### **Task 1**

Patient groups requiring special consideration are identified, and to the extent possible, equipment and supplies to address their needs are purchased and/or stockpiled in relation to the facility's size and role in the community. These groups include (but are not limited to):

- pediatric patients,
- burn patients,
- patients requiring airborne isolation,
- patients requiring decontamination,
- patients with functional limitations (e.g., hearing or visually impaired), and
- patients requiring dialysis/renal replacement therapy.

### **Task 2**

Facility understands regional/state plans or resources for specific groups (e.g., pediatric-specific disaster supplies, regional pediatric or dialysis networks) and how to access/activate them.

All institutions should prepare to initially stabilize and treat all types of victims during a disaster

## **Function 10. Planning**

### **Technical Specialists and Clinical Care Committee**

#### **Task 1**

Clinical care committee understands its interface with incident command, and in particular the medical care branch director, planning section chief, and planning cycle, including its role in developing strategies for the next operational period.

#### **Task 2**

Technical specialists understand their interface with the command and planning sections.

#### **Task 3**

Clinical care committee reviews current response strategies, including any triage decisions made, and modifies strategies, tools, or processes based on evolving incident information as part of the incident planning cycle.

## Personnel Management

### Task 1

Hospital bylaws, credentialing policies and procedures account for disaster use of nonhospital staff (including use of local/regional staff in accordance with coalition agreements).

### Task 2

Emergency operations plan includes anticipating orientation, mentoring, education, and clinical care policies for outside staff.

### Task 3

Policies for altered staffing ratios, shift lengths, and staff roles are examined, and any collective bargaining issues are identified, if not addressed.

### Task 4

As needed, emergency operations plan addresses the use of nontraditional assistance (family members, volunteers, medical reserve corps [MRC] providers) to provide non-medical patient care.

### Task 5

Hospital understands the process and supporting agreements (e.g., worker's compensation, liability) for sharing staff with outside facilities in need, including staffing of alternate care systems.

### Task 6

Hospital understands the need to attend to staff resilience and mental health risk to maintain the hospital's continuity of operations.

## Function 11. Administration

### Authority

#### Task 1

Administration (including corporate administration) has examined its disaster delegation of authority to incident commanders and made any changes necessary to ensure that crisis care decisions are supported (i.e., that the incident commander is acting with the authority of the institution). During a crisis, the administration may require additional communications and coordination with the incident commander.

#### Task 2

Administration understands relevant changes to agency/facility authorities and protections when the state declares an emergency/public health emergency, including legal protections or obligations for medical providers (e.g., duty to serve).

### Regulatory/Legal Issues

#### Task 1

Facility and/or corporate legal counsel are aware of CSC plans and implications for patient care.

### Notes and Resources

See Chapter 3 for a more detailed discussion.

## Task 2

Legal department identifies state and local laws and regulations that would impact the institution's ability to implement CSC plans and possible solutions (see Chapter 3 for a full list of functions).

# Core Functions of Hospital Facilities and Providers in the Implementation of CSC Plans

## *Hospital Provider Functions*

### Function 1. Notification

#### Task 1

Providers understand their call-back responsibilities during an incident, including potential roles as technical specialists or clinical care committee/triage team members.

#### Task 2

Providers ensure up-to-date contact information and acknowledge receipt of exercise and incident messaging.

### Function 2. Command, Control, Communications, and Coordination

#### Task 1

Providers receive information on community disaster roles, including the Medical Reserve Corps (MRC) and Emergency System for the Advance Registration of Volunteer Health Professionals (ESAR-VHP).

#### Task 2

Providers understand where they report, to whom they answer during a disaster, and how to execute their roles. (This may include private as well as public roles, e.g., MRC member.)

#### Task 3

Providers know how to contact hospital command center and request resources.

#### Task 4

Providers receive incident command training appropriate to their role in the command structure, including

- location of plans and actions taken to implement the continuum of care in their area, including use of conventional/crisis spaces and
- resources (job aids) or unit-based plans to guide capacity expansion.

#### Notes and Resources

If provider is a member of command staff, additional training is required; see Function 3 in "Hospital Facilities" section of this template.

### Function 3. Public Information

#### Task 1

Providers understand key sources of facility/community information in disaster (web, Twitter, hospital hotline, etc.).

### Function 4. Operations

#### Task 1

Providers understand unit-based actions during expansion of care from conventional to crisis (surge discharge, adapted care on unit, cot-based care, etc.).

#### Task 2

Providers are prepared to perform triage as it relates to their roles (may involve, e.g., triage for early discharge, triage for resources in emergency department/surgery/other units, participation in triage team).

#### Task 3

Providers likely to perform triage (both reactive and proactive) understand the criteria they may consider (as well as what not to consider) when making triage decisions.

### Function 5. Logistics

#### Space

##### Task 1

Providers understand disaster space utilization on their units, including contingency/crisis expansion as applicable.

#### Staffing

##### Task 1

Providers understand how their unit staffing and hours may change during a disaster.

##### Task 2

Providers understand through education and other communications how their roles may be changed/expanded during a crisis (e.g., burn nurses may have responsibility only for burn/wound care as other nurses assume responsibility for overall patient care), including incorporation process for staff from outside the unit or facility as applicable.

##### Task 3

Providers understand how changes in record-keeping and other duties may occur in crisis situations (e.g., where to find and how to use paper forms).

## Supplies

### Task 1

Providers can access supplies from pharmacy/central/sterile supply and understands any existing contingency plans in case of shortage.

## Function 6. Operations

### Mental Health

#### Task 1

Providers understand employee resilience plan, including sources of employee mental health support.

#### Task 2

Providers are trained in anticipating normal stress reactions, developing a personalized “resilience plan” and identifying coping resources, as well as self-triage indicators of traumatic stress.

### Notes and Resources

See mental health section of Chapter 4 for a more detailed discussion.

## Function 7. Legal Issues

### Task 1

Providers understand legal obligations and liabilities for practice both within and outside of their hospitals when:

- \* a disaster or public health emergency has been declared;
- \* a disaster or public health emergency has not been declared; and
- \* when providing other disaster relief functions (for example, if serving as MRC or disaster medical assistance team member).

### Notes and Resources

Chapter 3 provides more detailed discussion.