

# Template 8.1 Core Functions of the Out-of-Hospital and Alternate Care Systems in CSC Planning and Implementation

## *Outpatient Care Facilities*

### Function 1. Alerting

#### Task 1

Health care facility is able to receive and manage alerts from partner facilities (corporate, health care coalitions, hospital, or other facility partners), public health agencies (health alert network), and the National Weather Service.

#### Task 2

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

### Function 2. Notification

#### Task 1

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

- medical, administrative, and support staff; and
- command/supervisory staff (especially if part of the larger system).

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

#### Task 2

Facility identifies technical experts that can work with the administration to determine issues/policies related to infection control, infectious diseases, pediatric care, mental health care, and other specialties as required by the role of the facility. (These may be identified regionally.)

#### Notes and Resources

Institution should at least annually test notification systems and ensure that up-to-date contact information is available.

### Function 3. Command

#### Task 1

A hospital incident command system (HICS) (or other modified National Incident Management System [NIMS]- and community-compliant system) appropriate to the institution's size and role is utilized. Includes

- understanding how decisions regarding changes to facility policy or clinical practice are implemented during an incident (decisions system- or facility-based?);
- training and exercising with key staff;
- command staff being trained in 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 incidents (including the interface with the corporate structure as applicable); and
- appropriate resources (job aids) being available to guide capacity expansion decisions.

## Function 4. Control

### Task 1

Command staff/leadership understand, to the degree necessary for the size/scope of the facility's engagement, the interface for resource requests and the acquisition process (as well as any existing plans for resource triage/allocation) with:

- local public health and emergency management,
- local/regional hospital or other partner coalitions, and
- state resources (usually through local emergency management).

### Task 2

Command and other appropriate staff understand transfer and diversion policies in the area and their function during disaster situations (including any agreements to receive ambulances or referral patients and what to do when emergency medical services [EMS] cannot rapidly transfer a patient from the facility to the hospital).

### Task 3

Command staff understand the processes 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 care situations.

### Task 6

Command staff understand the process for rapid facility and response assessment in the immediate aftermath of an incident to gain situational awareness.

### Task 7

Command staff/administrators understand the process for determining facility shut-down procedures (if required) and notification/diversion of patients.

### **Task 8**

Command staff/administrators understand their authorities relative to the facility and its role in any larger system (e.g., authority to change staffing, hours, policy).

## **Function 5. Communications**

### **Task 1**

Facility has policies and procedures in place for sharing situational updates with staff, patients, and other facilities and agencies as necessary (ideally via multiple methods, potentially including):

- staff e-mails, text messages, paging, telephone, and other devices;
- announcements, handouts, and postings; and
- web-based and social media.

### **Task 2**

Facility has the ability to communicate with:

- local EMS (9-1-1 system) for emergency transportation,
- the local emergency operations center (or representative to same),
- the local/regional health and medical multiagency coordination center (as applicable), and
- other hospitals/partner facilities in the area.

## **Function 6. Coordination**

### **Task 1**

Command staff understand the interface between the institution and local public health and emergency management agencies and any local/regional health care coalitions during a disaster.

### **Task 2**

Institution 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 facility is part of a health care system, plans document the integration of facility response with the corporate response structure and processes.

### **Task 4**

If facility has a limited patient population (Department of Veterans Affairs [VA], pediatric, or other specialty facility), there is guidance/a plan for how that facility contributes to the response when an incident affects either its usual target population or other groups disproportionately.

## Function 7. Public Information

### Task 1

Facility coordinates information with other agencies and facilities and participates in jurisdictional joint information system (JIS) activities as appropriate.

## Function 8. Operations

### Conventional, Contingency, and Crisis Care Conditions

#### Task 1

Under conventional care conditions, command/supervisory staff know how to maximize capacity, including postponing elective appointments, adjusting staffing and hours, and other changes.

#### Task 2

Under contingency care conditions, command/supervisory staff can implement plans for repurposing patient care areas (e.g., changes to waiting areas to segregate infectious patients, space expansion) and understand the decision process for changes to clinical practice.

#### Task 3

Under CSC conditions, same as under contingency care conditions, but options are expanded to include:

- reuse and reallocation of supplies,
- changes in staff roles or facility role (e.g., change from specialty clinic to “flu center”), and
- adjusted standards for patient care according to circumstances.

### Mental Health

#### Task 1

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

#### Task 2

Facility has all personnel trained in basic “neighbor-to-neighbor, family-to-family” psychological first aid that includes psychological triage.

#### Task 3

Facility has a health care worker personal resilience plan with inoculation, self-triage, and evidence-based care elements.

### Palliative Care

#### Task 1

Facility has anticipated the need for adequate symptomatic management (analgesia, antiemetics, anxiolytics) for its patients (including those that will not receive other treatments). These medications may be in short supply in community pharmacies.

### Notes and Resources

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

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

### **Task 2**

Palliative care is addressed in the emergency operations plan, including palliative care principles, triage tools if applicable, home care and medical equipment referrals, counseling referrals, and family support resources.

### **Task 3**

Palliative care training (including just-in-time training) can be made available to facility staff.

## **Function 9. Logistics**

### **Staffing**

#### **Task 1**

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

#### **Task 2**

Facility assesses the number of staff potentially available during whole-community incidents, including situations that limit access to the facility, affect staff families, or result in provider illness/injury.

#### **Task 3**

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

### **Supplies**

#### **Task 1**

Identify key potential scarce resources based on types of incidents and stockpiles or identify alternative sources for these supplies if possible (e.g., N95 masks, selected medications).

#### **Task 2**

For highly vulnerable supplies, identify 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 request, receipt, and distribution of these supplies through public health agencies.

### **Space**

#### **Task 1**

Facility has examined available patient care space and conversion of non-patient care areas to patient care, as possible.

### **Special Considerations**

#### **Task 1**

Patient groups requiring special consideration are identified, and, to the degree possible, equipment and supplies to address the needs of these

### **Notes and Resources**

See <http://www.health.state.mn.us/oep/healthcare/scarce/index.html>.

groups are purchased and/or stockpiled in relation to the facility's size and role in the community. Considerations include (but are not limited to):

- pediatric patients;
- potential need for airborne isolation;
- patients with functional limitations (e.g., hearing or visually impaired);
- patients needing dialysis/renal replacement therapy; and
- severely mentally ill adults/severely emotionally disturbed children.

### **Task 2**

Facility understands any regional plans or resources for specific groups (e.g., regional pediatric or dialysis networks) and its role in such plans.

## **Function 10. Planning**

### **Task 1**

Facility understands how to access appropriate technical specialists and how they interface with the facility's (or corporate) command and planning functions (may be a regionally shared function—for example, a regional disaster medical advisory committee).

### **Task 2**

Facility and/or system uses an action planning process and can modify the strategies, tools, or process based on evolving incident information.

### **Task 3**

Facility and/or corporate bylaws and credentialing policies and procedures account for the use of outside staff during a disaster, including the use of local/regional staff in accordance with coalition agreements, and for the integration of outside staff, including orientation, mentoring, and supervision.

### **Task 4**

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

### **Task 5**

Facility understands the process and supporting agreements (e.g., related to worker's compensation, liability) for sharing staff with other facilities in need, including staffing of alternate care sites.

## **Function 11. Administration/Legal Issues**

### **Task 1**

Administration (including corporate administration outside of the facility) examines its delegation-of-authority processes and makes any changes necessary to ensure that CSC decisions are supported

### **Notes and Resources**

See Chapter 3 for a more detailed discussion.

(i.e., that facility decision makers are acting with the support of administration).

### **Task 2**

Administration understands relevant changes to facility authorities and protections when state declarations of emergency/public health emergency are made, including legal protections or obligations for medical providers (e.g., duty to serve).

### **Task 3**

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

### **Task 4**

State and local laws and regulations that would constrain the institution's ability to implement CSC plans and possible solutions are identified (may be a regional effort—see Chapter 3 for a detailed discussion of functions).

## **Core Functions of the Outpatient Sector in CSC Planning and Implementation**

### ***Long-Term Care Facilities***

#### **Function 1. Alerting**

##### **Task 1**

Long-term care facility is able to receive and manage alerts from partner facilities (corporate, hospital, or other facility partners), public health agencies (health alert network), and the National Weather Service.

##### **Task 2**

Emergency response plan provides triggers and the process for incident command activation.

#### **Function 2. Notification**

##### **Task 1**

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

- medical, administrative, and support staff; and
- command/supervisory staff (especially if part of the larger system).

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

## Task 2

Facility identifies technical experts (may be shared regionally) that can work with administration to determine issues/policies for infection control, infectious diseases, palliative care, and other specialty considerations.

## Function 3. Command

### Task 1

An HICS system (or other modified NIMS- and community-compliant system) is in place. Includes

- understanding how decisions regarding changes to facility policy or clinical practice are implemented during an incident (decisions system or facility based?);
- training and exercising with key staff;
- command staff being trained in 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 incidents (including the interface with the corporate structure as applicable); and
- appropriate resources (job aids) being available to guide capacity expansion decisions.

## Function 4. Control

### Task 1

Command staff understand the interface for resource requests and the acquisition process (as well as any existing plans for resource triage/allocation) with their local partners (regional medical coalitions and public health and emergency management agencies as applicable).

### Task 2

Command and other appropriate staff understand the interface with EMS and what services EMS will provide during evacuation and other events associated with an incident.

### Task 3

Command staff understand the processes 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 at their facility during a disaster.

### Task 5

Command staff/administrators understand the process for determining facility shut-down procedures (if required).

## Function 5. Communications

### Task 1

Facility has policies and procedures in place for providing situational updates to staff, patients, and their families. Ideally, these mechanisms have redundancy in case of failure of the primary system.

### Task 2

Facility has the ability to communicate with:

- local EMS (9-1-1 system) for emergency transportation,
- the local emergency operations center (or representative to same),
- the local/regional health and medical multiagency coordination center (as applicable), and
- other partner facilities as applicable.

### Notes and Resources

## Function 6. Coordination

### Task 1

Command staff understand how they are expected to interface with local public health and emergency management agencies and/or existing health care coalitions during an incident.

### Task 2

Institution 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 shared with these bodies.

### Task 3

If facility is part of a health care system, plans document the integration of facility response with the corporate response structure and processes.

## Function 7. Public Information

### Task 1

Facility contributes to jurisdictional JIS activities as appropriate.

## Function 8. Operations

### Conventional, Contingency, and Crisis Care Conditions

#### Task 1

Under contingency care conditions, command and unit staff are aware of how to adjust staff hours and responsibilities and resident locations to maximize capacity.

### Notes and Resources

## Task 2

Under CSC conditions, same as under contingency care conditions, but options are expanded to include

- reuse and reallocation of supplies;
- significant changes in staff roles; and
- adjusted standards for patient care according to circumstances (e.g., adjusting referral criteria to medical care vs. care at long-term care facility).

## Mental Health

### Task 1

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

### Task 2

Facility has all personnel trained in basic psychological first aid (PFA) that includes psychological triage.

### Task 3

Facility has a health care worker personal resilience plan with triage and referral elements.

## Palliative Care

### Task 1

Facility has planned for adequate symptomatic management (e.g., analgesia, antiemetics, anxiolytics) for patients (including those that will not receive other treatments).

### Task 2

Palliative care is addressed in the emergency operations plan, including palliative care principles and resources, incorporation of incident-specific triage criteria when applicable, and patient/family support resources.

### Task 3

Palliative care awareness training is provided to staff, and just-in-time training can be made available.

See Chapter 4 for a more detailed discussion.

See Chapter 4 for a more detailed discussion.

## Function 9. Logistics

### Staff

#### Task 1

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

#### Task 2

Facility considers alternative staffing plans during incidents that limit access to the facility or result in provider illness/family illness.

### Notes and Resources

### **Task 3**

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

## **Supplies**

### **Task 1**

Identify key potential scarce resources based on types of incidents and, to the degree possible, stockpiles or identify alternative sources for these supplies (e.g., N95 masks, antivirals, vaccines).

### **Task 2**

For highly vulnerable supplies, identify strategies for appropriate substitution, conservation, adaptation, reuse, and reallocation as appropriate.

### **Task 3**

For local or state cached supplies (such as a local pharmaceutical cache) or SNS supplies, facility understands the process for request, receipt, and distribution of these supplies.

## **Space**

### **Task 1**

Facility has examined available patient care space and conversion of non-patient care areas to patient care, as possible.

See <http://www.health.state.mn.us/oeep/healthcare/scarce/index.html>.

## **Function 10. Planning**

### **Task 1**

Facility and/or corporate bylaws and credentialing policies and procedures account for the use of outside staff during a disaster, including use of the Medical Reserve Corps or staff from partner facilities.

### **Task 2**

Need for orientation, mentoring, education, and supervision of outside staff is anticipated.

### **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**

Facility understands the process and supporting agreements (e.g., related to worker's compensation, liability) for sharing staff with other facilities in need, including staffing of alternate care sites.

## Function 11. Administration/Legal Issues

### Task 1

Administration (including corporate administration outside of the facility) examines its delegation-of-authority processes and makes any changes necessary to ensure that CSC decisions are supported (i.e., that facility decision makers are acting with the support of administration).

### Task 2

Administration understands relevant changes to facility authorities and protections when state declarations of emergency/public health emergency are made, including legal protections or obligations for medical providers (e.g., duty to serve).

### Task 3

Laws and regulations that would constrain the institution's ability to implement CSC plans and possible solutions are discussed/identified. (This may be a regional process.)

### Notes and Resources

See Chapter 3 for a more detailed discussion.

## Core Functions of the Outpatient Sector in CSC Planning and Implementation

### *Home Care/Medical Equipment Vendors (referred to as "Home Care")*

## Function 1. Alerting

### Task 1

Home care agencies are able to receive and manage alerts from public safety, corporate administration, public health agencies (health alert network), and the National Weather Service as appropriate.

### Task 2

Emergency response plan provides triggers and process for supervisor (incident commander if incident command system [ICS] used) to activate the surge capacity/CSC plan and indicators (if applicable) to prompt consideration of activation.

## Function 2. Notification

### Task 1

Able to alert staff within and external to the agency, including health care system partners as appropriate.

## **Task 2**

Staff understand what they are to do in a disaster, and appropriate notification policies are in place.

## **Function 3. Command**

### **Task 1**

Emergency response plan accounts for:

- understanding the organization and authorities of the incident management structure,
- training and exercising with key staff on the disaster response plan/crisis plan,
- familiarizing command staff with incident action planning principles, and
- appropriate resources (job aids) being available to guide disaster decisions.

## **Function 4. Control**

### **Task 1**

Command staff understand the interface for resource requests (as well as any existing plans for resource triage/allocation) with local public health/emergency management agencies and/or local health coalitions as applicable.

### **Task 2**

Command staff understand the processes for sheltering, relocation, and evacuation in response to threats to the agency, including facility assessment (includes suspension of services because of unsafe delivery conditions).

### **Task 3**

Command staff understand options for community law enforcement support for their personnel during a disaster if required.

### **Task 4**

Agency plan reflects a phased expansion of surge capacity/capabilities for conventional, contingency, and crisis care conditions.

## **Function 5. Communications**

### **Task 1**

Agency has policies and procedures in place for sharing situational updates with staff and clients (optimally redundant strategies in case of power or other system failures).

### **Task 2**

Agency has the ability to communicate with (as appropriate):

- the local emergency operations center,

- the local/regional health and medical multiagency coordination center (as applicable), and
- other partner agencies/facilities in the area.

## Function 6. Coordination

### Task 1

Command staff understand the policy interface between the agency and local public health and emergency management agencies and local/regional hospital coalitions.

### Task 2

If agency is part of a health care system, plans document the integration of agency response with the corporate response structure and processes.

### Task 3

Agency has a plan for coordinating the scope of home care services provided with other home care agencies to avoid significant inconsistencies.

## Function 7. Public Information

### Task 1

Agency provides information to the JIS for public dissemination as appropriate to its services.

### Notes and Resources

See <http://www.fema.gov/emergency/nims/PublicInformation.shtm>.

## Function 8. Operations

### Conventional, Contingency, and Crisis Care Conditions

#### Task 1

Under contingency care conditions, command and unit staff can implement strategies for supply substitution, conservation, and adaptation; extension of staff

responsibilities; and patient care strategies (which patients will receive services depending on demand).

#### Task 2

Under CSC conditions, same as under contingency care conditions, but expanded options to include

- reuse and reallocation of supplies (e.g., triage of home oxygen supplies),
- changes in staff roles,
- increased family provision of care and necessary education,
- provision/facilitation of palliative care,

### Notes and Resources

- resource allocation and triage decisions and interface with any regional triage teams/regional disaster medical advisory committees, and
- adjustments to patient care protocols according to circumstances.

## Mental Health Care

### Task 1

Understand how to access local mental health system resources.

### Task 2

A mental health triage system for at-risk patients, co-workers, and self-triage (for example, PsySTART) is in place.

### Task 3

Staff are trained in psychological first aid to support at-risk patients, co-workers, and themselves.

## Palliative Care

### Task 1

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

### Task 2

Palliative care is addressed in the emergency operations plan, including palliative care resources, the physician decision-making process, education, and any agency-specific procedures.

### Task 3

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

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

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

## Function 9. Logistics

### Staffing

#### Task 1

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

#### Task 2

Agency assesses the number of staff potentially available for large-scale incidents, anticipating limits due to community access problems (e.g., flooded roads), family obligations, or employee illness.

### Supplies

#### Task 1

Identify key potential scarce resources based on types of incidents and to the degree possible stockpiles or identify alternative sources for these supplies (e.g., home oxygen concentrators, oxygen tanks for use during power failures).

### Notes and Resources

See <http://www.health.state.mn.us/oep/healthcare/scarce/index.html>.

### **Task 2**

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

### **Task 3**

For local or state cached supplies (such as a local pharmaceutical cache) or SNS supplies, agency understands the process for request, receipt, and distribution of these supplies.

## **Special Considerations**

### **Task 1**

Patient groups requiring special consideration are identified and, to the degree possible, equipment and supplies to address the needs of these groups are purchased and/or stockpiled in relation to the agency's size and role in the community. Includes (but is not limited to):

- pediatric patients;
- need for isolation/infection control;
- patients with functional limitations (e.g., hearing or visually impaired); and
- patients needing dialysis/renal replacement therapy.

### **Task 2**

Agency understands any regional plans or resources for specific groups (e.g., pediatric-specific disaster supplies, regional pediatric or dialysis networks) and its role in such plans.

## **Function 10. Planning**

### **Task 1**

Agency is aware of the role of the state or regional disaster medical advisory committees and understands how to receive information from those bodies (or communicate with them if applicable).

### **Task 2**

Agency (or partner) has a plan for the clinical care committee or technical experts to review current response strategies and make modifications based on evolving information during a long-term incident.

### **Task 3**

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

### **Task 4**

Use of nontraditional assistance (family members, volunteers, Medical Reserve Corps providers) to provide care is addressed as needed within the emergency operations plan.

### **Task 5**

Orientation, mentoring, education, and clinical care policies for nonagency supplemental staff are anticipated (e.g., Medical Reserve Corps).

### Task 6

Agency understands the process and supporting agreements (e.g., related to worker's compensation, liability) for sharing staff with other agencies or facilities in need, including staffing of alternate care sites.

## Function 11. Administration/Legal Issues

### Task 1

Administration (including corporate administration outside of the facility) examines its delegation of authority to incident commanders during a disaster and makes any changes necessary to ensure that CSC decisions are supported (i.e., that the incident commander is acting with the authority of the agency). During a crisis, administration may require additional communications and coordination with the incident commander.

### Task 2

Administration understands relevant changes to agency authorities and protections when state declarations of emergency/public health emergency are made, including legal protections or obligations for medical providers (e.g., duty to serve).

### Task 3

Agency and/or corporate legal counsel are aware of surge capacity/CSC plans and implications for patient care (e.g., plans to triage the provision of home care or of medical resources).

### Task 4

Legal counsel identifies state and local laws and regulations that would constrain CSC plans and possible solutions (this may be a regional analysis).

### Notes and Resources

See Chapter 3 for more detailed discussion.

## Core Functions of the Outpatient Sector in CSC Planning and Implementation

### *Alternate Care Systems (ACS)*

## Function 1. Alerting

### Task 1

Public health and health care coalitions (at a minimum—likely also includes emergency management and EMS) identify a multiagency coordination (MAC) group prior to an incident that can assess and address the need for alternate care sites.

### Task 2

Process (and triggers and indicators, as applicable) for alerting the

medical advisory committee is defined in emergency operations plans at the agency, coalition, and jurisdiction levels according to local plans.

## Function 2. Notification

### Task 1

MAC group has a notification mechanism (including a redundant mechanism in case of failure of the primary mechanism) for informing stakeholders of activation/demobilization of ACS, including

- EMS;
- hospital coalitions/partner health care facilities;
- regional disaster medical advisory committee/clinical care committee members; and
- appropriate technical experts (including those in toxicology, radiation safety, infectious disease, critical care, emergency medicine, trauma surgery, blood banking, dialysis, pediatrics, and burn surgery as required).

### Task 2

Expectations of involved agencies and technical experts are understood prior to an incident, and appropriate activation/notification policies are in place.

### Notes and Resources

Institution should at least annually test notification systems and ensure that up-to-date contact information is available.

## Function 3. Command

### Task 1

Public health takes a leadership role in Emergency Support Function (ESF)-8 (Health and Medical) at the local and state levels to assess available resources vs. actual or potential demand, and to implement public alternate care systems as

required to supplement the usual health care system and any private (health care organized) alternate care sites.

### Task 2

A NIMS-compliant ICS is utilized to coordinate ESF-8 assets. Includes

- use of unified command when no one agency has the lead role (e.g., public health and hospital system);
- an understanding of where technical specialists, the clinical care committee, and the triage team fit into the incident management structure;
- training and exercises with key staff;
- use of incident action planning and planning section functions during longer-term incidents; and
- appropriate resources (job aids) to guide decisions regarding ACS.

### Task 3

Public agencies (public health, emergency management) understand their authorities to initiate ACS within the community at public sites

(private sites are established by the health care facilities that operate them).

## Function 4. Control

### Task 1

MAC group and ACS site staff understand the interface for resource requests and the acquisition process (as well as any existing plans for resource triage/allocation) with local and state emergency management.

### Task 2

Emergency management agreements/plans reflect how public health and health care facilities support sheltered populations with medical needs.

### Task 3

ACS site staff understand the need for security/access controls and community law enforcement support options as appropriate.

### Task 4

ACS options reflect a phased expansion of surge capacity/capabilities for conventional, contingency, and crisis care situations (from electronic to augmented services at private and public sites).

### Task 5

MAC group has a process for ongoing incident analysis to maintain situational awareness and facilitate ACS decisions.

## Function 5. Communications

### Task 1

Public health agencies have policies and procedures for exchanging situational updates with hospitals/outpatient care facilities, EMS, and emergency management.

### Task 2

MAC group/center has a means of communicating with key stakeholders (including those listed under Function 2, Task 1) to maintain incident communications (including redundant communications mechanisms as required)

## Function 6. Coordination

### Task 1

MAC group understands the interfaces among local public health and emergency management agencies and local/regional hospital coalitions, including existing agreements.

### Task 2

MAC group understands the function of the state disaster medical

advisory committee and any regional medical coordination center or regional disaster medical advisory committees, and can activate/facilitate regional groups according to local plans

## Function 7. Public Information

### Task 1

MAC group ensures that appropriate risk communications relevant to ACS are developed for the public regarding when and where to seek care (e.g., traditional media, websites, calling programs, e-mail, social media). This includes the ability to reach key cultural groups served by ACS.

### Task 2

MAC group or public health agencies coordinate information with other agencies and participate in JIS and JIC activities when implemented by the jurisdiction, state, or coalition.

### Notes and Resources

See <http://www.fema.gov/emergency/nims/PublicInformation.shtm>.

## Function 8. Operations

### Task 1

Local/state public health agencies maintain an inventory of usual and surge medical resources.

### Task 2

Local/state public health agencies understand private/public ACS capacities to augment health system capacity, including

- telephone hotlines and other “electronic care” (including coordination with private and public safety answering points);
- ambulatory care (“flu centers” or triage/casualty collection points); and
- nonambulatory care (shelter-based care, hospital overflow, federal medical station integration, limited emergency/surgical care).

### Task 3

For each of these public sites (or for similar sites that are incident specific) MAC group understands the activation process (and any authorities or agreements involved).

### Task 4

Plans are made for patient registration, tracking, and record keeping, including access to and storage of medical records.

### Task 5

Plans are made for laboratory and pharmacy services appropriate to the site, including clinical ordering and results systems.

### **Task 6**

Scope of clinical operations is defined and modified according to the evolving needs of the incident and the supplies available.

### **Task 7**

ACS site has staff trained to provide psychological first aid to patients/evacuees, can implement psychological triage processes (such as PsySTART) as required, and has a referral/management plan for those with acute mental health needs.

### **Task 8**

ACS policies and education address the provision of palliative care (either on site or facilitated in the home environment).

## **Function 9. Logistics**

### **Staffing**

#### **Task 1**

Local public health agencies identify sources of potential staffing (e.g., health care systems/coalitions, Medical Reserve Corps, EMS) for the various types of public ACS sites.

#### **Task 2**

ACS credentialing policies and procedures are congruent with applicable regulations and statutes.

#### **Task 3**

Plans are made for staff orientation, education, and supervision.

#### **Task 4**

Capacity of nontraditional resources (family members, volunteers) to provide nonmedical care is examined and addressed as needed within the ACS operations plan.

#### **Task 5**

Legal liability, worker's compensation, compensation, and other issues are addressed according to the source of the staff (e.g., hospital, volunteer, MAC group).

### **Supplies**

#### **Task 1**

Supply lists for each type of ACS (shelter, ambulatory, nonambulatory) are developed, optimally, including the source of initial supply and resupply.

#### **Task 2**

Emergency management and public health agencies, health care facilities, and medical supply vendors understand their role in the ACS set-up, resupply, and delivery processes.

#### **Task 3**

For local or state cached supplies (such as a local pharmaceutical

cache) or SNS supplies, MAC group/ACS facility understands the process for request, receipt, and distribution of these supplies.

## **Space**

### **Task 1**

Health care facilities identify privately owned spaces for ACS establishment on site or at other owned and modified sites.

### **Task 2**

Public health and emergency management agencies identify public spaces for major ACS facilities and establish any necessary agreements or authorities required to utilize them (recognizing that no-notice incidents may require ACS sites at ad hoc locations).

## **Special Considerations**

### **Task 1**

Patient groups requiring special consideration are identified, and, to the degree possible, equipment and supplies to address the needs of these groups are purchased and/or stockpiled in relation to the expected size of the alternate care site, potentially including

- pediatric patients,
- patients with behavioral and cognitive impairment,
- the need for isolation/infection control, and
- the need for contamination assessment (post-HAZMAT or radiological dispersal device with population-based exposure).

### **Task 2**

Facility understands any regional plans or resources for specific groups (e.g., pediatric-specific disaster supplies, regional pediatric or dialysis networks) and the ACS site's role in these plans.

## **Function 10. Planning**

### **Task 1**

Technical specialists are available as needed to provide input on infection control, clinical care, and other issues arising at the ACS site. This may include input from the regional or state disaster medical advisory committee.

### **Task 2**

Planning section maintains situational awareness and modifies clinical care guidelines or supply/staffing requests to meet demand/anticipated demand.

### **Task 3**

Planning section addresses policy modifications and demobilization based on incident demands.

## Function 11. Administration

### Authority

#### Task 1

Public health and emergency management examine their delegation of authority to public ACS site incident commanders during a disaster and make any changes necessary to ensure that CSC decisions to open an ACS site are supported (i.e., that the incident commander is acting with the authority of the agency and any necessary political entities). During a crisis, the administration may require additional communications and coordination with the incident commander.

#### Task 2

Public health and emergency management agencies understand their authorities to open and provide ACS services, including the ability to facilitate private ACS sites through use of regulatory relief and emergency orders.

### Regulatory and Legal Issues

#### Task 1

Health care facilities and emergency management agencies understand relevant changes to agency/facility authorities and protections when state declarations of emergency/public health emergency are made, including legal protections or obligations for medical providers (e.g., duty to serve)

#### Task 2

Agency heads/political leaders are aware of surge capacity/CSC plans and implications for patient care, including ACS sites.

#### Task 3

Legal counsel identify state and local laws and regulations that would constrain public and private ability to open ACS sites and potential relief mechanisms.

### Notes and Resources

See Chapter 4 for a more detailed discussion.

## Core Functions of the Outpatient Sector in CSC Planning and Implementation

### *Out-of-Hospital Providers*

## Function 1. Notification

### Task 1

Providers ensure that up-to-date contact information and acknowledgment of receipt of exercise and incident messaging are provided to employers (and any other relevant groups, such as the Medical Reserve Corps).

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

### Task 1

When a disaster occurs that affects the providers' facility/agency, providers understand where they report, to whom they answer, and how to execute their roles. They also understand the range of their potential roles within the rest of the health care system and opportunities for volunteer assignment (for example, reassignment to an alternate care site or a hospital within the corporate system).

### Task 2

Providers know how to contact and provide situational updates to and/or request resources from their administrator/emergency operations center/command center as applicable to the facility/agency plan.

### Task 3

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

- knowledge of the location of plans and actions for the full continuum of care in their area, including the use of crisis spaces and staffing; and
- understanding of appropriate resources (job aids) to guide capacity expansion decisions or other unit-based plans.

### Notes and Resources

## Function 3. Public Information

### Task 1

Providers understand key sources of facility/community information in a disaster (e.g., web, social media, e-mail, hotline).

## Function 4. Operations

### Task 1

Providers understand facility-based actions during expansion of care from conventional to crisis (e.g., expanded facility hours, scheduling changes, triage of appointments, use of ancillary spaces).

### Task 2

Providers are prepared to perform triage as it relates to their role (may involve triage of appointments, or may involve another triage role within their system, such as telephone triage).

### 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.

### Notes and Resources

See the ethics section of Chapter 4.

#### **Task 4**

Providers understand sources of employee mental health support.

#### **Task 5**

Providers understand normal stress reactions and coping mechanisms, as well as danger signs, and receive training in psychological first aid and psychological triage appropriate for their roles.

#### **Task 6**

Providers understand their potential role in providing/facilitating palliative care during a disaster.

See the mental health and palliative care sections of Chapter 4 for a more detailed discussion.

### **Function 5. Logistics**

#### **Task 1**

Providers understand the utilization of space in their facility and other expansion plans that involve their department/unit.

#### **Task 2**

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

#### **Task 3**

Providers understand how their role may be changed/expanded during a crisis, including incorporation of staff from outside the unit or facility, and any potential roles at other sites within their health system (if applicable).

#### **Task 4**

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

#### **Task 5**

Providers understand the process for requesting necessary clinical resources during an incident.

### **Function 6. Legal Issues**

#### **Task 1**

Providers understand legal obligations and liabilities for practice both within and outside of their facility/agency 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 a Medical Reserve Corps or disaster medical assistance team member).

#### **Notes and Resources**

Chapter 3 provides a more detailed discussion.