Los Angeles County Medical and Health Operational Area Coordination Program

Healthcare Surge Planning Guide

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LOS ANGELES COUNTY

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AMBULATORY SURGERY CENTERS

COMMUNITY HEALTH CENTERS (CLINICS)

DIALYSIS CENTERS

EMERGENCY MEDICAL SERVICES (EMS) PROVIDERS

HOME HEALTH AND HOSPICE AGENCIES

HOSPITAL

SKILLED NURSING FACILITES/LONG TERM CARE

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Overview

Background

Los Angeles (LA) County is a vast and diverse county covering an approximately 4,000 square mile area including mountains, valleys, deserts and an island (Catalina). Comprised of 88 cities and serving a population of more than 10 million people, the challenges are great when responding to medical disasters.

The complexity of the healthcare community adds to these challenges with about 100 acute care hospitals of which approximately 75% are 9-1-1 receiving hospitals, two Veterans Affairs medical centers, over 300 clinics, over 400 skilled nursing facilities, more than 60 public and private emergency medical service providers, and over 2,000 other healthcare providers including 250+ surgery centers, 180+ dialysis centers, and 800+ home health agencies (including at home hospice care). These numbers are current as of date of printing, however, they are constantly evolving.

Originally the surge planning project was focused on a pandemic or sustained community-wide communicable disease outbreak, such as influenza. However, in recognizing that a true surge guide should include all hazards, this guide identifies key operational steps and coordinated strategies for sectors across the healthcare system spectrum to meet the healthcare needs of the community during a medical surge related to any disaster. The top hazards identified for Los Angeles County are earthquake, emergent diseases and pandemic influenza. Wildland urban interface fires are also a concerning hazard but are not within the top 3 identified by Public Health.

Goals and Objectives

The purpose of healthcare surge planning is to ensure the optimal care of patients, both current patients and those that result from the incident, in the most appropriate healthcare setting without causing an undue hardship on other sectors in the healthcare system.

The goals of the sector specific surge strategies are to:

- Ensure optimal patient care at the most appropriate healthcare setting
- Increase capacity/capability to meet the anticipated increased demand due to surge
- Ensure the continuity of business operations at all healthcare facilities

To meet these overarching goals, the surge strategies fall under four main categories:
Capacity (**Space**): Expand and/or repurpose space to care for current and/or additional patients
Personnel (**Staff**): Maintain staffing levels and/or expand the workforce to assist with the response
Medical Material (**Stuff**): Ensure adequate supplies and equipment
Operations (**System)**: Ensure operations are adapted/maintained as needed to meet the service needs of the community

Implementation and Waivers

The surge strategies described in this guide were identified by a collaboration of sector specific healthcare stakeholders. In the review of these strategies, some local, state and federal policies and regulations were identified as potential barriers to full implementation of possible surge strategies particularly in some sectors. While this Guide identifies surge strategies that may be implemented during a disaster response, some program/policy flexibility or suspension authorization may be required prior to full implementation.

HEALTHCARE SURGE PLANNING PROCESS

Successful local and regional healthcare emergency preparedness planning and response involves bringing together planners from key healthcare facility sectors and organizations to work toward constructing a county specific medical surge guide. It is LA County's goal to address these unique challenges from a "systems level" perspective, requiring the participation of private and public stakeholders to develop an effective and operational Guide specific to LA County. LA County started with existing preparedness programs that have already been in place in Los Angeles County such as the Disaster Resource Center (DRC) program funded by the Hospital Preparedness Program (HPP).

The planning began in March of 2009, the Centers for Disease Control and Prevention's Division of Healthcare Quality Promotion (DHQP), in partnership with the Oak Ridge Institute for Science and Education (ORISE), selected LA County to participate in a workshop aimed at improving community healthcare response during an influenza pandemic. The project was titled the Mass Medical Care Framework and was a collaborative effort between the Department of Public Health (DPH), and the Department of Health Services Emergency Medical Services (EMS) Agency. Due to the size and complexity of LA County, its healthcare system, and the many participating stakeholders, it was determined that the most effective and efficient way to manage this project was to organize it into phases.

Phase I of the original project focused on information gathering, sharing and system partner engagement.

Phase II focused on the development of sector specific workgroups, namely hospitals, clinics, and skilled nursing facilities, whose purpose was to identify potential surge strategies including the barriers for implementation.

Phase I and II culminated in workshops for information sharing, healthcare sector networking, and strategy collaboration. The Mass Medical Care Workshops gathered private and public stakeholders to develop the concepts and outline for an effective and operational Guide specific to Los Angeles County. Phase II signaled the completion of the CDC Mass Medical Care Framework project, however, LA County decided to build on the original project to include other healthcare sectors with the intent on producing a document that could guide all healthcare sectors in preparing for a surge.

Phase III brought in the remaining healthcare partners - ambulatory surgery centers, dialysis centers, home health/hospice agencies and Emergency Medical Services (EMS) providers. As

with the previous sectors, workgroups were formed and put together surge strategies specific to their role in a disaster.

BROAD ISSUES/CHALLENGES FOR ALL SECTORS

- Optimizing medical care during a long-term communicable and community wide disease outbreak compared to optimizing medical care during an acute non-communicable incident
- Inaccurate picture of available emergency staffing due to double (and triple+) counting of staffing resources, i.e., staffing resources may be listed on multiple registries or work in multiple locations
- Establishing effective and efficient communication pathways to and from the many healthcare sectors to the LA County Emergency Medical Services (EMS) Agency for incident reporting and ongoing incident communication, and, communication pathways and content between sectors or agencies. Strategy considerations include regional/sector reporting, the use of trade associations (e.g., CCALAC, CAHF, etc.), the use of other governmental agencies (like CDPH L&C's Los Angeles District Office), the actual communication tool (telephone tree, ReddiNet, etc.), and the data elements to report
- Authorization, flexibility, suspension or waivers of certain regulatory requirements regarding use of space and staffing
- Clarify role of statutes vs. regulations, i.e. those that can only be waived by the governor, etc.
- Liability protection for exercising good faith response efforts even while program flexibility and waivers are implemented for applicable regulations
- Reimbursement concerns

HOW TO USE THIS GUIDE

The many valuable tools found within this guide should be reviewed including how to request resources from the EMS Agency (Medical and Health DOC) during a large scale event affecting patient care, key contacts list that may be helpful both in the in planning phase and during an incident, and direction on how to obtain waivers for applicable policies and regulations pertaining to certain strategies is also included.

The majority of the guide contains surge strategies for each healthcare sector including ambulatory surgery centers, clinics, dialysis centers, emergency medical services (EMS) providers, home health and hospice agencies, hospitals, and skilled nursing facilities. Each sector should review the pre-identified strategies for their specific sector and determine which ones should be considered for inclusion in facility/agency surge planning. Sectors are also encouraged to review other sector strategies as some of the strategies overlap and having an understanding of others capacity and capabilities prior to a large scale event may assist decision making during a response.

MEDICAL AND HEALTH COORDINATION

The coordination of LA County's medical and health response is a collaborative effort between the LA County Department of Health Services (DHS), Department of Public Health (DPH), and Department of Mental Health (DMH) all of whom fall under the Los Angeles County Health Agency. The EMS Agency Director and the Health Officer have the authority under the California Health and Safety Code to jointly act as the Medical and Health Operational Area Coordinator (MHOAC). The Director of LA County EMS Agency has been designated and serves as the MHOAC for LA County. When activated during an incident, all Department Operations Centers (DOC) assist the MHOAC with the coordination of the response. The DOCs are organized according to the Incident Command System (ICS).

Department Roles in a Disaster

Los Angeles County Department of Health Services Emergency Medical Services Agency

- Coordinate the medical response
  - Assessment of immediate medical needs
  - Coordination of patient distribution and medical evaluations
  - Coordination of out of hospital medical care providers
  - Coordinate pre-hospital emergency medical services (patient destination and transportation)
  - Coordination with inpatient and emergency care providers
  - Coordination of disaster medical and health resources
  - Coordination of the establishment of temporary field treatment sites

Los Angeles County Department of Public Health

- Coordinate the public health response
  - Investigation and control of communicable disease
  - Conduct health surveillance and epidemiological analyses
  - Identify at risk populations for the effective deployment and delivery of public health resources
  - Provide case definition
- Provide critical public health information
- Establish Points of Dispensing (PODs), when medical countermeasures are indicated
- Management of exposure to hazardous agents
- Assurance of drinking water and food safety
- Assurance of the safe management of liquid, solid and hazardous waste

Los Angeles County Department of Mental Health

- Coordinate the mental health response
  - Assess the immediate and ongoing mental health impact

- Provide critical public information with Health Agency and community partners
- Provide mental health support, crisis counseling, outreach and education to the community, first responders, and county staff
- Maintain the 24-hour DMH Duty Officer line
- Provide referrals for mental health follow up for those most impacted by the disaster
- Distribute disaster mental health related brochures and educational materials

Regional Disaster Medical and Health Program

When county resources have been exhausted, the next step in response would be to connect with State appointed Mutual Aid Region representative. There are 6 State Mutual Aid Regions within California of which Los Angeles, Orange, Ventura, Santa Barbara and San Luis Obispo counties are designated as Region I. Each region has an appointed Regional Disaster and Medical Health Coordinator (RDMHC), and a Regional Disaster and Medical Health Specialist (RDMHS) Program to coordinate response within their region. The RDMHC serves as the medical and health link throughout the Mutual Aid Region and to the State; ensuring requests for resources unavailable within the OA are processed and filled. They can also obtain information from other regions, communicate policy level decisions for response activities and guidance developed at the State level.

Situational Awareness/Information Sharing

Situational awareness is important in providing a common operating picture of the jurisdiction's status, from the individual facility level to the entire operational area. During an incident, the MHOAC will conduct assessment polls of healthcare facilities' status to gain situational awareness in order to develop a common operating picture of the operational area. This information is used by government agencies: local, state and federal to initiate response actions including, but not limited to, regulatory authorizations, statutory suspensions and waivers needed to implement a number of the strategies in this Framework. Situational awareness also allows the MHOAC to prioritize resource requests and other response activities.

Integration of Sectors

Communication – Communication will be managed in a variety of methods. The DHS DOC collaborates with the DPH DOC/MHOAC and County EOC along with other applicable departments to share incident related information including healthcare sectors. Information may be shared via electronic notification systems such as ReddiNet, Everbridge Incident Notification, Los Angeles (LAHAN) and California Health Alert Network (CAHAN). Communication may not always be directly between the DHS DOC and the sector but may be through a means directly associated with that particular healthcare sector. For example:

- Community Clinics communicate both, medical and health as well as non-medical and health incident specific information to CCALAC. CCALAC will convey aggregate incident specific information to the DHS DOC.
- Skilled Nursing Facilities communicate directly with the Health Facilities Inspection Division (HFID) (L&C District Office). As a function of their emergency response, HFID contacts SNFs to gather facility status, and communicate any relevant incident specific information to the DPH DOC.
- Dialysis centers should communicate any operational change to End State Renal Disease (ESRD) Network 18 as Los Angeles County's designated coordinating entity for this sector.

Patients – In a surge incident it is the priority of the jurisdiction that the medical and health needs of the community are met. In order to achieve this, some changes may be made to existing EMS Agency policies in order for patients to receive care at the most appropriate setting without causing undue burden on others. For example, during a surge incident, non-acute patients presenting at hospital emergency departments may be referred to alternate care sites such as community health centers (clinics) to seek care. The DHS DOC may also direct ambulance and paramedic services to transport minor, stable BLS patients to clinics that offer more comprehensive services. Patients may be directed to obtain care at another similar center than their regular one as hospitals may not have access to the care they need e.g. dialysis centers are encouraged to have an agreement with other dialysis centers located geographically close to their location. Through facility assessments the DHS DOC/MHOAC will decide when to use alternate care sites.

Resources – All requests for medical resources will be made to the DHS DOC. Distribution of available medical resources will vary by health sector. The primary method of distribution for equipment and supplies will be for healthcare facilities to pick up the items they request from the EMS Agency Disaster Staging Facility (DSF). For hospitals in the DRC Program, some equipment and/or supplies may be distributed to umbrella facilities through their DRC. If the DHS DOC receives any non-medical and health resource requests and/or communication, they will be forwarded to the LA County Emergency Operations Center (EOC) or be routed to the appropriate City EOC.

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HEALTHCARE SECTOR STRATEGIES

Within each sector a description, key response goals, and indicators are given prior to the sector's specific strategies.

Indicators and Implementation

Each healthcare sector has a set of indicators to trigger the implementation of their surge strategies at the facility/company level. When a sector is considering a strategy that may require some flexibility or waiver to an existing law/regulation, the appropriate authorities should be notified. For example:

- HFID - In the process of implementing specific strategies, notification must be made to L&C for appropriate approvals, if applicable. Acting as the medical health liaison to CDPH's Emergency Preparedness Office (EPO), HFID provides information to assist in response decisions at the State level. Notification to L&C also serves as an indicator to initiating any requests to the Governor's office for statutory suspensions for any surge strategies that do not fall under L&C regulatory authorization.
- MHOAC – The MHOAC conducts a countywide assessment to obtain incident specific information. Sectors should indicate their level of response during the medical surge incident, to the DHS DOC. Communicating this information serves as a countywide indicator and will provide the situational awareness necessary for the jurisdiction to determine when to declare a local emergency and activate a countywide surge response. Healthcare sectors are strongly encouraged to utilize ReddiNet. Along with a ReddiNet assessment poll, additional methods of information collection may be utilized (see page 67).

Implementation of the strategies should be conducted through the appropriate government coordinating agency's processes and procedures.

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HEALTHCARE SECTOR: AMBULATORY SURGERY CENTERS

Sector Description

There are approximately 250 CMS certified Ambulatory Surgery Centers (ASC) within the LA County. Some are corporate owned, whereas many are owned by physicians, predominantly surgeons and GI specialists and are generally standalone facilities. Licenses to operate ASCs are obtained from the local jurisdiction or city where-in the facility lies. Most of the CMS certified ASCs are also accredited through the Accreditation Association of Ambulatory Health Care (AAAHC).

ASCs can be very diverse in both size and function. They can perform a number of different procedures ranging from simple endoscopies to large abdominal and orthopedic surgeries. Others are in the reproductive field dealing with embryos and infertility procedures. Some see 1-2 patients each day and others up to 30 depending on the complexity of the procedures being performed.

ASC hours of service are typically Monday through Friday, with some exceptions and they are not permitted to keep patients in their care for longer than 23 hours. All cases are scheduled and normal day-to-day operations do not permit walk-in patients. Using ASCs during a countywide surge will involve a significant change in daily operations.

Key Response Goals

Primary goal: To maintain business operations
Secondary goal: To support the healthcare community by possibly accepting non-traditional patients and/or assisting in another applicable way

Indicators

One or more of the following indicators should be met prior to surge strategy implementation

- Emergency Medical Services (EMS) Agency/Medical Alert Center (MAC) notification of system wide surge
- Notification from neighboring facilities of their limited capability to provide care to their patients and are requesting assistance

Note: The following strategies are a work in progress and will be updated as needed based on resources, capabilities and technology that is available. They should not be construed as policy or procedure but more of a peer reviewed document to help guide ASC decision making during a disaster. Strategies may not be appropriate for all ASCs or all incidents.

STRATEGIES AND CONSIDERATIONS – AMBULATORY SURGERY CENTERS

SPACE – Strategies for ASCs Objective: Increase the ability to adapt during a disaster by using traditional space and repurposing use of other space		
#	**Strategy**	**Regulatory and other considerations**
1	▫ Cancel elective surgery cases	▪ Can utilize space for surge patients
2	▫ Increase space by converting non-patient care areas into patient care areas for treatment	▪ Examples include breakrooms, conference rooms, etc. ▪ Maintain break room or other assigned area for staff/families to rest ▪ Ensure planning to maintain patient monitoring for nontraditional patient care areas ▪ Ensure infection control procedures are maintained ▪ Ensure space is appropriate/safe for the types of patients cared for in these areas e.g. pediatrics versus adults ▪ Identify an area(s) appropriate for triage
3	▫ Partner with geographically close facilities	▪ Establish communication/partnerships with facilities that address sharing of space, e.g. hospitals, physician offices, other ASCs, home health agencies, etc.
4	▫ Utilize parking lots or other outdoor space	▪ Legal regulations and limitation for outdoor space ▪ Weather and time of day (consider ways to shelter e.g. use of EZ ups) ▪ Security and safety e.g. consider traffic pattern issues ▪ Consider using for registration, family waiting, triage, vaccinations
5	▫ Serve as charging stations	▪ Home health patients may need power to support their medically necessary equipment such as oxygen concentrators, ventilators, etc. ▪ Suggest a minimum of 2 employees be present to oversee use of center ▪ Choose areas where outlets are linked to back-up power source

STAFF – Strategies for ASCs
Objective: Maintain adequate staffing levels to assist with response

#	Strategy	Regulatory and other considerations
6	▫ Encourage staff to be prepared at home	▪ Staff may not be willing to come in to work or stay at work if they are not prepared at home ▪ Recommend staff should have an emergency plan and enough emergency supplies for each family member to last at least 72 hours ▪ Encourage staff to maintain a half tank of gas at all times
7	▫ Develop/Implement disaster/emergency training for staff	▪ Assign and train staff for disaster roles preferably before an incident e.g. security, triage, registration, communication (liaison) roles ▪ At a minimum, train/test staff's competency on disaster preparedness/response procedures when hired and annually ▪ Plan for just-in-time (JIT) training
8	▫ Notification/activation of staff	▪ Ensure staff contacts are up to date ▪ Call in off-duty staff and/or request current staff to remain ▪ Determine a mechanism of contacting staff, e.g. text, phone, email, automated notification systems (Everbridge, One Call Now, etc.)
9	▫ Partner with geographically close facilities	▪ Establish communication/partnerships with facilities that address sharing of staff e.g. hospitals, physician offices, other ASCs, home health agencies, etc. ▪ Hospitals may be able to utilize ASC staff
10	▫ Develop procedures to accept volunteers	▪ Determine if you will accept volunteers and have a policy for both LA County Disaster Healthcare Volunteer (DHV) program and for spontaneous volunteers ▪ If accepting spontaneous volunteers, each center should determine what each person is required to have e.g. actual license/certificate, BLS and ALS card, type of background i.e. ER, OR, etc. ▪ DHV staff have had credentialing and background checks done by the EMS Agency ▪ If DHV volunteers are needed, a Resource Request Form must be completed and sent to the Department Operations Center (DOC) at the EMS Agency

STUFF – Strategies for ASCs Objective: Ensure adequate supplies and equipment		
#	**Strategy**	**Regulatory and other considerations**
11	▫ Ensure emergency supply of, including but not limited to, food, water, generator fuel, waste management products, personal supplies, and alternative communication tool e.g. analog phone	▪ Recommend a 24 hr. supply at minimum for patients, families, staff and volunteers ▪ Storage area for supplies can be limited - water can be stored outside if not in direct sunlight and should not be sitting directly on concrete ▪ Digital phone system will not be operable if the power is out – consider maintaining an analog phone which can be attached to the telephone port of a fax machine
12	▫ Utilize current inventory of supplies	▪ Implement conservation of all supplies ▪ Maintain standards of care during conservation of supplies
13	▫ Contact traditional/non-traditional vendors for resupply	▪ Many healthcare entities utilize the same vendors and therefore supplies may be limited ▪ Recommend agreements with local merchants including pharmacies, supermarkets and hardware stores
14	▫ Partner with geographically close facilities	▪ Establish communication/partnerships with facilities that address sharing of supplies and/or equipment e.g. hospitals, physician offices, other ASCs, home health agencies, etc.
15	▫ Contact LA County EMS Agency through the DOC for medical resources	▪ After exhausting all traditional ways of securing medical supplies, LA County DOC for health may be contacted through the established resource requesting process

SYSTEMS/OPERATIONS – Strategies for ASCs Objective: Ensure operations are adapted/maintained as needed		
#	**Strategy**	**Regulatory and other considerations**
16	▫ Extend/adjust operating hours	▪
17	▫ Accept minor, stable patients via BLS transport or from hospitals	▪ Define types of patients facility is able to accept.
18	▫ Update disaster plan to include specifics for surge	▪ Considerations will be different for each facility depending on location e.g. near an airport versus an industrial or residential area; also may depend if located within a building or free-standing ▪ Security will be very important during an incident
19	▫ Assist and house staff family members including pets	▪ Knowing that family are able to stay at ASC may encourage staff to stay and/or return to work to assist with response ▪ Family should be advised to bring own food, water and supplies
20	▫ Offer vaccinations/prophylaxis to staff and their family members as directed by Public Health	▪ Have a policy/procedure to address prophylaxis ▪ Determine how many family members you are able to cover and include in your policy/procedure ▪ May encourage staff to stay/return to work during a public health emergency
21	▫ Develop disaster policies and procedures outlining your response capabilities	▪ Determine what you can do for your community
22	▫ Partner with geographically close facilities for planning purposes	▪ Establish communication/partnerships with facilities that are interested in planning together for disasters e.g. hospitals, physician offices, other ASCs, home health agencies, etc. and share plans ▪ Attend Disaster Resource Center (DRC) meetings every other month as able ▪ Recommend written agreements

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HEALTHCARE SECTOR: COMMUNITY HEALTH CENTERS (CLINICS)

Sector Description

The clinics (community health centers) in Los Angeles County are as diverse as the populations they serve. Clinics may be associated with hospitals, be independent, private non-profit Federally Qualified Health Centers (FQHC), or part of the LA County Department of Health Services (DHS) Ambulatory Care Network (ACN). Non-profit Community Health Centers and Free Clinics are referred to collectively as "Community Health Centers" and operate primary care sites throughout the County. These clinics represent a mix of public and private entities that provide primary health care, including medical, dental, mental health and other social services and offer specialty pediatrics and women's health care. Some are equipped with laboratory, radiology, pharmacy, and/or dispensary capabilities. However, due to regulations, they are unable to provide 24 hour patient care and satellite sites that work under a parent's site license are limited to 20 hours of operations per week. They serve the uninsured, underinsured, working poor, high-risk and vulnerable populations, addressing cultural differences and economic disparities that can impact the health of their patients.

Community Clinic Association of Los Angeles County

Currently, the Community Clinic Association of Los Angeles County (CCALAC) represents 58 clinic organizations with more than 280 sites, which serve as the medical homes for more than 1.4 million patients per year; 45 of these organizations have a Memorandum of Agreement with CCALAC to participate in disaster preparedness activities.

LAC DHS Ambulatory Care Network

There are 8 Comprehensive Health Centers within the ACN, two Multi-Service Ambulatory Care Centers (MACCs), 2 Ambulatory Surgery Centers, 10 Health Centers, and 1 school-based clinic. All sites provide non-emergency, ambulatory, out-patient medical services. This network provides over 900,000 patient encounters each year. These DHS clinics provide an assortment of primary, specialty, and non-emergent medical and dental care; and many have laboratory, radiology, and pharmacy services. A few facilities also have mental health staff on-site.

Key Response Goals

Primary goal: To maintain operations and continue to provide care to current patients

Secondary goal: To expand operations to accept lower acuity patients to alleviate surge on acute care facilities

Indicators

One or more of the following indicators should be met prior to surge strategy implementation

- EMS/MAC notification of a system wide surge
- 20% above average daily census
- Inability to transfer patients to a higher level of care

Note: The following strategies are a work in progress and will be updated as needed based on resources, capabilities and technology that is available. They should not be construed as policy or procedure but more of a peer reviewed document to help guide clinic decision making during a disaster. Strategies may not be appropriate for all clinics or all incidents.

STRATEGIES AND CONSIDERATIONS - CLINICS

SPACE – Strategies for Clinics

Objective: Maintain operations and/or take on additional patients by repurposing the use of space

#	Strategy	Regulatory and other considerations
1	▫ Increase space via converting non-patient care areas into patient care areas for triage and treatment	▪ Examples include: Break rooms Meeting rooms Adjacent building Auditoriums ▪ 22 CCR 75072: Spaces approved for specific use at the time of licensure shall not be converted to other uses without the written approval of the CDPH. ▪ Notify project officer PAL 2014.5 ▪ Notify insurance company
2	▫ Utilize non-traditional space for patient care	▪ Los Angeles Fire Code, Appendix Chapter 1, ▪ Section 105: A tent having an area in excess of 200 square feet (10x20), must have an operational permit. A canopy in excess of ▪ 400 square feet (20x20) must have an operational permit. - When utilizing tents or canopies for drills, in accordance with the above Fire Code, permits are needed. ▪ Work with neighboring organizations if sharing business space (e.g. office building, shared parking lot, etc.) ▪ Tents ▪ Mobile Health Centers/Units
3	▫ Partner with geographically close facilities	▪ Consider partnering with geographically close health centers to address sharing of space e.g. one health center could treat patients with influenza like illness (ILI), and the other treat non-ILI patients ▪

STAFF – Strategies for Clinics Objective: Maintain appropriate staffing levels and/or expand the workforce		
#	**Strategy**	**Regulatory and other considerations**
4	▫ Encourage staff to be prepared at home	▪ Staff may not be willing to come in to work or stay at work if they are not prepared at home ▪ Recommend staff should have an emergency plan and enough emergency supplies for each family member to last at least 72 hours ▪ Establish emergency contacts for all family members including children and animals e.g. daycare, schools, veterinarians, etc. ▪ Encourage staff to maintain a half tank of gas at all times as lines may be long and/or there is no power
5	▫ Develop/Implement disaster/emergency training for staff	▪ Utilize back office staff ▪ Assign and train staff for disaster roles preferably before an incident e.g. security, triage, registration, communication (liaison) roles ▪ Plan for just-in-time (JIT) training ▪ Reassign clinical staff normally assigned to non-patient care positions to skill set to support operations during a medical surge incident ▪ Cross train e.g. adult skilled RNs to supervise pediatric RNs to treat a surge of adult patients and vice versa ▪ Develop disaster related standardized procedures for the following earthquake, pandemic influenza and fire related injuries: lacerations, crush injuries, burns, head injuries, fractures, respiratory distress, pain control, chest pain, fever, and burns. Ensure staff remain within their scope of practice
6	▫ Notification/activation of staff	▪ Ensure staff contacts are up to date ▪ Call in off-duty staff and/or request current staff to remain ▪ Determine a mechanism of contacting staff, e.g. text, phone, email, automated notification systems (Everbridge, One Call Now, etc.)
7	▫ Partner with geographically close facilities	▪ Establish communication/partnerships with facilities that address sharing of staff e.g. hospitals, physician offices, other clinics, home health agencies, etc.
8	▫ Develop procedures to accept volunteers	▪ Determine if you will accept volunteers and have a policy for both LA County Disaster Healthcare Volunteer (DHV) program and for spontaneous volunteers - for sample volunteer implementation policies, see the CCALAC Disaster and Volunteer Utilization Toolkit: appendices 1a & 1b ▪ If accepting spontaneous volunteers, each center should determine what each person is required to have

		e.g. actual license/certificate, BLS and ALS card, type of background i.e. ER, OR, etc. ▪ DHV staff have had credentialing and background checks done by the EMS Agency ▪ If DHV volunteers are needed, a Resource Request Form must be completed and sent to the Department Operations Center (DOC) at the EMS Agency ▪ Credentialed: DHV and Medical Reserve Corps (MRC) Affiliated: Government Disaster Service Workers, Non-Government Organization trained volunteers (Red Cross, Medical/Nursing Schools, and other established organizations) Spontaneous: Unknown, non-credentialed and non-affiliated volunteers ▪ California Government Code Section 8659: liability for clinical volunteers rendering services at the express or implied request of government. ▪ Health Resources and Services Administration (HRSA Form 10) ▪ California Government Code Section 8659: liability for clinical volunteers rendering services at the express or implied request of government
9	▫ Utilize families to render supportive care under direction of a healthcare provider	▪ Non-medical, supportive care only
10	▫ Develop plans to provide dependent care (children, pets, etc.) for staff	▪ Identify space and protocols to provide dependent care for staff
11	▫ Provide vaccination and prophylaxis to healthcare system staff/family in accordance with public health recommendations	▪ Identify protocols to provide vaccination and prophylaxis which should include # of family members they can cover

STUFF – Strategies for Clinics Objective: Ensure adequate supplies and equipment		
#	**Strategy**	**Regulatory and other considerations**
12	▫ Maintain an emergency supply of, including but not limited to, food, water, generator fuel, waste management products, personal supplies	▪ Recommend a 24 hr. supply at minimum for patients, families, staff and volunteers ▪ Storage area for supplies can be limited - water can be stored outside if not in direct sunlight and should not be sitting directly on concrete as chemicals may leach into the water when it gets hot. Consider storing water on wooden pallets or boards
13	▫ Utilize current inventory of medical and non-medical (tables, chairs, etc.) including items in disaster cache	▪ Implement conservation of all supplies ▪ Maintain standards of care during conservation of supplies ▪ Identify and streamline process for use of PPE including guidelines for reuse and fit testing
14	▫ Contact traditional/non-traditional vendors for resupply	▪ Many healthcare entities utilize the same vendors and therefore supplies may be limited ▪ Recommend agreements with local merchants including pharmacies, supermarkets and hardware stores ▪
15	▫ Have alternative communication devices	▪ Suggest obtaining radios for use during an incident
16	▫ Partner with geographically close facilities	▪ Establish communication/partnerships with facilities that address sharing of supplies and/or equipment e.g. hospitals, physician offices, other clinics, home health agencies, etc.
17	▫ Contact LA County EMS Agency through the DOC for medical resources	▪ After exhausting all traditional ways of securing medical supplies, LA County DOC for health may be contacted through the established resource requesting process

SYSTEMS/OPERATIONS – Strategies for Clinics

Objective: To maintain and/or increase operations by redirecting resources for non-essential services and providing services to a broader patient population

#	Strategy	Regulatory and other considerations
18	▫ Expand triage capacity	▪
19	▫ Cancel and/or reschedule non-urgent/routine appointments - Well child - Social services	▪
20	▫ Increase type and level of service by 1. Accepting minor, stable ambulatory patients from hospitals via referral and/or via EMS Providers 2. Performing minor procedures e.g. laceration repair and stabilization of musculoskeletal injuries	▪ Only patients with minor non-life threatening illness or injury, normal mental status, and normal vital signs with any of the following chief complaints: minor lacerations, isolated fractures of extremities, emotional upset (unless a threat to themselves or others), fevers, nausea/vomiting/diarrhea, mildly ill (non-specific complaints), minor head injuries (who are alert, with no loss of consciousness or vomiting), and minor complaints following traffic accidents should be accepted ▪ Each clinic should consider defining the types of patient that they would be comfortable receiving
21	▫ Extend operating hours	▪ Determine minimum and/or maximum number of additional hours ▪ Decide appropriate workforce expansion ▪ Labor Memorandums of Understanding (MOU) – know if an emergency clause exists and how to execute it ▪ Notify project officer ▪ Health and Safety Code 1206(h): Satellite sites, under the parent license and only allowed to be open 20 hours per week ▪ Continue to provide care to health center patients (stable and noncritical), maintaining patients beyond 24 hours ▪ Health and Safety Code 1200 (a): Clinic (Community Health Center) is defined as…providing services or treatment to patients who remain less than 24 hours
22	▫ Provide medication refills by phone for existing patients	▪ Will lessen non-event related/urgent patient visits ▪ May need dedicated personnel ▪ Ability to pay could be an issue for current patients if asked to refill prescriptions at a non-contracted pharmacy
23	▫ Facilities with a pharmacy or licensed pharmacists dispense medications for non-established health center patients	▪ 340B Program limits distribution of pharmaceuticals purchased through program to specific patient population. ▪ Identify protocol for non-established patients - Cash and carry - Credit cards - Promissory note

HEALTHCARE SECTOR: DIALYSIS CENTERS

Sector Description

In Los Angeles County, there are approximately 23,000 dialysis patients and over 160 dialysis centers. Dialysis centers perform mostly hemodialysis, however some also perform peritoneal dialysis, and both are for people with renal failure, often called End Stage Renal Disease (ESRD). Both hemodialysis and peritoneal dialysis may also be performed at home by the patient and/or trained caregiver. Traditional in-center hemodialysis is performed by trained health care professionals typically three days each week, for three to four hours per treatment, per patient Across the United States under the direction of CMS, there is an ESRD network responsible for different states and territories who, among other things, provide support to ESRD patients and dialysis centers. LA County is under ESRD Network 18.

Key Response Goals

Primary goal: To maintain operations and continue providing care to current patients

Secondary goal: To expand operations to increase the number of patients able to be dialyzed in order to assist other dialysis patients whose centers are inoperable

Indicators

One or more of the following indicators should be met prior to surge strategy implementation:

- EMS/MAC notification of a system wide surge, or notification from ESRD Network 18,
- Notification from neighboring dialysis centers of their inability to provide care to their current patient population

Note: The following strategies are a work in progress and will be updated as needed based on resources, capabilities and technology that is available. They should not be construed as policy or procedure but more of a peer reviewed document to help guide dialysis center decision making during a disaster. Strategies may not be appropriate for all dialysis centers or all incidents.

SPACE – Strategies for Dialysis Centers Objective: To maintain operations and/or repurpose space in order to take on additional patients		
#	**Strategy**	**Regulatory and other considerations**
1	▫ Partner with geographically close facilities	▪ Establish communication/partnerships with facilities that address sharing of space, e.g. other dialysis centers, hospitals (Next Stage Machine), physician offices, ASCs, Sub-acute facility, etc. ▪ De novo sites (Completed dialysis centers that are awaiting for licensing to open) ▪ Pre-establish site prior to incident
2	▫ Use non-traditional areas of facility for patient care	▪ Approval needed from regulatory agency(ies) to expand treatment stations ▪ Network 18 serves as the intermediary contact for CMS ▪ Additional chairs and/or gurneys would be needed ▪ Training Room ▪ Examination rooms
3	▫ Identify alternative care sites	▪ Retail store has been utilized in previous disasters
4	▫ Serve as charging stations – for example: home care patients that need electricity to power their oxygen concentrators, ventilators, etc.	▪ Suggest a minimum of 2 employees be present to oversee use of center ▪ Choose areas where outlets are linked to back-up power source

STRATEGIES AND CONSIDERATIONS – DIALYSIS CENTERS

STAFF – Strategies for Dialysis Centers Objective: Maintain appropriate staffing levels and/or expand the workforce		
#	**Strategy**	**Regulatory and other considerations**
5	▫ Encourage staff to be prepared at home	▪ Provide preparedness checklist. ▪ Consider providing group discounts for purchasing items.
6	▫ Call in off-duty staff	▪ Utilize clerical staff to contact staff ▪ Utilize mass notification system to contact staff ▪ Identify concerns related to staff to patient ratio ▪ Consult professional boards ▪ Optimal, industry standard, RN 1 to 10, Dialysis Technician 1 to 4 ▪ Acceptable staffing TBD at the time of event based on the event and the acuity level of patient load, by the clinical staff on site and/or Medical Director

7	▫ Develop policies and procedures to accept and assign volunteers	▪ Check company policy for volunteer acceptance ▪ Determine scope of work for volunteer assignments ▪ Consider credentialing and license verification issues ▪ Develop Memorandum of Understanding (MOU) with neighboring facilities ▪ Staff from a closed sister facility ▪ Staff from a closed facility geographically close ▪ Staff to report to local facility if unable to report to their work location ▪ Request staff through the LA County Disaster Healthcare Volunteer (DHV) System
8	▫ Develop/Implement disaster/emergency training for staff	▪ Consider requesting non-clinical volunteers from the local jurisdiction, when specialized skills are not required ▪ Runners/Messengers ▪ Patient registration ▪ Patients transport coordination ▪ Providing perimeter security (entrances and parking lots) ▪ Medical Director to establish protocol for deciding if non-clinical staff can apply pressure to dialysis access after treatment
9	▫ Develop just-in-time training to train staff and volunteers in emergency protocols	▪ Peritoneal dialysis nurses can only do hemodialysis if cross-trained ▪ Examples include: - Triage of dialysis patients to include but not limited to; patient assessment, date of last treatment, weight, and respiratory status - Emergency dialysis protocol such as 3K for 3 hours with any dialyzer and non-reuse
10	▫ Notification/activation of staff	▪ Ensure staff contacts are up to date ▪ Determine a mechanism of contacting staff, e.g. text, phone, email, automated notification systems (Everbridge, One Call Now, etc.) Cell phones may need to be utilized if main phone lines are down ▪ Call in off-duty staff and/or request current staff to remain at work

STUFF – Strategies for Dialysis Centers Objective: Ensure adequate supplies and equipment		
#	**Strategy**	**Regulatory and other considerations**
11	▫ Create and maintain emergency supplies for staff and patients	▪ Consider additional people who may be at your facility (patient family members) ▪ Identify what supplies would best serve your staff and patients ▪ Consider patient diet and consult a dietician ▪ Supply for the recommended 96 hours, but a minimum of 24 hours of food, potable water and emergency supplies ▪ Each center should have an individualized "must have" supply list ▪ Consider storing 2-4 weeks of Heparin and bicarbonate
12	▫ Conserve Resources	▪ With an influx of patients, normal par-level of two week supply will be utilized in a shorter duration of time
13	▫ Develop emergency agreements with existing supply vendors	▪
14	▫ Develop agreements with local vendors/pharmacies to provide supplies/medications	▪
15	▫ Partner with geographically close facilities	▪ Establish communication/partnerships with healthcare entities that address sharing of supplies e.g. other home health agencies, ASCs, hospitals, etc. ▪ Recommend moving supplies and equipment from non-functional facilities
16	▫ Ensure adequate fuel for generator (if applicable)	▪ Only applicable to facilities with generators ▪ Know what equipment will be able to run in your facility on generator power and for what duration of time (number of dialysis machines) ▪ Ensure staff is trained (at least two) to operate generator
17	▫ Ensure home dialysis patient have back-up supplies and a treatment plan for use during disasters	▪ Only applicable to facilities with home dialysis patients
18	▫ Request resources from LA County EMS Agency DOC	▪ Must have exhausted own resources and supplies ▪ Medical supply assistance must be requested through the Department of Health Services (DHS) Department Operations Center (DOC) through the established resource requesting process

SYSTEMS/OPERATIONS – Strategies for Dialysis Centers Objective: To maintain and/or increase operations by redirecting resources for non-essential services and providing services to a broader patient population		
#	**Strategy**	**Regulatory and other considerations**
19	▫ Implement and/or develop patient triage criteria	▪ Recommend protocols for triage and treatment of patient be established by Medical Director ▪ Prioritization for treatment and type of treatment, e.g. 2K/2 hours or 3K/3 hours
20	▫ Extend/adjust hours of operation	▪ Review company policy ▪ Consider downtime for RO machine regeneration ▪ Ensure adequate supplies ▪ Ensure staffing, manage staff hours ▪ Ensure appropriate approvals from L&C and/or accreditation agency ▪ Ensure adequate marketing to inform patients
21	▫ Implement and/or develop policies and procedures to shorten dialysis treatment	▪ Important to include all potential emergency options in written plans, e.g. 2K for 2 hours with any dialyzer and non-reuse
22	▫ Develop a facility disaster plan to address: - Evacuation - Sheltering in place - Patient Surge - Communication strategies with staff, patients and local Emergency Management	▪ Develop and provide training to staff on Plans ▪ Drill and exercise plans, e.g. simulate a facility evacuation of patients
23	▫ Create patient centered disaster plans to include: - Patient information cards - Sample 3-day diet - Back-up transportation plan	▪ Determine the frequency of re-education patients, e.g. annually or bi-annually
24	▫ Coordinate with transportation services companies in disaster/emergency events	▪ Consider having an up-to-date list of local transportation companies
25	▫ Develop protocol for dialyzing “visiting” patients that also addresses potential Hepatitis B (Hep B) patients	▪ Currently patients are separated and any treating staff must have the Hep B antibody ▪ Maintain a list of staff who have Hep B antibodies ▪ For patients whose Hep B status is unknown, bleach dialyzers to sanitize
26	▫ Develop protocol to contact the home dialysis patient.	▪ Maintain up to date phone list ▪ Have alternative list in case power there is no access to computers

27	▫ Offer vaccinations/prophylaxis to staff and their family members as directed by Public Health	▪ Have a policy/procedure to address prophylaxis ▪ Determine how many family members you are able to cover and include in your policy/procedure ▪ May encourage staff to stay/return to work during a public health emergency
28	▫ Develop disaster policies and procedures outlining your response capabilities - Provide first-aid - Call 911 to transport to appropriate facility	▪ Determine what you can do for your community ▪ Dialysis patients will need the full support of dialysis centers therefore non-dialysis patients should be referred to other facilities for appropriate care

HEALTHCARE SECTOR: EMS PROVIDER AGENCIES

Sector Descriptor

EMS providers are any fire department or private ambulance company that provide medical care in the pre-hospital setting. In LA County there are 36 public providers (fire departments) and more than 35 licensed private ambulance companies who meet this description most of whom operate 24/7. Since new by-laws were passed in 2013 requiring all private ambulance companies to be licensed through LA County, many others are in the process of obtaining licensure; therefore, the number of licensed private ambulance companies is expected to increase by at least 100% in the near future. Some private ambulance companies only do inter-facility transfers whereas others are contracted by a fire department to assist with 9-1-1 transports.

All EMS providers are guided by pre-hospital policies and procedures regarding staffing, care and patient destination based on the chief complaint of each patient during normal day-to-day operations. Each EMS provider is also bound by the scope of practice and training of their team members namely EMTs and paramedics. They will all be faced with unique challenges, based on their areas of operation and contracts, during a county-wide surge in patients requesting care and many of the pre-hospital policies and procedures may need to be suspended so the most acute patients receive the most appropriate care.

Key Response Goals

Primary goal: To maintain operations and continue to provide care to patients in the pre-hospital setting

Indicators

General Indicators: One or more of the following indicators should be met prior to surge strategy implementation

- Inability to support regular dispatch, treatment and/or transportation of all patients
- Established communication routes are disabled
- See specific Indicators/Triggers columns in the strategies on the following pages

Specific Indicators: Each section has specific indicators and triggers which are shown in the first row of each section

Surge Strategies

The EMS Provider strategies are laid out differently than the other sectors – they have four separate components of Dispatch, Treatment, Transport and Coordination/Communication under which the four S's (space, staff, stuff and system) fall as applicable.

Note: The following strategies are a work in progress and will be updated as needed based on resources, capabilities and technology that is available. They should not be construed as policy or procedure but more of a peer reviewed document to help guide EMS provider decision making during a disaster. Strategies may not be appropriate for all providers or all incidents.

DISPATCH – EMS PROVIDERS

SPACE – Dispatch Strategies for EMS Providers		
Indicators/Triggers		
▫ Dispatch center inoperable		
#	**Strategy**	**Regulatory and other considerations**
1	▫ Dispatch centers should consider having alternative locations or partnerships with other dispatch centers	▪ Can be applied to the centers that are overwhelmed or have technology impact issues ▪ Alternate sites identified need to be included in planning process, and exercised
2	▫ Consider a location in another county	▪
3	▫ Have remote sites where calls can be diverted to e.g. regional dispatch centers, Exclusive Operating Area (EOA) Memorandum of Understanding (MOU), etc.	▪
4	▫ Coordinate with Primary Public Safety Answering Point (PSAP) to transmit incident/response instructions to jurisdictional fire/Emergency Medical Services (EMS) provider	▪
5	▫ Contact EMS Agency to request generator for power	▪ Contacting EMS Agency is a last resort when other resources have been exhausted ▪ Generator will require an electrician for hook up

STAFF – Dispatch Strategies for EMS Providers		
Indicators/Triggers		
▫ Unable to maintain staffing to answer incoming calls ▫ Staff overwhelmed by call volumes ▫ Patient calls exceed the available EMS resources ▫ Staff unable to report to work e.g. impassable roads, incapacitated vehicle, or other reason/direct effect of the incident		
#	**Strategy**	**Regulatory and other considerations**
6	▫ Implement tiered dispatch examples include: a) Single resource response b) Dispatch based on call type ▫ Units given stacked calls by dispatch and will prioritize response themselves	▪ Maintain/adhere to minimum staffing levels at all times if able
7	▫ Decline dispatch to non-life threatening calls and refer them to nurse advice line (2-1-1, PH, etc.)	▪ Need to include PH in planning
8	▫ Use prerecorded message, if applicable to filter calls	▪ An example of prerecorded message "If you are calling about the incident at City Hall, we have units responding; if you have a life threatening emergency, press # 1; if you do not have a life-threatening emergency and would like to speak with a nurse, press #2"
9	▫ Utilize social media for communication to employees and the public	▪
10	▫ Have staff report to a predetermined destination for work assignment	▪
11	▫ Hold over shift/recall off-duty dispatcher and utilize supervisors	▪
12	▫ Bring in back-up dispatchers not currently on the floor, if available	▪ For example, LAFD have 24 hours shifts resting in-house, those staff would be brought in as back-up
13	▫ If available, utilize police dispatch who will relay information to Emergency Operations Center (EOC)/Department Operations Center (DOC)	▪

STUFF – Dispatch Strategies for EMS Providers		
Indicators/Triggers		
▫ Employees stranded/working for extended periods of time		
#	**Strategy**	**Regulatory and other considerations**
14	▫ Have a plan for stocking or obtaining emergency provisions (food, blankets, personal hygiene items, bathrooms, cots, first aid supplies, etc.)	▪
15	▫ Utilize traditional and non-traditional vendors for restocking	▪ Having an emergency agreement with vendors ahead of time would be beneficial
	▫ Use of established resource requesting through Department of Health Services (DHS) DOC	▪ ☐ Last resort when all other sources have been exhausted
16	▫ Encourage personal preparedness at home and at work (e.g. family plans, cell phone chargers, extra medication, etc.)	▪

SYSTEM/OPERATIONS – Dispatch Strategies for EMS Providers		
Indicators/Triggers		
▫ Unable to maintain staffing to answer calls ▫ Staff overwhelmed by call volumes ▫ Patient calls exceed the available EMS resources ▫ Inability to use current dispatch center		
#	**Strategy**	**Regulatory and other considerations**
17	▫ Link smaller dispatch centers to larger ones for support prior to incidents	▪ Systems may not be compatible
18	▫ Dispatch to initiate roll call to formulate response plan with incoming staff	▪
19	▫ Utilize manual means for dispatch if system is down	▪
20	▫ Utilize area command	▪
21	▫ Inform public if 9-1-1 is down, to contact a local fire station directly or go there for assistance utilizing Joint Information Center (JIC) messaging e.g. emergency alerts	▪

TREATMENT – EMS PROVIDERS

STAFF – Treatment Strategies for EMS Providers		
Indicators/Triggers		
▫ Staff unable to report to work: e.g. impassable roads, incapacitated vehicles, or other reason/direct effects of the incident		
#	**Strategy**	**Regulatory and other considerations**
22	▫ Implement "Reduction in Staffing Plan"/alternate staffing plan	▪ Consider writing a plan if none exists
23	▫ Have alternate location for staff to report to e.g. EOC, incident command, staging area, closest facility, battalion headquarters, etc. in the event that communication lines are inoperable	▪ All providers should consider arranging a place for their staff to report to. LA County Fire Department (LACoFD) utilizes a Disaster Information Card which includes areas to report to according to type of personnel e.g. On-duty personnel (Type A) should report to their primary work location. If unable to do so, they report to the nearest battalion headquarters; Off-duty (Type B) personnel should contact their nearest battalion headquarters within 4 hours after the event and report availability status. These cards are distributed to all personnel at hire and annually.
24	▫ EMS providers should follow their business continuity plans	▪ Consider writing a plan if none exists
25	▫ Encourage staff to register as Disaster Healthcare Volunteers (DHV)	▪ - Register at http://www.lacountydhv.org/surgeunit/
26	▫ Establish a procedure to accept volunteers through the DHV registry	▪ There are currently 285 PM and EMTs in the DHV registry however providers do not have a mechanism to use volunteers at this time
27	▫ Plan for utilization of spontaneous volunteers and/or those sponsored by another LA County agency that report to your agency	▪ Determine if your department is willing to accept spontaneous volunteers and determine what they are allowed to do ▪ Consider using Community Emergency Response Team (CERT) volunteers for support positions e.g. security, traffic standby, etc. ▪ Consideration should be given to liability, workers comp, etc. for all non-departmental staff
28	▫ Utilize staff sponsored by another approved LA County agency	▪ EMS Agency waiver of sponsorship requirement in Prehospital Care Policy Nos. 803 and 1006

29	▫ Request staff from DHV registry	▪ Staff requests are made through the EMS Agency DOC by the established resource requesting process
30	▫ EMS Agency to waive/alter staffing policy if applicable	▪ Waiver of Prehospital Care Policy No. 408, ALS Unit Staffing
31	▫ Request mutual aid partners to assist through Standardized Emergency Management System (SEMS)	▪ Last resort when all others resources are exhausted
32	▫ Implement just-in-time training	▪ May be needed for staff that are assigned a different role than their regular job assignment
33	▫ Have space available for staff family members	▪ Staff may be more comfortable responding if they can bring their family/pets

Indicators/Triggers

▫ System overwhelmed as public requests for assistance exceed available resources

#	Strategy	Regulatory and other considerations
34	▫ Implement Prehospital Care Policy No. 519, Management of Mass Casualty Incidents (MCI) if applicable	▪ Use of Prehospital Care Policy No. 519 authorizes use of Prehospital Care Policy No. 806 ▪ Utilization of START (Simple Triage and Rapid Treatment) and Jump START (START for pediatrics) triage
35	▫ Utilize Prehospital Care Policy No. 806, without base contact, and transport to most appropriate receiving facility	▪
36	▫ Staff to assess, treat and release those that do not have life-threatening complaints	▪ May require waiver of provider policy/procedure
37	▫ Have casualty collection points	▪ Patients go to one place for assessment instead of providers responding to them directly

STUFF – Treatment Strategies for EMS Providers		
Indicators/Triggers		
▫ Running low on treatment supplies		
#	**Strategy**	**Regulatory and other considerations**
38	▫ Plan for conservation of PPE and supplies	▪ Maintain standard of care during conservation of supplies
39	▫ Utilize traditional and non-traditional vendors for restocking	▪ Having an emergency agreement with vendors ahead of time would be beneficial ▪ Replenish supplies from hospital stock when dropping off patients
40	▫ Identify and utilize available medical caches e.g. at some fire stations and hospitals (Disaster Resource Centers or DRCs)	▪
41	▫ Have contracts with other providers for assistance with supplies	▪
42	▫ Use of established resource requesting through Department of Health Services (DHS) DOC	▪ Last resort when all other sources have been exhausted

SYSTEM/OPERATIONS – Treatment Strategies for EMS Providers		
Indicators/Triggers		
▫ Unable to contact base station due to volume of calls or communications are down		
#	**Strategy**	**Regulatory and other considerations**
43	▫ Use Prehospital Care Policy No. 806 Procedures Prior to Base Contact and transport without base contact to most appropriate facility as able	▪ 806 allows paramedics to utilize procedures within LA County scope of practice that are not covered by 806.1 only if base contact cannot be established and, in their judgment, a life-saving procedure is needed ▪ Contact MAC if unable to make contact with base station
Indicators/Triggers		
▫ Incident requires mass prophylaxis or treatment		
#	**Strategy**	**Regulatory and other considerations**
44	▫ Expand EMS providers role e.g. vaccinating	▪ Need EMS Medical Director approval who will need to get Emergency Medical Services Authority (EMSA) approval first
Indicators/Triggers		
▫ Many patients to treat with limited resources and time ▫ Unable to utilize current Patient Care Record (PCR) due to time and resource constraints		
#	**Strategy**	**Regulatory and other considerations**
45	▫ To expedite treatment of patients while continuing to track them consider use of triage tags, multi-patient MCI forms (hard copy or electronic), or ICS 214 (Activity Form) instead of writing/inputting on a regular EMS report form for each patient	▪ Ideally all patients should have a PCR

TRANSPORT – EMS PROVIDERS

STAFF – Transport Strategies for EMS Providers		
Indicators/Triggers		
▫ There are wait times for ambulance personnel at acute care facilities		
#	**Strategy**	**Regulatory and other considerations**
46	▫ Hand over care of patient(s) to receiving staff immediately in order to go back into service	▪ EMS Agency to issue directive to receiving facilities to release providers immediately with no wall time
Indicators/Triggers		
▫ Staff unable to report to work: e.g. due to impassable roads, incapacitated vehicles, or other reason/direct effects of the incident		
#	**Strategy**	**Regulatory and other considerations**
47	▫ Implement "Reduction in Staffing Plan"/alternate staffing plan	▪ Consider writing a plan if none exists
48	▫ Designate a recall number with pre-recorded message	▪
49	▫ Have alternate location for staff to report to e.g. EOC, incident command, staging area, closest facility, battalion headquarters, etc. in the event that communication lines are inoperable	▪ Providers should consider arranging a place for their staff to report to. LA County Fire Department (LACoFD) utilizes a Disaster Information Card which includes areas to report to according to type of personnel e.g. On-duty personnel (Type A) should report to their primary work location. If unable to do so, they report to the nearest battalion headquarters; Off-duty (Type B) personnel should contact their nearest battalion headquarters within 4 hours after the event and report availability status. These cards are distributed to all personnel at hire and annually.
50	▫ EMS Providers should follow their business continuity plans	▪ Consider writing a plan if none exists
51	▫ Encourage staff to register as DHVs	▪ Register at: http://www.lacountydhv.org/surgeunit/
52	▫ Establish procedure to accept volunteers through the DHV registry	▪ There are currently 285 PM and EMTs in the DHV registry however providers do not have a mechanism to use volunteers at this time

53	▫ Plan for utilization of spontaneous volunteers and/or those sponsored by another LA County agency that report to your agency	▪ Determine if your department is willing to accept spontaneous volunteers and determine what they are allowed to do ▪ - Consider using Community Emergency Response Team (CERT) volunteers for support positions e.g. security, traffic standby, etc. ▪ - Consideration should be given to liability, workers comp, etc. for all non-departmental staff
54	▫ Utilize providers sponsored by another approved LA County agency	▪ EMS Agency waiver of sponsorship requirement in Prehospital Care Policy Nos. 803 and 1006
55	▫ Request staff from DHV registry	▪ Staff requests are made through the EMS Agency DOC by the established resource requesting process
56	▫ Use BLS to transport ALS patients	▪ Waiver of Prehospital Care Policy No. 408, ALS Unit Staffing by EMS Agency
57	▫ Transport more than 1 patient per ambulance	▪ Group appropriate patients that are going to the same facility
58	▫ Consider utilizing air resources to transport staff	▪
59	▫ Request mutual aid partners to assist through Standardized Emergency Management System (SEMS)	▪ Last resort when all others resources are exhausted ▪ Regional requests would go through the MAC to the Regional Disaster Medical and Health Coordinator/Specialist (RDMHC/S)
60	▫ Implement just-in-time (JIT) training	▪ May be needed for regular staff assigned a different role than their regular job assignment, or for supplemental staff

STUFF – Transport Strategies for EMS Providers		
Indicators/Triggers		
▫ Not enough ambulances to transport all patients		
#	**Strategy**	**Regulatory and other considerations**
61	▫ Designate ambulance transport solely for moderately/seriously ill or injured patients	▪
62	▫ Use alternative transportation e.g. buses to transport minor patients	▪
63	▫ Transport more than 1 patient per ambulance	▪
64	▫ Request Fire Operational Area Coordinator (FOAC) response	▪ May be activated when more than 10 ambulances are required for a response
65	▫ Use alternate transport vehicle to access patients in areas where ambulances are unable to get to e.g. trucks, quads, all - terrain vehicles (ATV), etc.	▪
Indicators/Triggers		
▫ Running low on supplies		
#	**Strategy**	**Regulatory and other considerations**
66	▫ Utilize normal restocking procedures if able	▪
67	▫ Request Disaster Medical Supply Units (DMSU) for supplies	▪
68	▫ Identify and utilize available medical caches e.g. at some fire stations and hospitals (DRCs)	▪
69	▫ Request resources through the EMS Agency DOC standardized procedure	▪ Resource requested should be submitted through the EMS Agency DOC

Indicators/Triggers		
▫ Fuel supply issues for responders		
#	**Strategy**	**Regulatory and other considerations**
70	▫ Need written county-wide plan for accessing fuel in a disaster situation	▪ No current written plan in place. County Office of Emergency Management (OEM) aware ▪ County Internal Services Department (ISD) has temporary/generic account numbers that can be assigned to County staff for distribution of fuel to non-county departments that are assisting with response ▪ Suggest ISD provide access codes for providers prior to incident ▪ Provide fuel keys for providers
71	▫ Consider assigning fuel numbers/billing codes to contracted ambulance companies	▪ ISD has plan to send employee to fueling stations (ISD, Sheriff's stations, etc.) to keep track of who is using the fuel for billing purposes ▪ Contact the EMS Agency DOC and/or County EOC for direction during an incident
72	▫ Each provider should have a fuel plan	▪ Consider contracting with gas companies and require that all vehicles maintain at least half a tank of gas at all times ▪ Consider other sources of fuel such as bus systems, metro link, DWP, armory, ports. Prior contact would be beneficial ▪ Fuel tankers (wet hosing)

SYSTEM/OPERATIONS – Transport Strategies for EMS Providers		
Indicators/Triggers		
▫ Vehicle maintenance issues		
#	**Strategy**	**Regulatory and other considerations**
73	▫ Each provider should have a fleet management plan addressing items such as refueling, replacement of tires, etc.	▪ Logistics of communication, tracking/sharing resources regarding vehicle matters could be an issue ▪ Space issues – specialized tires/supplies take up a large amount of space
74	▫ Approach traditional and non-traditional vendors as needed e.g. Sears, Firestone, Metro, etc.	▪ Consider prearranging contracts with non-traditional vendors/companies ▪ Vendors may have similar issues as providers related to mobility
75	▫ Ensure you address fleet supply needs in a business continuity plan/recovery	▪
Indicators/Triggers		
▫ Inability to take patients to specialty centers		
#	**Strategy**	**Regulatory and other considerations**
76	▫ Attempt to take patients to the most appropriate receiving facility however, may need to take to the best available	▪ Obtain waivers from EMS Agency for all transportation and destination policies ▪ Attempt should be made to transport patients to most appropriate facility as able e.g. ST Elevation Myocardia Injury (STEMI) to STEMI Receiving Center (SRC), etc. ▪ Ensure staff are aware of surge plans including Burn and Pediatric
Indicators/Triggers		
▫ Emergency rooms/hospitals are overwhelmed with response		
#	**Strategy**	**Regulatory and other considerations**
77	▫ Transport patients to alternate care sites e.g. clinics, ambulatory surgery centers, etc.	▪ Ensure that staff are aware of the plan to utilize alternate care sites during a large scale event ▪ Providers are not used to going to alternate care sites therefore education prior to using, or just-in-time training needs to be given ▪ Ask Medical Alert Center (MAC) for list of available alternate care sites

		▪ Health & Safety Code suspension required from L&C to transport to anywhere other than an approved 9-1-1 receiving facility
78	▫ Have a plan to guide staff on when to utilize alternate care sites e.g. have a list indicating which alternate care sites patients should be transported to first (comprehensive centers vs smaller clinics)	▪

Indicators/Triggers

▫ Regular routes inaccessible/
Inability to utilize regular routes

#	Strategy	Regulatory and other considerations
79	▫ Predetermine alternative street routes for common roadways	▪ Recommend each unit have a hardcopy of road maps within LA County for use during power/cell tower outages

COORDINATION/COMMUNICATION – EMS PROVIDERS

SYSTEM/OPERATIONS – Coordination/Communication Strategies for EMS Providers		
Indicators/Triggers		
▫ Inability to communicate with all providers		
#	**Strategy**	**Regulatory and other considerations**
80	▫ Recommend all private ambulance companies are on ReddiNet or have radios for communication during disasters that do not require access of cell towers	▪ Encourage all providers to contract with ReddiNet as it is becoming more widely utilized. ▪ Cost to providers
81	▫ Have a redundant communication system e.g. HAM radio, satellite phone, etc.	▪ Consider linking in with local HAM radio operators
82	▫ Send Liaison to PSAP/Incident Commander (IC)	▪
83	▫ All providers, both public and private, should create communication pathways and protocols and utilize clear text	▪
84	▫ Have alternate location for staff to report to e.g. EOC, incident command, staging area, closest facility, battalion headquarters, etc. in the event that communication lines are inoperable	▪
Indicators/Triggers		
▫ Compromised communication systems		
#	**Strategy**	**Regulatory and other considerations**
85	▫ Recommend all providers use a unified command in a central area or pre-designated PSAP	▪
Indicators/Triggers		
▫ Inability to use current communication method		
#	**Strategy**	**Regulatory and other considerations**
86	▫ Perform area surveys/sweeps (district recon; windshield survey; jurisdictional survey, etc.)	▪
87	▫ Establish communication failure protocols	▪

88	▫ Use of HAM radio operators and/or satellite phones if available	▪
89	▫ Use of notification tools e.g. Everbridge, Mir3 etc.	▪

Indicators/Triggers

- ▫ Public unable to access 911 in a large scale disaster

#	Strategy	Regulatory and other considerations
90	▫ Coordinate public notices/emergency alerts with JIC	▪
91	▫ Utilize social media, CalTrans, Freeway information line, cell phone companies, etc.	▪ Not all departments utilize or have access to social media sites

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HEALTHCARE SECTOR: HOME HEALTH AND HOSPICE AGENCIES

Sector Description

There are more than 800 home health agencies including those who provide home hospice care in LA County. Most home health and hospice agencies are stand-alone companies with only a small number having more than one business location. There are a few agencies who are part of a larger healthcare system that oversee different healthcare entities.

Duties performed by home health/hospice staff include general activities of daily living, e.g. bathing, to complex wound care and care of ventilator dependent patients. Staff may include nursing assistants, RNs, LVNs, and therapists such as occupational and physical that assist in carrying out orders given by the patient's doctor. Hospice agencies may also have social workers and chaplains on staff.

One major challenge facing home health staff is notifying EMS of patients who are medically fragile and live in an area affected by a disaster that they are unable to reach.

Note: *Inpatient hospice facilities are considered Skilled Nursing Facilities (SNF) which are covered under Skilled Nursing Facilities healthcare sector on page 63 of this guide.*

Key Response Goals

Primary goal: To maintain operations and continue to care for current patients

Secondary goal: Accept early discharge patients from acute care facilities, or assist other home health agencies who are unable to care for current patients

Indicators

One or more of the following indicators should be met prior to surge strategy implementation:

- EMS/MAC notification of a system wide surge
- Impedance of staff being able to treat regular patients due to an incident, e.g. wild fire, earthquake, etc.

Note: The following strategies are a work in progress and will be updated as needed based on resources, capabilities and technology that is available. They should not be construed as policy or procedure but more of a peer reviewed document to help guide home health/hospice agency decision making during a disaster. Strategies may not be appropriate for all agencies or all incidents.

STRATEGIES AND CONSIDERATIONS – HOME HEALTH AND HOSPICE AGENCIES

SPACE – Strategies for Home Health/Hospice Agencies
Objective: To maintain space in order to continue operations to support patient care activities

#	Strategy	Regulatory and other considerations
1	▫ Develop an alternate site plan for office if current location not accessible or functional	▪ Some locations to consider are: Local hospital Staff homes/vehicles Ambulatory surgery centers (ASC) City Emergency Operations Center (EOC) ▪ Consider written partner agreements with each site Contact city emergency operations manager for support
2	▫ Partner with geographically close healthcare entities	▪ Establish communication/partnerships with healthcare entities that address sharing of space e.g. other home health agencies, ASCs, hospitals, physicians offices, etc.

STAFF – Strategies for Home Health/Hospice Agencies
Objective: To maintain appropriate staffing levels and/or expand the work force

#	Strategy	Regulatory and other considerations
3	▫ Encourage staff to be prepared at home	▪ Staff may not be willing to come in to work or stay at work if they are not prepared at home ▪ Recommend staff should have an emergency plan and enough emergency supplies for each family member to last at least 72 hours ▪ Encourage staff to maintain a half tank of gas at all times for vehicles used for patient visits as lines may be long at gas stations, and/or there is no power
4	▫ Develop/Implement disaster/emergency training for staff	▪ At a minimum, train/test staff's competency on disaster preparedness/response procedures when hired and annually ▪ Develop disaster competency sheets ▪ Plan for just-in-time (JIT) training ▪ Plan to utilize any additional personnel if available in an appropriate role
5	▫ Notification/activation of staff	▪ Ensure staff contacts are up to date ▪ Determine a mechanism of contacting staff, e.g. text, phone, email, automated notification systems (Everbridge, One Call Now, etc.) Cell phones may need to be utilized if main phone lines are down

		▪ Call in off-duty staff and/or request current staff to remain at work ▪ Answering service staff/afterhours staff should know your disaster protocols ▪ Agencies should have knowledge of the answering service disaster protocols
6	▫ Appropriate utilization of available staff	▪ Staff may not be able to reach their regularly assigned patients but may be able to care for those closest to their location – consider mapping personnel with patients geographically ▪ Important to always prioritize patients according to level of care - ensure staff are aware of patient's acuity/triage level e.g. low, medium, high ▪ Consideration may be given to language and culture when assigning staff, however, not a priority during a disaster ▪ Remind staff to utilize the established interpreter service such as AT&T Language Line, CyraCom, etc. ▪ Ensure staff always carry their ID badges which may allow them access to patient areas restricted by law enforcement ▪ Utilize family members for supportive care
7	▫ Partner with geographically close facilities	▪ Establish communication/partnerships with healthcare entities that address sharing of staff e.g. other home health agencies, ASCs, hospitals, etc.
8	▫ Develop procedures to accept volunteers	▪ Determine if you will accept volunteers and have a policy that addresses volunteers from LA County Disaster Healthcare Volunteer (DHV) program and also spontaneous volunteers ▪ If accepting spontaneous volunteers, each center should determine what each person is required to have e.g. actual license/certificate, BLS and ALS card, home care experience, etc. ▪ DHV staff have had credentialing and background checks done by the EMS Agency ▪ If DHV volunteers are needed, a Resource Request Form must be completed and sent to the Department Operations Center (DOC) at the EMS Agency ▪ Consider utilizing own employees for patient care and volunteer staff for non-patient care activities ▪ Waiver may be required from CDPH – Title 22 states "cannot contract out primary services"

STUFF – Strategies for Home Health/Hospice Agencies		
#	**Strategy**	**Regulatory and other considerations**
9	▫ Ensure emergency supply of, including but not limited to, food, water, waste management products, fuel (for generator if applicable) and personal supplies for staff	▪ Recommend a 24 hr. supply at minimum both in the office and in each provider's vehicle that they use for patient visits ▪ Storage area for supplies ▪ Consider obtaining a generator for your office if building does not have one
10	▫ Utilize current inventory of supplies	▪ Implement conservation of supplies ▪ Maintain standards of care during conservation of supplies ▪ Ensure staff who visit patients have extra supplies, including medications if applicable, in their vehicles or in patient homes
11	▫ Contact traditional/non-traditional vendors for resupply	▪ Many healthcare entities utilize the same vendors and therefore supplies may be limited ▪ Examples of non-traditional vendors include local pharmacies, hardware stores, supermarkets, etc. ▪ Develop an emergency partner agreement with vendors/supply companies e.g. pharmacy, DME companies, etc. ▪ Obtain knowledge of vendors emergency restocking plans e.g. oxygen companies, infusion companies, etc.
12	▫ Partner with geographically close facilities	▪ Establish communication/partnerships with healthcare entities that address sharing of supplies e.g. other home health agencies, ASCs, hospitals, etc.
13	▫ Contact LA County EMS Agency through the DOC for medical resources	▪ After exhausting all other ways of securing medical resources, LA County DOC for Health may be contacted through the established resource requesting process
14	▫ Supply a disaster documentation packet for each care provider	▪ Packet should include paper maps and assessment/intake forms to meet minimum information requirements e.g. consent, oasis documentation, medication sheets, etc. ▪ Required by CMS to be completed for new patients within five business days– would require waiver to exceed five day timeframe.

SYSTEMS/OPERATIONS – Strategies for Home Health/Hospice Agencies		
#	**Strategy**	**Regulatory and other considerations**
15	▫ Develop disaster policies and procedures outlining your response capabilities	▪ Determine what you can do for your community e.g. accept discharges from hospitals to free up beds to accept more acute patients
16	▫ Partner with geographically close facilities for planning purposes	▪ Establish communication/partnerships with facilities that are interested in planning together for disasters e.g. hospitals, physician offices, other ASCs, home health agencies, etc. and share plans ▪ Attend Disaster Resource Center (DRC) meetings every other month as able ▪ Recommend written agreements

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HEALTHCARE SECTOR: HOSPITALS

Sector Description

LA County is home to approximately 100 acute care hospitals of which approximately 75% are 9-1-1 receiving facilities, which includes two Veterans Affairs medical centers. These hospitals represent a mix of public and private entities with a range in bed capacity from 8 to over 500. Some are independent facilities and others are part of larger healthcare systems.

A general acute care hospital is defined as "...having an organized medical staff which provides 24-hour inpatient care, including the following basic services: medical, nursing, surgical, anesthesia, laboratory, radiology, pharmacy, and dietary services," 22 CCR 70005(a). These hospitals are licensed by the California Department of Public Health (CDPH).

Included within these acute care hospitals are designated specialty centers such as Emergency Department Approved for Pediatrics (EDAP), STEMI (ST Elevation Myocardial Infarction) Receiving Centers, Trauma Centers, etc.

Key Response Goal

Primary goal: To maintain operations and increase capacity in order to preserve the life and safety of the patients and ensure appropriate healthcare delivery to the community

Indicators

One or more of the following indicators should be met prior to surge strategy implementation:

- EMS Agency/MAC notification of system wide surge
- Inpatient/observation beds at capacity
- Influx of patients (mass casualty incidents, catastrophic event, emerging infectious diseases (EID), pandemics, etc.)

Note: The following strategies are a work in progress and will be updated as needed based on resources, capabilities and technology that is available. They should not be construed as policy or procedure but more of a peer reviewed document to help guide hospital decision making during a disaster. Strategies may not be appropriate for all hospitals or all incidents.

STRATEGIES AND CONSIDERATIONS – HOSPITALS

**Description of the CCRs (California Code of Regulations) can be found on page 61 after the strategies*

SPACE - Strategies for Hospitals Objective: To create additional and/or repurpose space to care for increased patient load		
#	**Strategy**	**Regulatory and other considerations**
1	▫ Utilize licensed space for other types of patients	▪ Use outpatient beds for inpatient care ▪ Use internal skilled beds as acute patient areas ▪ Convert adult space to pediatric space ▪ Convert pediatric space to adult space ▪ 22 CCR 70805* ▪ 22 CCR 70809(a)* ▪ 22 CCR 70811(c)*
2	▫ Increase capacity in patient care areas	▪ Expedite discharges ▪ Downgrade patients ▪ Cancel elective surgeries ▪ Increase capacity of patient rooms e.g. 2 patients in a single room, 3 patients in a double room, etc. - 22 CCR 70805* - 22 CCR 70809(a)* - 22 CCR 70811(a)* ▪ Create additional negative pressure rooms by shutting off ventilation - 22 CCR 70823* - 22 CCR 70855*
3	▫ Open hospital floors that are vacant	▪ 22 CCR 70805* ▪ 22 CCR 70809(c)*
4	▫ Use areas of hospital unlicensed for inpatients	▪ GI lab ▪ Recovery Room ▪ Outpatient surgery space ▪ Physical therapy areas ▪ Ensure planning to maintain patient monitoring for non-traditional patient care areas ▪ Ensure infection control procedures are maintained ▪ Define appropriate types of patients for these areas ▪ 22 CCR 70805* ▪ 22 CCR 70809(c)*
5	▫ Use non-traditional areas of hospital for patient care	▪ Hallways ▪ Cafeterias ▪ Conference rooms, break rooms ▪ Parking structures - ▪ Use tents/shelters to create additional patient care areas – constitutes a conversion of space on hospital property

		▪ Ensure planning to maintain patient monitoring for non-traditional patient care areas ▪ Ensure infection control procedures are maintained ▪ Define appropriate types of patients for these areas ▪ Consideration should be given to limitations for outdoor space including weather, time of day and security - 22 CCR 70805* - 22 CCR 70809(c)* ▪ Written approval from the local fire authority required for tent use
6	▫ Partner with geographically close facilities	▪ Establish communication/partnerships with Coalition partners that address sharing of space, e.g. facilities who belong to the same healthcare system other acute care facilities (hospitals), clinics, Ambulatory Surgery Centers (ASC), Long Term Care (LTC), etc. ▪ Refer to Disaster Resource Center (DRC) Regional Response Plan

STAFF – Strategies for Hospitals
Objectives: Maintain appropriate staffing levels and/or expand the workforce

#	Strategy	Regulatory and other considerations
7	▫ Encourage staff to be prepared at home	▪ Staff may not be willing to come in to work or stay at work if they are not prepared at home ▪ Recommend staff should have an emergency plan and enough emergency supplies for each family member to last at least 72 hours ▪ Establish emergency contacts for all family members including children and animals e.g. daycare, schools, veterinarians, etc. ▪ Encourage staff to maintain a half tank of gas at all times as lines may be long and/or there is no power
8	▫ Develop/Implement disaster/emergency training for staff	▪ Assign and train staff for disaster roles preferably before an incident both clinical and non-clinical – keep within scope of practice ▪ At a minimum, train/test staff's competency on disaster preparedness/response procedures when hires and annually ▪ Plan for just-in-time (JIT) training ▪ Security will be very important – identify those who can be reassigned to security and provide training prior to an event ▪ 22 CCR §70214 (a)* ▪ 22 CCR §70214 (a)(1)*

9	▫ Notification/activation of staff	▪ Regularly update staffing rosters ▪ Call in off-duty staff and/or request current staff to remain ▪ Identify employees that will be available during a disaster-prior to the disaster ▪ Ensure staff are aware of any prophylaxis plans for them and their family ▪ Determine a mechanism of contacting staff, e.g. text, phone, email, automated notification systems (Everbridge, One Call Now, etc.) ▪ Reassign administrative staff to clinical roles ▪ Consider staffing agreement with facilities who belong to the same healthcare system ▪ Contact approved staffing agencies ▪ Use of non-conventional staff to assist clinical staff to assist with simple procedures e.g. family, community and faith-based organizations ▪ Request relaxation of nurse/patient ratios – see hospital policy - 22 CCR 70217: Nurse ratios ▪ AB 394: California RN Staffing Ratio Law, requires Governor's Standby Order for Statutory Suspension - 22 CCR §70217 (m)* ▪ Government Code 8659: Nurse, No liability for service at request of authorized official during the state of war emergency, a state of emergency, or a local emergency, unless willful act or omission
10	▫ Partner with geographically close facilities	▪ Establish communication/partnerships with Coalition partners that address sharing of staff, e.g. facilities who belong to the same healthcare system, other acute care facilities (hospitals), clinics, Ambulatory Surgery Centers (ASC), Long Term Care (LTC), etc. ▪ Refer to Disaster Resource Center (DRC) Regional Response Plan
11	▫ Develop procedures to accept volunteers	▪ Refer to hospital policy regarding volunteer use for both LA County Disaster Healthcare Volunteer (DHV) program and for spontaneous volunteers ▪ DHV staff have had credentialing and background checks done by the EMS Agency ▪ If DHV volunteers are needed, a Resource Request Form must be completed and sent to the DOC of the EMS Agency ▪ If accepting spontaneous volunteers considerations should include credentialing, previous experience, liability and insurance, etc.

STUFF – Strategies for Hospitals Objective: Ensure adequate supplies and equipment		
#	**Strategy**	**Regulatory and other considerations**
12	▫ Ensure emergency supply for staff, patients and visitors	▪ Refer to hospital policy regarding 96 hour rule ▪ Should include but not limited to, food, water, pharmaceuticals, generator fuel, waste management products and personal supplies
13	▫ Utilize current inventory supplies	▪ Implement conservation of supplies e.g. limit/reduce frequency of baths, linen changes, etc. ▪ Maintain standards of care during conservation of supplies
14	▫ Contact traditional/non-traditional vendors for resupply	▪ Many healthcare entities utilize the same vendors and therefore supplies may be limited ▪ Notify vendors regarding anticipated needs and determine availability of supplies ▪ Recommend agreements with non-traditional vendors e.g. warehouse stores (Costco, Sam's Club, Home Depot, etc.), grocery stores, disaster vendors (SOS, More Prepared, etc.), sporting goods stores, local animal hospital, etc.
15	▫ Partner with geographically close facilities	▪ Establish communication/partnerships with Coalition partners that address sharing of stuff, e.g. facilities who belong to the same healthcare system, other acute care facilities (hospitals), clinics, Ambulatory Surgery Centers (ASC), Long Term Care (LTC), etc. ▪ Refer to Disaster Resource Center (DRC) Regional Response Plan
16	▫ Contact Department of Health Services Department Operations Center (DOC) for medical resources	▪ After exhausting all traditional ways of securing medical supplies, LA County DOC may be contacted through the established resource requesting process

SYSTEMS/OPERATIONS – Strategies for Hospitals Objective: Ensure operations are adapted/maintained as needed		
#	**Strategy**	**Regulatory and other considerations**
17	▫ Develop plans to provide dependent care (children, pets, etc.) for staff	▪ Identity space and protocols to provide for dependent care
18	▫ Offer vaccinations/prophylaxis to staff and their family members as directed by Public Health	▪ Identify protocols to provide vaccination/prophylaxis Include number of family members covered per staff ▪ Update antibiotics distribution plan for implementation if the Medical Countermeasure plan is activated in the County
19	▫ Update disaster plan to include specifics for surge	▪ Ensure disaster policies and procedures outline response capabilities to surges as applicable (pandemic, trauma, burn and pediatric surge plans) ▪ Ensure response capabilities if LA County EMS lifts catchment boundaries ▪ Ensure response capabilities if LA County EMS relaxes prehospital policies (specialty centers and patient destination policies)
20	▫ Develop disaster policies and procedures outlining your response capabilities	▪ Determine what capabilities the hospital has with consideration of various types of surges
21	▫ Partner with geographically close facilities for planning purposes	▪ Establish communication/partnerships with facilities that are interested in planning together for disasters e.g. other local hospitals, clinics, long term care facilities, ASCs, home health agencies, etc. and share plans ▪ Attend Disaster Resource Center (DRC) meetings where regional response plans are in place ▪ Recommend written agreements

*California Code of Regulation Titles:

1. 22 CCR §70214 (a) : There shall be a written, organized in-service education program for all patient care personnel, including temporary staff as described in subsection 70217(m). The program shall include, but not be limited to orientation and the process of competency validation as described in subsection 70213 (c)
2. 22 CCR §70214 (a)(1) : All patient care personnel, including temporary staff as indicated in subsection 70217(m), shall receive and complete orientation to the hospital and their assigned patient care unit before receiving patient care assignments. Orientation to a specific unit may be modified in order to meet temporary staffing emergencies as described in subsection 70213(e)
3. 22 CCR §70217: Nurse ratios
4. 22 CCR §70217 (m): Unlicensed personnel may be utilized as needed to assist with simple nursing procedures, subject to the requirements of competency validation. Hospital policies and procedures shall describe the responsibility of unlicensed personnel and limit their duties to tasks that do not require licensure as a registered or vocational nurse
5. 22 CCR §70805: Spaces approved for specific uses at the time of licensure shall not be converted to other uses without the written approval of CDPH
6. 22 CCR §70809(a): No hospital shall have more patients or beds set up for overnight use by patients than the approved licensed bed capacity except in the case of justified emergency when temporary permission may be granted by the CDPH Director or designee
7. 22 CCR §70809(c): Patients shall not be housed in areas which have not been approved by CDPH for patient housing and which have not been granted a fire clearance by the State Fire Marshal
8. 22 CCR §70811(a): Patients shall be accommodated in rooms with a minimum floor area (as detailed in 22 CCR 70811 (a) (1) and (a) (2))
9. 22 CCR §70811(c): Patient rooms which are approved for ambulatory patients only shall not accommodate non-ambulatory patients
10. 22 CCR §70823: A private room shall be available for any patient in need of physical separation as defined by the infection control committee. Private toilet facilities shall be immediately adjacent to this room
11. 22 CCR §70855: Heating, air conditioning and ventilation systems shall be maintained in operating condition to provide a comfortable temperature and to meet the new construction requirements in effect at the time plans were approved for the facility.
12. AB 394: California RN Staffing Ratio Law, requires Governor's Standby Order for Statutory Suspension

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HEALTHCARE SECTOR: SKILLED NURSING FACILITIES/LONG TERM CARE

Sector Descriptor

Skilled nursing facilities (SNFs), sometimes called nursing homes, long term care facilities, or convalescent hospitals, provide comprehensive nursing care for chronically ill or short-term residents of all ages, along with rehabilitation and specialized medical programs.

Subacute care facilities are units often in a distinct part of a SNF, whose focus is on intensive rehabilitation, complex wound care and post-surgical recovery for residents of all ages who no longer need the level of care found in an acute care hospital. Some residents may also require the use of ventilators. Subacute care facilities are separate units and primarily funded by Medical (Medicaid).

In LA County there are over 400 SNFs, operated by both corporations and independent owners. These are inclusive of non-profit and proprietary health facilities. The most common bed capacity is 99 licensed beds due to regulatory requirements on the amount of skilled staff that is required to be on duty. The average occupancy at most SNFs is 87%.

Most SNFs do not have a physician on-site, nor do they have a pharmacy. SNFs use a service to provide patient specific medications in unit dose packaging and over-the-counter (OTC) medications. Most do not have pediatric services and very few facilities have negative pressure isolation capabilities.

Key Response Goals

Primary goal: To maintain operations and continue to provide care to current patients

Secondary goal: Accept early discharge patients from acute care hospitals, or assist other SNFs in need

Indicators

One or more of the following indicators should be met prior to surge strategy implementation

- EMS/MAC notification of a system wide surge
- Inability to transfer patients to an acute care facility
- Notification from neighboring facilities of their inability to provide care to their current patient population

Note: The following strategies are a work in progress and will be updated as needed based on resources, capabilities and technology that is available. They should not be construed as policy or procedure but more of a peer reviewed document to help guide SNF decision making during a disaster. Strategies may not be appropriate for all SNF or all incidents.

STRATEGIES AND CONSIDERATIONS – SKILLED NURSING FACILITIES

SPACE – Strategies for SNFs Objective: To maintain current operations and/or repurpose space in order to take on additional patients		
#	**Strategy**	**Regulatory and other considerations**
1	▫ Cohort Patients: Group like-patient types together to maximize efficient delivery of patient care.	▪ Maintain all infection control precautions and procedures
2	▫ Use licensed space for other types of patients, if applicable (use of SNF bed for sub-acute and vice versa)	▪ Designate wards or areas of the facility that can be converted to negative pressure or isolated from the rest of the ventilation system for cohorting infectious patients ▪ Use these areas for infectious patients to minimize disease transmission to uninfected patients.22 CCR 72603: Spaces approved for specific uses at the time of licensure shall not be converted to other uses without the approval of CDPH ▪ 22 CCR 72321: Prohibits a skilled nursing facility from admitting or treating any patient with an infectious disease unless that patient can be accommodated in a room vented to the outside ▪ 8 CCR 5199-E: Aerosol Transmissible Disease Standard – Requires use of appropriate PPE
3	▫ Convert common areas into patient care, add the use of cots, beds, or other sleeping surfaces	▪ Cafeterias ▪ Recreation areas ▪ Lounges ▪ Lobbies ▪ Rooms with unlicensed beds ▪ Unused spaces - 22 CCR 72607(b): Patients shall not be housed in areas which have not been approved by CDPH for patient housing and which have not been given a fire clearance by the State Fire Marshal.
4	▫ Transfer patients to lower level of care (e.g. RCF) or discharge patients to family residents, temporarily.	▪ Have agreements in place with facilities that provide lower levels of care ▪ Pre-identify which patients may be able to be temporarily discharged to their families
5	▫ Increase capacity in patient care areas	▪ 22 CCR 72607(a): A facility shall not have more patients or beds set up for use than the number for which it is licensed except in case of emergency when temporary permission may be granted by the CDPH Director or designee. ▪ Convert single rooms to double rooms ▪ Convert double rooms to triple rooms

STAFF – Strategies for SNFs Objective: Maintain appropriate staffing levels and/or expand the workforce		
#	**Strategy**	**Regulatory and other considerations**
6	▫ Encourage staff to be prepared at home	▪ Staff may not be willing to come in to work or stay at work if they are not prepared at home ▪ Recommend staff should have an emergency plan and enough emergency supplies for each family member to last at least 72 hours ▪ Encourage staff to maintain a half tank of gas at all times
7	▫ Rely on existing staff	▪ Increase the number of hours per work shift ▪ Call in off-duty and/or per diem staff ▪ Reassign licensed administrative staff to patient care roles CA Industrial Welfare Commission Order # 4-2001, 3(B) (9)-(10) outlines the number of hours that healthcare personnel may work during a healthcare emergency ▪ 22 CCR Section 72038: “Direct caregiver” means a registered nurse, a licensed vocational nurse, a psychiatric technician, and a certified nurse assistant, or a nursing assistant participating in an approved training program, while performing nursing services as described in sections 22 CCR 72309, 72311 and 72315. A person serving as the Director of Nursing services in a facility with 60 or more licensed beds when giving direct care, not included in nursing hours per patient day
8	▫ Call upon external sources for temporary staff	▪ Nurse staffing agencies - 22CCR 72535 states this requirement for skilled nursing facilities; 22 CCR 72535 states this requirement for intermediate care facilities
9	▫ Develop procedure to accept volunteers	▪ Long-term care health facilities are required to document a health screening, including tuberculosis PPD test, within 7 days of hiring or 90 days prior to an employee's start-date. 22CCR 72535 states this requirement for skilled nursing facilities; 22 CCR 72535 states this requirement for intermediate care facilities. Unless directed by CDPH Licensing & Certification, this requirement must be met during a healthcare surge and a health screening process should be incorporated into the facility's plan for acceptance and assignment of staff ▪ Determine if you will accept volunteers and have a policy for both LA County Disaster Healthcare Volunteer (DHV) program and for spontaneous volunteers ▪ DHV staff have had credentialing and background checks done by the EMS Agency

		▪ If DHV volunteers are needed, a Resource Request Form must be completed and sent to the Department Operations Center (DOC) at the EMS Agency
10	▫ Identify which functions can be performed by: - Community-based organizations - Family members - Private contractors	▪ Consider non-clinical support, such as laundry services and meal preparation and delivery ▪ Utilize families to render supportive care under direction of a healthcare provider
11	▫ Partner with geographically close facilities	▪ Establish communication/partnerships with facilities that address sharing of staff e.g. hospitals, other SNFs, home health agencies, etc.

STUFF – Strategies for SNFs Objective: Ensure adequate supplies and equipment		
#	**Strategy**	**Regulatory and other considerations**
12	▫ Have enough pharmaceuticals to be self-sufficient to operate at or near full capacity for a minimum of 72 hours, with a goal of 96 hours	▪ CA HSC Sections 1261.5 and 1261.6, 22 CCR 72377, and 22 CCR 73375 limit the number of drugs a skilled nursing facility or intermediate care facility can maintain beyond patients' current supply of medication.
13	▫ Have enough supplies and equipment to be self-sufficient to operate at or near full capacity for a minimum of 72 hours, with a goal of 96 hours	▪
14	▫ PPE: Provide appropriate personal protective equipment and training for all staff	▪ Identify/streamline process for use of PPE including guidelines for reuse and fit testing
15	▫ Contact local traditional/non-traditional vendors for resupply, while utilizing conservation measures in supplies and equipment	▪ Many healthcare entities utilize the same vendors and therefore supplies may be limited ▪ Recommend agreements with local merchants including pharmacies, supermarkets and hardware stores
16	▫ Partner with geographically close like facilities	▪ Establish communication/partnerships with facilities that address sharing of stuff e.g. hospitals, other SNFs, home health agencies, etc.
17	▫ Contact LA County EMS Agency through the DOC/MAC for medical resources	▪ After exhausting all traditional ways of securing medical supplies, LA County DOC for health may be contacted through the established resource requesting process – resource request should be completed

COMMUNICATION

The Medical Alert Center (MAC) is the designated 24/7 emergency communications center for the EMS Agency and is expanded upon activation of the DHS DOC to support medical and health providers in the event of a disaster or significant incident.

Upon activation of the DOC, the priorities and resources of the EMS Agency shift to supporting the medical and health resource request needs of the County and their partners.

Communication Systems

The following means may be used by all healthcare sectors if available for any communication between your facility and the DOC/MAC including resource requesting. (See EMS Agency Communication Plan at http://file.lacounty.gov/SDSInter/dhs/206683_Communication.pdf)

- **ReddiNet:** An internet based communication tool that is used for day-to-day communication between the MAC and hospitals. It plays a vital communication role during any incidents or disasters - see following page for more information on ReddiNet Assessment Polling
- **Fax Machine**: May be used for any emergency communications.
- **Landline/Cellular Telephone**: Serve as primary method of emergency and non-emergency communication.
- **Email**: contact the DOC for the email that may be used during an incident.
- **Amateur/HAM Radio**: Amateur radio network provides emergency communication for agencies in situations where primary communication systems and infrastructure are diminished.
- **Satellite phones:** Each DRC has at least 1 satellite phone which functions like a push-to-talk radio. These will be used as a last resort.
- **VMED28:** A radio communication utilized by the MAC to share information with hospitals and EMS providers

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REDDINET ASSESSMENT POLLING

HEALTHCARE SECTOR COLORS*					
	Normal Operations	**Under Control**	**Modified Services**	**Limited Services**	**No Services**
ASC	No assistance from the jurisdiction is required	No assistance from the jurisdiction is required			Unable to care for patients
CLINIC	No assistance from the jurisdiction is required	No assistance from the jurisdiction is required	Some assistance from the jurisdiction is required		Unable to care for patients
DIALYSIS	No assistance from the jurisdiction is required	No assistance from the jurisdiction is required	Some assistance from the jurisdiction is required		Unable to care for patients
HHH	No assistance from the jurisdiction is required	No assistance from the jurisdiction is required	Some assistance from the jurisdiction is required		Unable to care for patients
HOSPITAL	No assistance from the jurisdiction is required	No assistance from the jurisdiction is required	Some assistance from the jurisdiction is required	Significant assistance from the jurisdiction is required	Unable to care for patients
SNF/LTC	No assistance from the jurisdiction is required	No assistance from the jurisdiction is required	Some assistance from the jurisdiction is required	Significant assistance from the jurisdiction is required	Unable to care for patients

*See following page for an explanation of what each color represents

REDDINET ASSESSMENT POLLS EXPLANATION

Ambulatory Surgery Centers (ASC)

- Green (Normal Operations): No assistance from the jurisdiction is required. ASC is operational and is in business-as-usual mode. Can assist with response and is able to accept minor stable patients
- Yellow (Under Control): No assistance from the jurisdiction is required. ASC is operational and is in business-as-usual mode. Can assist with response with use of space, staff and/or stuff. Unable to accept additional patients.
- Black (No Services): Unable to care for patients as ASC is closed for business. No assistance from jurisdiction is required.

Community Health Centers (Clinics)

- Green (Normal Operations): No assistance from the jurisdiction is required. Clinic is operational and is in business-as-usual mode. Can assist with response and is able to accept minor stable patients.
- Yellow (Under Control): No assistance from the jurisdiction is required. Clinic is operational and is in business-as-usual mode. Unable to accept additional patients.
- Orange (Modified Services): Some assistance from the jurisdiction is required. Clinic has begun to modify their services.
- Black (No Services): Unable to care for patients as clinic is closed for business. No assistance from jurisdiction is required.

Dialysis Centers

- Green (Normal Operations): No assistance from the jurisdiction is required. Center is operational and is in business-as-usual mode. Can assist with the response and is able to accept additional patients who need dialyzed.
- Yellow (Under Control): No assistance from the jurisdiction is required. Center is operational and is in business-as-usual mode. Unable to accept additional patients.
- Orange (Modified Services): Some assistance from the jurisdiction is required. Center has begun to modify their services.
- Black (No Services): Unable to care for patients. Assistance from jurisdiction is required to help find centers that will accept their priority patients who need dialysis.

Hospitals

- Green (Normal Operations): No assistance from the jurisdiction is required. Hospital is operational and is in business-as-usual mode.
- Yellow (Under Control): No assistance from the jurisdiction is required. Hospital is experiencing an increase in demand for care, however, is able to manage their situation without assistance.
- Orange (Modified Services): Some assistance from the jurisdiction is required. Hospital has begun to modify their services.
- Red (Limited Services): Significant assistance from the jurisdiction is required. Hospital is struggling to meet the demand for care and is able to support limited services only.
- Black (No Services): Unable to care for patients. Immediate assistance from the jurisdiction is required. Evacuation may be necessary.

Home Health/Hospice Agencies (HHH)

- Green (Normal Operations): No assistance from the jurisdiction is required. Agency is operational and is in business-as-usual mode. Can assist with response by accepting early discharged from hospitals.
- Yellow (Under Control): No assistance from the jurisdiction is required. Agency is operational and is in business-as-usual mode. Unable to accept additional patients.
- Orange (Modified Services): Some assistance from the jurisdiction is required. Agency has begun to modify their services as they are unable to care for and/or reach all patients.
- Black (No Services): Unable to care for/reach patients. Assistance from jurisdiction is required to reach patients who have been triaged as high risk. Should be referred to County OEM/EOC.

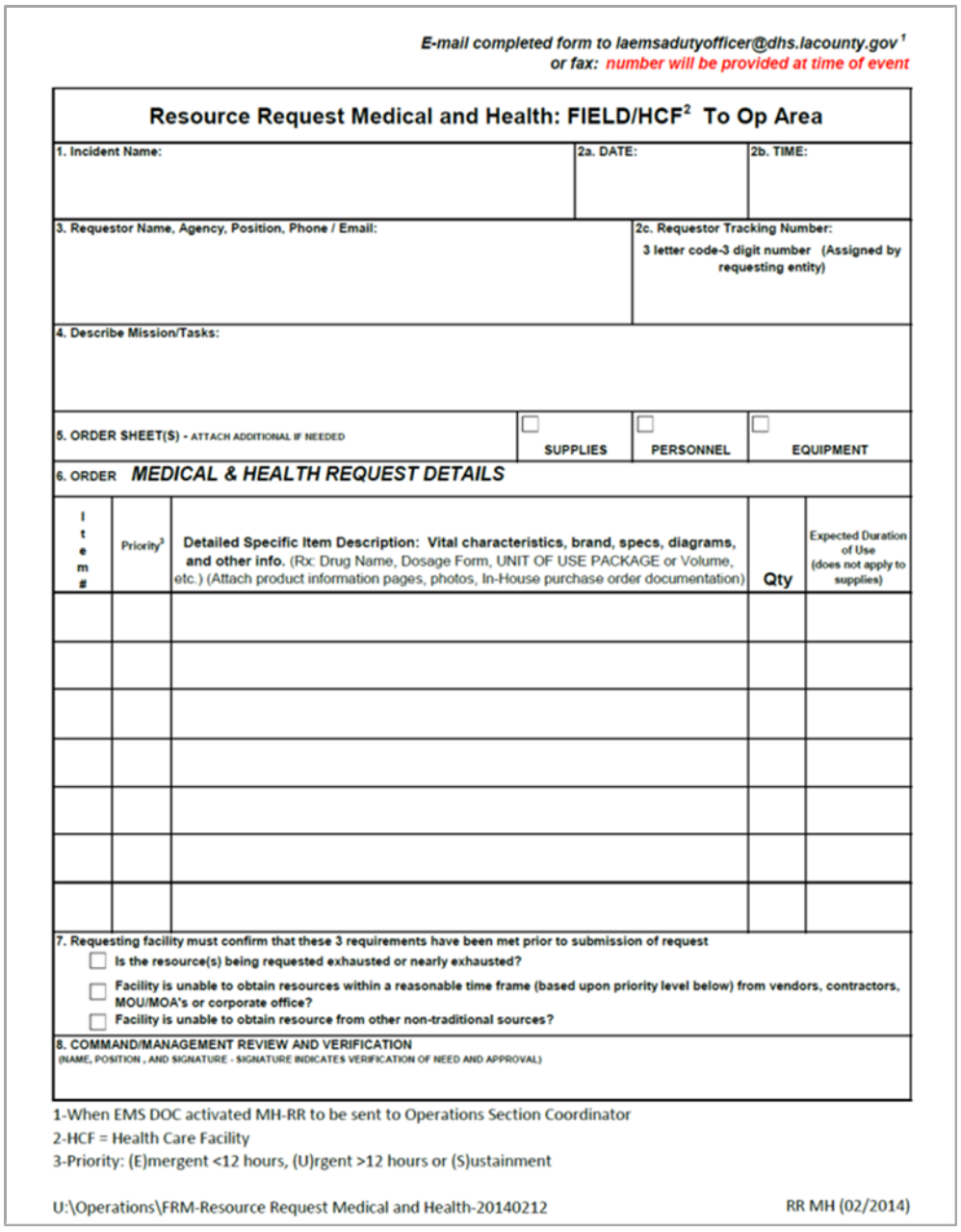
Skilled Nursing Facilities/Long Term Care (SNF/LTC)

- Green (Normal Operations): No assistance from the jurisdiction is required. Facility is operational and is in business-as-usual mode. Can assist with the response by accepting discharges from hospitals and/or patients from other SNF/LTC.
- Yellow (Under Control): No assistance from the jurisdiction is required. Unable to accept additional patients.
- Orange (Modified Services): Some assistance from the jurisdiction is required. SNF/LTC has begun to modify their services.
- Red (Limited Services): Significant assistance from the jurisdiction is required. SNF/LTC is struggling to meet the demand for care.
- Black (No Services): Unable to care for patients. Assistance from jurisdiction is required to help find facilities that will accept their patients.

RESOURCE REQUESTING

The EMS Agency has a finite supply of medical resources that may be requested through the DOC during an incident when all other sources have been exhausted. Healthcare sectors must utilize the standardized resource requesting process by submitting a Resource Request via ReddiNet, email, fax, or by phone as a last resort. Examples of resources available include IV solutions, dressings, masks, pharmaceuticals, PPE, ventilators, etc. Personnel may also be requested in the same manner.

Non-medical resources including water, power, gas, phone outages, food, and water are not available from the DHS DOC. These resources should be requested directly through the company/vendor who supply the service, or through the healthcare sector's city's Emergency Operations Center (EOC).



E-mail completed form to laemsadutyofficer@dhs.lacounty.gov[1]
or fax: number will be provided at time of event

Resource Request Medical and Health: FIELD/HCF[2] To Op Area

1. Incident Name:	2a. DATE:	2b. TIME:
3. Requestor Name, Agency, Position, Phone / Email:	2c. Requestor Tracking Number: 3 letter code-3 digit number (Assigned by requesting entity)	
4. Describe Mission/Tasks:		
5. ORDER SHEET(S) - ATTACH ADDITIONAL IF NEEDED	☐ SUPPLIES	☐ PERSONNEL ☐ EQUIPMENT

6. ORDER ***MEDICAL & HEALTH REQUEST DETAILS***

Item #	Priority[3]	Detailed Specific Item Description: Vital characteristics, brand, specs, diagrams, and other info. (Rx: Drug Name, Dosage Form, UNIT OF USE PACKAGE or Volume, etc.) (Attach product information pages, photos, In-House purchase order documentation)	Qty	Expected Duration of Use (does not apply to supplies)

7. Requesting facility must confirm that these 3 requirements have been met prior to submission of request
- ☐ Is the resource(s) being requested exhausted or nearly exhausted?
- ☐ Facility is unable to obtain resources within a reasonable time frame (based upon priority level below) from vendors, contractors, MOU/MOA's or corporate office?
- ☐ Facility is unable to obtain resource from other non-traditional sources?

8. COMMAND/MANAGEMENT REVIEW AND VERIFICATION
(NAME, POSITION , AND SIGNATURE - SIGNATURE INDICATES VERIFICATION OF NEED AND APPROVAL)

1-When EMS DOC activated MH-RR to be sent to Operations Section Coordinator
2-HCF = Health Care Facility
3-Priority: (E)mergent <12 hours, (U)rgent >12 hours or (S)ustainment

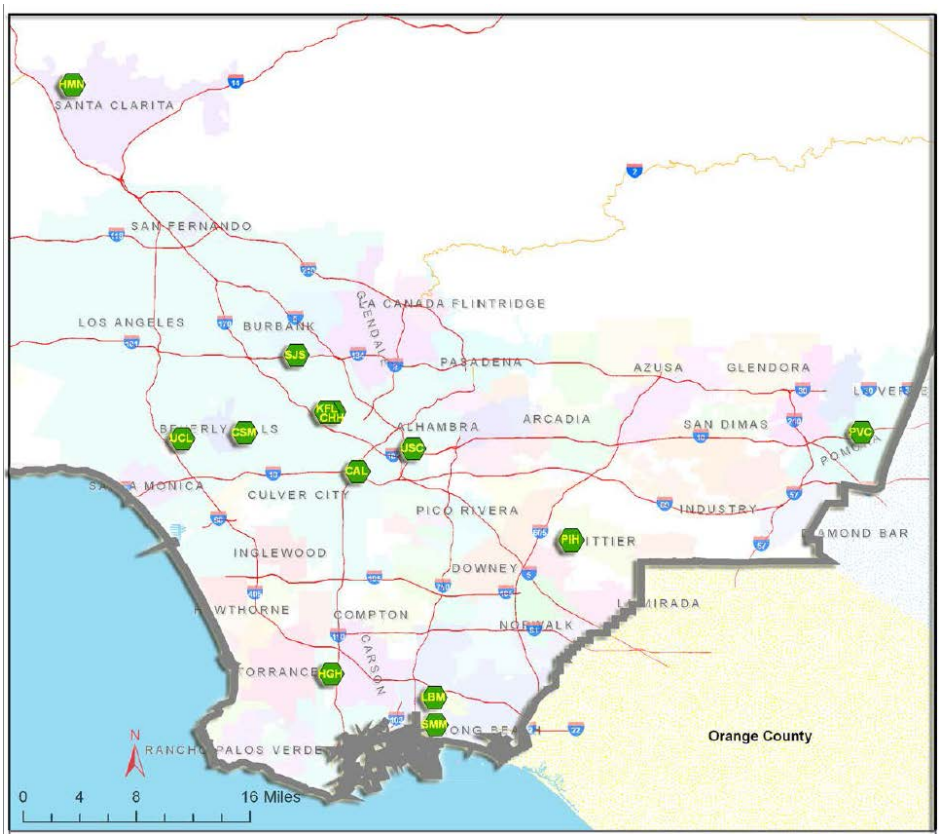
U:\Operations\FRM-Resource Request Medical and Health-20140212 RR MH (02/2014)

DISASTER RESOURCE CENTER (DRC) PROGRAM

The DRC Program was developed to assist the healthcare community to work together regionally within the County on emergency preparedness and response. Thirteen hospitals have been designated as DRCs within ten geographic regions – Children's Hospital Los Angeles (CHLA), Henry Mayo Newhall Memorial Hospital, Kaiser Los Angeles Medical Center/California Hospital Medical Center, LAC Harbor - UCLA Medical Center, LAC+USC Medical Center, Long Beach Memorial Medical Center/Saint Mary Medical Center, Pomona Valley Hospital Medical Center, Presbyterian Intercommunity Hospital-Whittier, Providence Saint Joseph Medical Center, and Ronald Reagan - UCLA Medical Center/Cedars Sinai Medical Center. Each DRC has a cache of supplies ranging from pharmaceuticals to tents which can be deployed anywhere within the County following a resource request submission to the MAC. The Community Clinic Association of Los Angeles County (CCALAC) is also a DRC but only has clinic related supplies.

Each of the hospital DRCs, with the exception of CHLA, have been assigned 8-10 'umbrella' acute care facilities and provide training, planning, drilling and facilitating a regional disaster preparedness plan. Bimonthly meetings are held with active participation from each umbrella facility to exchange information, discuss best practices and provide opportunities to share knowledge on many subjects. EMS providers, clinics, long term care facilities, ambulatory surgery centers, home health providers and dialysis centers are encouraged to attend their local DRC meetings creating an environment of whole community planning.

For more information on LA County's DRC Program, contact the DRC Coordinator in the Disaster Services section of the EMS Agency at (562) 347-1500 or go to the Disaster Services tab on the main EMS Agency website at http://dhs.lacounty.gov/wps/portal/dhs/ems



CDPH LICENSING AND CERTIFICATION

HFID Role in Response

- Alerts and communicates with facilities via California Health Alert Network (CAHAN)
- Acts as the medical health liaison to the Emergency Preparedness Office providing situational awareness to assist in response decisions
- Coordinates evacuation activities of LTC facilities
    - The Regulatory Relief process is a natural progression, starting with local resource needs which become the triggers to justify and expedite suspensions of State and waivers of Federal laws.
    - **Authorizations:** An alternative method, already identified in regulation, used to meet a regulatory requirement. For example:
        - 5% total licensed beds used for other than classified use (22 CCR 70809(b)
        - Space conversion (22 CCR 70805 – hospitals, 22 CCR 72603 - SNF)
    - **Program Flexibility:** An alternative method, **not** already identified in regulation, used to meet a regulatory requirement. (22 CCR 70363)
        - These "work arounds" provide facilities latitude in meeting existing regulatory requirements.
        - Authorization and Program Flexibility can be granted by L&C District Offices and do not require a Governor's Executive Order.
- NOTE: CDPH HFID has no authority to provide State suspensions or Federal waivers.
    - State Suspensions: Require Governor's Executive Order. Suspends specific sections of state law/regulations. Available only during the most catastrophic incidents.
    - Federal Waivers (Section 1135): Require Secretary of the US Department of Health and Human Services approval. Reduce regulatory barriers to efficient disaster response. Available only for specific geographic regions.

Recommended Steps for Expedient Approval from HFIC

Request for regulatory relief prior to an incident.

1. Complete facility specific Healthcare Surge Plan/Policy/Emergency Operations Plan
2. Ensure plan contains required information
3. Submit to HFID district office
4. HFID approval will be confirmed in writing and a copy kept in the facility's file at the L&C district office
5. Facility should keep a copy of the written approval with a copy of facility license
6. At the onset of a declared healthcare surge incident, contact the L&C district office, to give verbal notification of plan implementation.

Request for regulatory relief occurs after the onset of the incident.

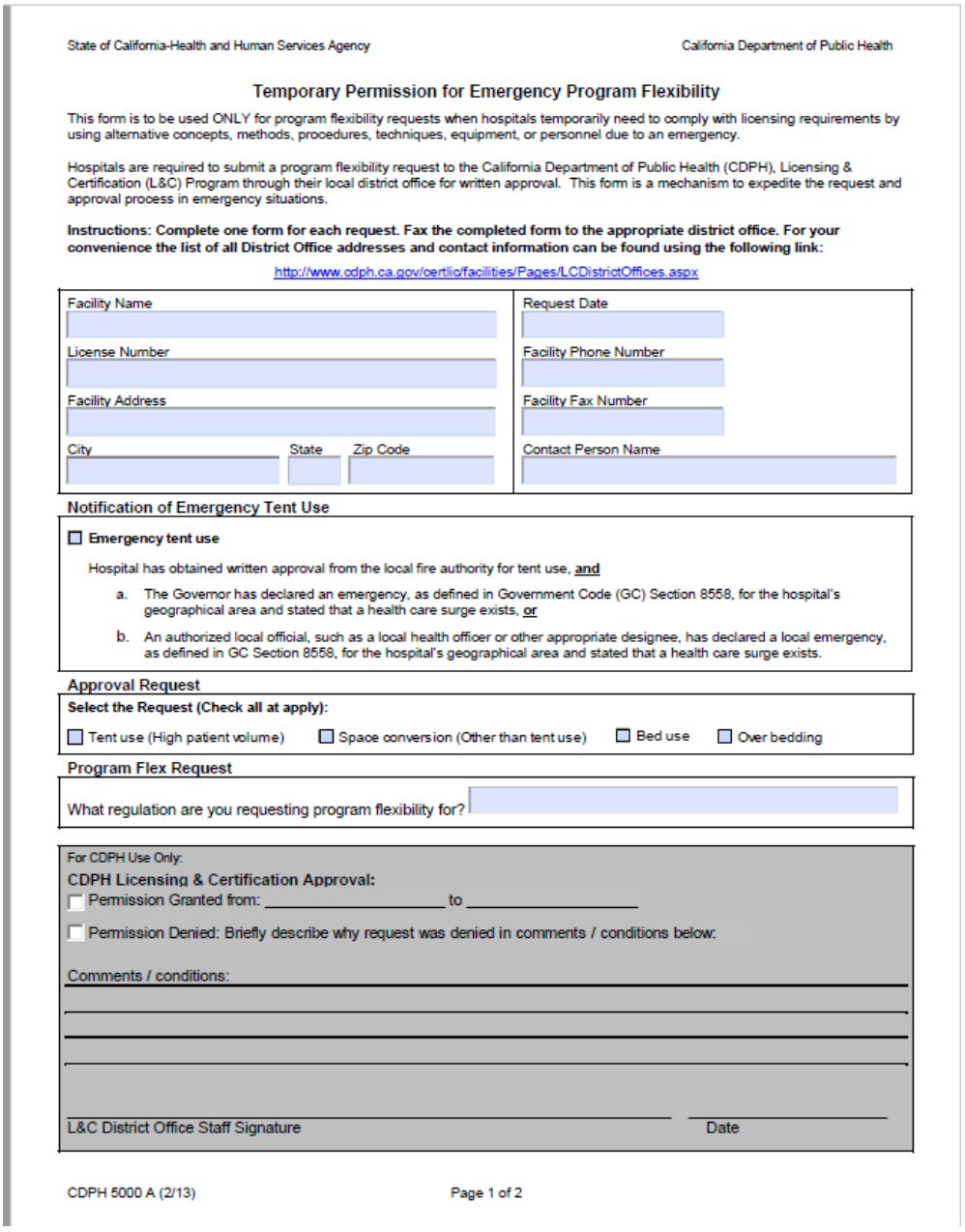
1. Complete *Temporary Permission for Program Flexibility* form https://archive.cdph.ca.gov/pubsforms/forms/CtrldForms/cdph5000A.pdf (also see page 75)

2. Submit form immediately to L&C district office
3. Wait to receive approval from L&C, verbally or in writing. If approval given verbally, it will be confirmed through a fax sent to the facility.

When to contact: Immediately upon recognizing emergency conditions that will require use of these strategies.

Who to contact: HFID

Contact phone numbers: (213)974-1234



State of California-Health and Human Services Agency — California Department of Public Health

Temporary Permission for Emergency Program Flexibility

This form is to be used ONLY for program flexibility requests when hospitals temporarily need to comply with licensing requirements by using alternative concepts, methods, procedures, techniques, equipment, or personnel due to an emergency.

Hospitals are required to submit a program flexibility request to the California Department of Public Health (CDPH), Licensing & Certification (L&C) Program through their local district office for written approval. This form is a mechanism to expedite the request and approval process in emergency situations.

Instructions: Complete one form for each request. Fax the completed form to the appropriate district office. For your convenience the list of all District Office addresses and contact information can be found using the following link:

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

Facility Name | Request Date
License Number | Facility Phone Number
Facility Address | Facility Fax Number
City | State | Zip Code | Contact Person Name

Notification of Emergency Tent Use

☐ **Emergency tent use**

Hospital has obtained written approval from the local fire authority for tent use, **and**

a. The Governor has declared an emergency, as defined in Government Code (GC) Section 8558, for the hospital's geographical area and stated that a health care surge exists, **or**

b. An authorized local official, such as a local health officer or other appropriate designee, has declared a local emergency, as defined in GC Section 8558, for the hospital's geographical area and stated that a health care surge exists.

Approval Request

Select the Request (Check all at apply):

☐ Tent use (High patient volume) ☐ Space conversion (Other than tent use) ☐ Bed use ☐ Over bedding

Program Flex Request

What regulation are you requesting program flexibility for?

For CDPH Use Only:

CDPH Licensing & Certification Approval:

☐ Permission Granted from: _____ to _____

☐ Permission Denied: Briefly describe why request was denied in comments / conditions below:

Comments / conditions:

L&C District Office Staff Signature — Date

CDPH 5000 A (2/13) Page 1 of 2

KEY CONTACTS LIST

Government

Disaster Services Section/EMS Agency

- Monday-Thursday 7:30am-5:00pm (562)347-1500

Emergency Preparedness and Response Division/DPH

- Monday-Friday 8:00am-5:00pm (213)637-3600

Los Angeles County Department of Health Services Emergency Medical Services Agency

- 24/7 Medical Alert Center (MAC): (866)940-4401
- Duty Officer Email: laemsadutyofficer@dhs.lacounty.gov
- http://dhs.lacounty.gov/wps/portal/dhs/ems/

Los Angeles County Department of Public Health

- Emergency Preparedness and Response Program 24/7: (213)989-7140
- Biological Incident Reporting to Acute Communicable Disease Control: (213)240-7941
- Duty Officer Email: phemergdesk@ph.lacounty.gov
- http://publichealth.lacounty.gov

Los Angeles County Department of Mental Health

- 24/7 Access Center: (800)854-7771
- http://dmh.lacounty.gov

Los Angeles County Department of Coroner

- 24/7: (323)343-0714
- http://coroner.lacounty.gov

California Department of Public Health, Licensing and Certification

- Los Angeles District Office: (213)974-1234
- www.cdph.ca.gov/programs/LnC/Pages/LnC.aspx

Sector Associations

Ambulatory Surgery Centers
California Surgery Center Association (CASA)

PO Box 3811, Merced, CA 95344, Tel: (530)790-7990, Fax: (530)790-7644

www.calsurgery.org

Role during a response: None.

Community Health Centers - Clinics
Community Clinic Association of Los Angeles County

1055 Wilshire Blvd., Suite 1400, Los Angeles, CA 90017, Tel: (213)-201-6500, Fax: (213)250-2525

www.ccalac.org

Role during a response: CCALAC serves as a primary conduit for information between county agencies and its member clinics.

Dialysis Centers
ESRD Network 18

700 N. Brand Blvd., Suite 405, Glendale, CA 91203, Tel: (888)268-1539, Fax: (888)637-4767, email: network18@nw18.esrd.net

www.esrdnetwork18.org

Role during a response: Network 18's primary role is communication of essential information that will affect dialysis facilities. Facilities should inform Network 18 if they need to close and this information may be forwarded to applicable county agencies such as the EMS Agency.

Home Health and Hospice Agencies
California Association for Health Services at Home (CAHSAH)

3780 Rosin Court, Suite 190, Sacramento, CA 95834, Tel: (916)641-5795, Fax: (916)641-5881
http://cahsah.org

Role during a response: None

Hospitals
Hospital Association of Southern California

515 South Figueroa Street, Suite 1300, Los Angeles, CA 90071, Tel: (213)538-0700, Fax: (213)629-4272
www.hasc.org

Role during a response: HASC serves as a conduit for information between county agencies and its member hospitals. They send information via their email distribution list, and post information and links on their website.

Skilled Nursing Facilities
California Association of Healthcare Facilities

2201 K Street, Sacramento, CA 95816, Tel: (916)441-6400, Fax: (916)441-6441

www.cahfdisasterprep.com

Role during a response: CAHF's primary role is communication. They push out information to their email distribution list and activate a "current events" section of their website to post alerts and links. They also act as technical advisors to CDPH in terms of their LTC stakeholders.

ACRONYMS

AAAHC	Accreditation Association for Ambulatory Health Care
ASC	Ambulatory Surgery Center
ASPR	Assistant Secretary for Preparedness and Response
CAHAN	California Health Alert Network
CAHF	California Association of Healthcare Facilities
CCALAC	Community Clinic Association of Los Angeles County
CCR	California Code of Regulations
CDC	Centers for Disease Control and Prevention
CDPH	California Department of Public Health
CERT	Community Emergency Response Team
CMS	Centers for Medicare and Medicaid Services
DaVERT	DaVita Emergency Response Team
DCAC	Disaster Coalition Advisory Commission
DHQP	Division of Healthcare Quality Promotion
DHS	Department of Health Services
DHV	Disaster Healthcare Volunteers
DOC	Department Operations Center
DPH	Department of Public Health
DRC	Disaster Resource Center
DSF	Disaster Staging Facility
EDAP	Emergency Department Approved for Pediatrics

EMS	Emergency Medical Services
EMSA	Emergency Medical Services Authority
EOC	Emergency Operations Center
EOP	Emergency Operations Plan
EPO	Emergency Preparedness Office
ESRD	End Stage Renal Disease
FEMA	Federal Emergency Management Agency
FOAC	Fire Operational Area Coordinator
HFID	Health Facilities Inspection Division
HHH	Home Health and Hospice
HPP	Hospital Preparedness Program
ICS	Incident Command System
ILI	Influenza Like Illness
JIC	Joint Information Center
JIT	Just in time
LAHAN	Los Angeles Health Alert Network
L&C	Licensing and Certification
MAC	Medical Alert Center
MAC	Multi Agency Coordination
MHOAC	Medical and Health Operational Area Coordinator
MMC	Mass Medical Care

MOU	Memorandum of Understanding
MRC	Medical Reserve Corps
OA	Operational Area
OEM	Office of Emergency Management
ORISE	Oak Ridge Institute for Science and Education
OTC	Over the counter
PCR	Patient Care Record
PIO	Public Information Officer
POD	Points of Dispensing
PPE	Personal Protective Equipment
RDMHC	Regional Disaster Medical and Health Coordinator
RDMHS	Regional Disaster Medical and Health Specialist
ReddiNet	Rapid Emergency Digital Data Information Network
SEMS	Standardized Emergency Management System
SNF	Skilled Nursing Facility
START	Simple Triage and Rapid Treatment
STEMI	ST Elevation Myocardial Infarction

ONLINE REFERENCES

California Department of Public Health Standards and Guidelines for Healthcare Surge During Emergencies - Foundational Knowledge
http://www.bepreparedcalifornia.ca.gov/cdphprograms/publichealthprograms/emergencypreparednessoffice/epoprogramsandservices/surge/surgestandardsandguidelines/documents/foundationalknowledge_final.pdf

California Public Health and Medical Emergency Operations Manual -
https://www.cdph.ca.gov/programs/aids/Documents/FinalEOM712011.pdf

Community Clinic Association of Los Angeles County - www.ccalac.org

Everbridge - https://www.everbridge.com/

Los Angeles County EMS Agency Communication Plan
http://file.lacounty.gov/SDSInter/dhs/206683_Communication.pdf

Los Angeles County Healthcare Coalition -
http://file.lacounty.gov/SDSInter/dhs/217042_HealthcareCoalitionGovernanceDocument.pdf

Mass Fatality Management Guide for Healthcare Entities -
http://file.lacounty.gov/SDSInter/dhs/206150_1MFMG4HE.pdf

Medical and Health Operation Area Coordinator - Health and Safety Code §1797.153
http://codes.findlaw.com/ca/health-and-safety-code/hsc-sect-1797-153.html

Los Angeles County Healthcare Coalition -
http://file.lacounty.gov/SDSInter/dhs/217042_HealthcareCoalitionGovernanceDocument.pdf

ReddiNet - http://www.reddinet.com/

Los Angeles County Emergency Medical Services Agency

http://dhs.lacounty.gov/wps/portal/dhs/ems

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County of Los Angeles Public Health

Health Services Los Angeles County

Los Angeles County Department of Mental Health hope. recovery. wellbeing.