North Carolina Hospital Association Mutual Aid Agreement
Standard Operating Guide

Purpose Statement

This standard operating guide (SOG) serves to support the effective implementation of the North Carolina Hospital Association (NCHA) Mutual Aid Agreement (MAA) during times of crisis. Intended as a planning guide for adjustment of signatory emergency operations plans (EOP); the contents aid organizations in readying themselves for use of the MAA as an effective extension of their emergency plans.

This document is not legally binding and, like the mutual aid agreement it supports, describes the voluntary sharing of resources amongst signatories.

This document does not constitute legal advice. Each facility and health system is expected to consider their own situation when implementing any portion of this SOG.

Table of Contents

Activation of the Mutual Aid Agreement

Activation of the Mutual Aid Agreement (MAA) is contingent on voluntary engagement between the signatories at the time of the incident. When activated, the MAA is active between two or more consenting signatories.	
Response Phase	
Step 1	When an incident causes the need for activation of the provisions within the MAA activate the: • Emergency operations plan (EOP) • incident command system (ICS)
Step 2	Notify supporting agencies: • Signatories of the NCHA MAA which may be considered supporting facilities for the incident • Local emergency management • Healthcare coalition/regional advisory committee • Joint information system contacts • NCHA https://www.ncha.org/ 919-677-2400
Step 3	**Incident management team**: Gain agreement from signatories of the NCHA MAA which may be considered supporting facilities for the incident
Recovery Phase	
Step 1	Communicate with supporting agencies regarding status and termination
Step 2	Return processes and agreements to normal or 'new normal' state
Step 3	Update procedures and policies to accommodate lessons learned

Management of Public Information and Media

In compliance with National Incident Management System implementation, and in order to produce and distribute the most accurate, credible, and timely information to the media and to the public, where possible, the Affected and Supporting Hospitals will use of the Joint Information System. The Joint Information System allows Public Information Officers from the Affected and Supporting Hospitals to work closely together to perform key tasks and better communications during incidents. The following resources exist to assist your Public Information Officers in this process.

- Courses in emergency management and public relations –
    - Public Information System:

http://training.fema.gov/EMIWeb/IS/courseOverview.aspx?code=IS-702.a

    - National Incident Management System & Incident Command System courses (at minimum 700a, 100.HE, 200.HCa; 800.b if Federal partners are participating in response)
    - http://training.fema.gov/IS/crslist.aspx?page=3

- Basic Guidance for Public Information Officers - http://www.fema.gov/media-library-data/20130726-1824-25045-3342/fema_517_basic_guidance_for_public_information_officers__pios__2007.pdf

- Hospital Incident Command System Job Action Sheets for Command (scroll to second sheet for Public Information Officer duties) - http://www.hicscenter.org/docs/143.pdf

- Key Online Resources for Health care related emergency information –
    - http://www.bt.cdc.gov/firsthours/resources/websites.asp
    - www.cdc.gov
    - www.bt.cdc.gov
    - www.dhs.gov
    - www.dhhs.gov
    - www.epa.gov
    - www.redcross.org
- Health care emergency communications education and training tools - http://emergency.cdc.gov/cerc/

Communication and Coordination

For an effective regional or statewide medical response, each facility should maintain situational awareness, have an understanding of the common operating picture, and be able to provide accurate and accessible information to stakeholders in a rapid, user-friendly manner.

At the onset of an incident, the effected facility should assess the situation, identify and prioritize requirements, establish incident objectives and activate available resources and capabilities to support the healthcare facility(ies).

Upon activation, the effected facility(ies) should send out a request for information on the current status of healthcare facilities in the region. This request for information should be disseminated to all healthcare facilities as soon as there is a threat or potential threat of an incident. Healthcare facilities will need to update their information on a frequent basis. If SMARTT is activated, NCOEMS will determine the schedule for facilities to update their information.

Healthcare Facility Status Information Needed:

- Bed capacity
- Staffing levels
- Facility capabilities
- Epidemiological projections, if applicable
- Casualty estimates
- Specialty services available or needed
- Transportation Requirements/Assets

Communication Tools

The effected facility will use all available communication tools during an incident. SMARTT and WebEOC should be used to communicate and coordinate if the Internet and connectivity are available. These systems help provide greater visibility of status and needs among all healthcare facilities, the state, and other response organizations.

Communication tools may include, but are not limited to:

- SMARTT
- WebEOC
- Landline telephones
- Dedicated telephone lines
- Fax
- E-mail/Distribution Lists
- VIPER Medical Network
- VHF/UHF Radio (insert frequencies)
- HAM radios
- Satellite phones
- Cellular phones

Information Collection and Dissemination

During an emergency, there is a strong likelihood that communications will be degraded and different locations will have varying levels of capability. All available forms of communication should be used. The State, Region or Local Jurisdiction will specify how information should be submitted back when making a request for resource/information. The effected healthcare facility(ies) will disseminate information using as many communication methods as available to ensure receipt of information.

Sharing Information with EOCs and Other First Responders

Facilities should make reasonable efforts to submit information and requests using standard NIMS/HICS forms unless otherwise directed. In some cases the regional healthcare coalition may serve as a consolidated communication and coordination center to share information bi-directionally with emergency management offices, healthcare facilities, EMS agencies, public health, and other appropriate organizations.

Patient Triage, Transport, and Repatriation

Transfer - Repatriation Quick Response Guide

Affected Hospital

Follow this Guide when you have determined the hospital can no longer provide safe services due to an unsafe environment and patients must be transported to another healthcare facility. It is recognized that based on circumstances and the threat of harm, it may not be possible for the Affected Facility to accomplish these tasks. In this case, it is suggested to designate other agencies to provide the communications/support/resources. Follow EMTALA requirements. Refer to EMTALA associated document. Implement Hospital Incident Command.	
Response Phase	
Step 1	Contact local County Emergency Management and your Trauma RAC and let them know of the status. Information / requests should include: • Numbers of patients • Patient Acuity • Category(s) of beds needed • Transport needs • Time frame for evacuation
Step 2	Contact Supporting Healthcare Facilities and let them know of the status.
Step 3	Notify your Trauma RAC of the status and request support to manage the event.
Step 4	Request Trauma RAC to activate NCOEMS SMARTT system to perform a bed capacity inquiry.

Step 5	Enter the hospital status and information into WebEOC. Plan to monitor the WebEOC during the course of the event.
Step 6	Prioritize the order of transfer of patients.
Step 7	Prepare patients for transfer. These actions include the gathering of medications for transport, equipment that is needed to accompany the patient, patient belongings and valuables, health information records
Step 8	Complete the Patient Information Section (front page) of the North Carolina Emergency / Disaster Event Patient Transfer Form.
Step 9	Establish Staging -Transportation Area
Step 10	To facilitate rapid loading of patients for transportation, when requested to do so, move patients to Staging / Transportation Area.
Step 11	Staging / Transportation Area staffing should review the patient information and complete the Transportation Section (back page) of the North Carolina Emergency / Disaster Event Patient Transfer Form.
Step 12	Assist the transportation team as required.
Step 13	Send the North Carolina Emergency / Disaster Patient Transfer Form with the transportation team and retain a copy for the Affected Hospital' s records.
Step 14	Contact family / emergency contact and provide the patient status.
Step 15	Confirm arrival of the patient(s) at the Supporting Facility. Document the information.
Recovery Phase	
Step 16	Continue communications with Supporting Facility(s) regarding repatriation plan. Use Normal Operations Transfer Procedures for the repatriation process.

Forms

HICS 251 Facility System Status Report
HICS 255 Master Patient Evacuation Tracking
HICS 260 Patient Evacuation Tracking (Individualized Patient Information)

Supporting Hospital

Follow this Guide when you have determined that you are able to participate in assisting a hospital that can no longer provide safe services due to an unsafe environment and patients must be transported to another healthcare facility. It is recognized that based on circumstances and the threat of harm, it may not be possible for the Affected Facility to accomplish their tasks. In this case, be willing to provide the communications/support/resources that are requested by the Affected Facility. Follow EMTALA requirements. Refer to EMTALA associated document. Implement Hospital Incident Command.	
Response Phase	
Step 1	Implement Patient Surge Emergency Operations Plan.
Step 2	Notify your Trauma RAC of the status and request support to manage the event.
Step 3	Provide to the Affected Facility (or designated agency), the following information: • Number, acuity level and type of patients that can be received at your facility

	• Time frame in which you can receive patients.
Step 4	Confirm facility has updated the NCOEMS SMARTT system.
Step 5	Enter the hospital status and information into WebEOC. Plan to monitor the WebEOC during the course of the event.
Step 6	Establish the Receiving Staging -Transportation Area
Step 7	Assist the transportation team as required.
Step 8	Review the North Carolina Emergency / Disaster Patient Transfer Form with the transportation team and retain a copy.
Step 9	Notify the Affected Facility of the patient(s) arrival.
Step 10	Contact family / emergency contact and provide the patient status.
Recovery Phase	
Step 11	Continue communications with Affected Facility(s) regarding repatriation plan. Use Normal Operations Transfer Procedures for the repatriation process.

Forms

HICS 255 Master Patient Evacuation Tracking

HICS 260 Patient Evacuation Tracking (Individualized Patient Information)

North Carolina Emergency / Disaster Event Patient Transfer Form
North Carolina Hospital Association Mutual Aid Agreement

<table>
<tr><th colspan="4">Patient Information Section</th></tr>
<tr><td colspan="3">Patient Name: Last First Name MI</td><td>Transfer Information
Reason:
Date:
Time:</td></tr>
<tr><td colspan="2">Patient Date of Birth
(mm/dd/yyyy):</td><td>Gender
Male___ Female ___</td><td>Transferring Physician Name

Contact Number:</td></tr>
<tr><td>Room</td><td>Unit</td><td>Admit Date:

DOS (if applicable):</td><td>Accepting Physician Name

Contact Number:</td></tr>
<tr><td colspan="3">Patient Language of Choice:
English ___ Spanish ___

Other _____</td><td>Advance Directives:
Do Not Resuscitate (DNR)__ Yes(Attach form) __No
__ DNI
__ Living Will
__ MOLST
__Healthcare Proxy</td></tr>
<tr><td colspan="3">Patient Diagnosis:
Primary_____
Secondary_____

Mental Health Diagnosis Yes___ No___ IVC___</td><td>Allergies: None ___Yes____ Specify:_____

Medications: Provide MAR List / Record

Weight: _____(Pounds/Kilograms)</td></tr>
<tr><td colspan="3">Orientation / Mental Status:
Alert___ Oriented___ Disoriented___
Forgetful___ Drowsy ___ Unresponsive___
Speech Clear___ Difficult___ Aphasia ___

Other _____</td><td>Weight Bearing Status:
- None____
- Limited ___
- Full___
- Impairment Left Leg ___Right Leg ___
Device: Cane___Walker___ Wheelchair___</td></tr>
<tr><td colspan="3">Sensory / Assistive Devices:
Vision Good___ Poor___ Blind ___
Glasses Yes___ No ___
Hearing Aid Yes ___ No___ (Right ___ Left ___)
Dentures Yes___ No___ Partial___ Full___</td><td>Respiratory Needs: None ___Yes____
Oxygen ____ Device Flow Rate_____
CPAP___BPAP___
Trach_____
Other_____
Vent Settings:</td></tr>
<tr><td colspan="3">Risks:
Aspiration Yes ___ No___
Fall Yes ___ No___
Seizure Yes ___ No___
Elopement Risk Yes ___ No___
Wanders Yes ___ No___
Potential Harm to Self / Others Yes ___ No___
Custodial Forensics Yes ___ No___</td><td>Special Care Requirements If YES - Comment
Infection Control Precaution: Yes ___ No___
- MRSA___ VRE___ C-Diff___ TB___
- Other _____
- Enteric Precautions _____
- Airborne Isolation _____
Comment_____
Restraints: Yes ___ No___
Other _____</td></tr>
<tr><td colspan="3">Dietary:
Feeding Tube___
Specialty Diet (Identify)</td><td>Medical Devices:
IV Access: No ___ Yes ___ Size/Site_____
Saline Lock___ PICC___ AV Shunt ___
Foley ___
Other _____</td></tr>
<tr><td colspan="4">Notes:

Patient Information Completed By: Name: _____Title_____ Contact@ _____</td></tr>
</table>

Transportation Section
To be Completed By Transportation Officer or Designee

Transfer From:	**Transfer To:**
Evacuation Mobility Assessment **___Green : 1 Staff for Many Patients** **___Yellow: 1 Staff to 1 Patient** **___Red : Multiple Staff to 1 Patient** **Wheelchair___** **Stretcher ___** **Bariatric____ Yes___ No___** **# of Staff Required to Move Patient_____**	**Required Equipment for Transport** **IV Pump ___** **Vent____** **Cardiac Monitor___** **Feeding Tube Pump ___** **Balloon Pump___** **LVAD___** **Isolette___** **Other_____**
Health Information Records included: **DNR Form __** **Advance Directive ___ MOLST ___** **Code Status / Do Not Resuscitate ___** **Diagnostic Studies ___** **Discharge Summary ___** **History/Physical ___** **Medication Reconciliation ___** **Medication Record ___** **Operative Report ___** **Patient Information Sheet ___** **Other _____**	**Medications** **Required for Transport Yes___No___ If Yes, list:** **Send 3 days of medications if possible.** **Patient Belongings:** **Sent with patient ____Yes ____ No** **Given to: _____**
Patient's Family / Emergency Contact Notification **Name_____** **Relationship _____** **Contact Number _____** **Contacted :** **___NO** **___ YES Date _____Time _____** **By Whom: _____**	**Transportation Information** **Transportation Service: _____** **Type of Vehicle:** **Ambulance___ Bus___ Bariatric___Other _____** **Time Left Affected Facility: _____**
Notes / Comments	
Transport Information Completed By: **Name: _____Title_____ Contact@ ( ) _____**	
Patient's Arrival @ Supporting Facility Confirmed By:	
Affected Facility **Name _____** **Contact Number ( )_____** **Date:_____ Time: _____**	**Supporting Facility** **Name _____** **Contact Number ( ) _____** **Date:_____ Time: _____**

Transfer of Personnel, Equipment and Supplies

Affected Hospital

This guidance is for use when you have determined that your hospital can no longer provide safe services without the support of personnel, supplies, and/or equipment from another facility. It is recognized that based on circumstances and the threat of harm, it may not be possible for the Affected Facility to accomplish these tasks. In this case, it is suggested to designate other agencies to provide the communications/support/resources. Implement your Emergency Operations Plan Implement Hospital Incident Command.	
Personnel	
1	The Affected Hospital will advise the Supporting Hospital where and to whom its personnel are to report.
2	**Credential Verification:** Follow disaster credentialing procedures for staff supporting the facility. If the licensing and/or certifying board is unavailable, status of licenses and certifications shall be obtained from the supporting facility. Depending on certification or license verify with the Chief Nursing Officer, Chief Medical Officer or other Chief Executive in charge of licensing and credentialing.
3	**Record Keeping:** While deployed at the Affected Hospital, the Supporting Hospital staff should maintain their own daily personal time and expense records in a form and style specified or approved by the Supporting Hospital. These should be turned in to and maintained by the Supporting Hospital to assist with payroll and potential insurance or disaster cost recovery. HICS 256 form – Procurement Summary Report
4	**Food and Housing:** Unless specifically arranged otherwise, the Affected Hospital will be responsible for providing food and housing for the Supporting Hospital staff from the time of their arrival until the time of their departure. However, the Supporting Hospital staff should try to be self-sufficient to the greatest extent possible.
5	**Briefing of Staff:** The Affected Hospital should provide a situational and special procedure briefing and just-in-time instruction on personal safety practices and any unfamiliar equipment for personnel from the Supporting Hospital.
6	Supporting Hospital staff will be under the supervision and control of the appropriate officials of the Affected Hospital, and will follow the medical protocols and standard operating procedures of the Affected Hospital.
Equipment and Supplies	
1	The Affected Hospital is responsible for the maintenance and the safe and medically prudent operation of the equipment by appropriately licensed, trained and professional staff while it is in their possession.
2	The Affected Hospital will clean and disinfect, or otherwise remove any potentially infectious materials from the loaned equipment before returning it.

Supporting Hospital

This guidance is for use when you have determined that your hospital can no longer provide safe services without the support of personnel, supplies, and/or equipment from another facility. It is recognized that based on circumstances and the threat of harm, it may not be possible for the Affected Facility to accomplish these tasks. In this case, it is suggested to designate other agencies to provide the communications/support/resources. Implement your Emergency Operations Plan Implement Hospital Incident Command.	
Personnel	
1	Any personnel, supplies, materials and/or equipment must be requested by the Affected Hospital. Any

	unrequested personnel, supplies, materials and/or equipment sent by a Supporting Hospital could be considered a "gift" and as such not reimbursable.
2	When providing assistance, the personnel, supplies, materials and/or equipment of any Supporting Hospital delivered to and operating at the Affected Hospital will be under the operational control of the Affected Hospital.
3	It is the responsibility of the Supporting Hospital to send any requested personnel, supplies, materials and/or equipment to the Affected Hospital in a safe and efficient manner since the Affected Hospital may not be able to handle this due to the nature of the disaster that it is facing.
4	While deployed to the Affected Hospital, staff from the Supporting Hospital will continue to be subject to the human resources policies and procedures of the Supporting Hospital.
5	Insurance: Each signatory should consider and plan for the portability of insurance products during activation of the MAA. These could include liability, worker's compensation, facility related insurance, and any other applicable insurance products. During activation of the MAA, communication and coordination with the insurance companies is advised.
Equipment and Supplies	
1	The Supporting Hospital follows their equipment and supply loaning policy.
2	The Supporting Hospital should keep a log of all supplies equipment sent to and received back from the Affected Hospital. When possible the log should include the condition, type, size and/or model of the item. HICS 257 form – Resource Accounting Record
3	Attempts will be made by the Supporting Hospital to send supplies and/or equipment identical to or similar to the supplies and/or equipment at the Affected Hospital. When unfamiliar supplies or equipment must be sent, a subject matter expert from the Supporting Hospital will be sent also to provide just-in-time training to the Affected Hospital staff.

Examples of Forms

Relocation of Personnel Form
HICS 257 form – Resource Accounting Record
HICS 256 form – Procurement Summary Report

Reimbursement for Transferred Personnel, Equipment and Resources

This guidance is for use when you have determined that your hospital can support a hospital that has been affected by a disaster. It is recognized that based on circumstances and the threat of harm, it may not be possible for the Affected Facility to accomplish these tasks. In this case, it is suggested to designate other agencies to provide the communications/support/resources. Implement your Emergency Operations Plan Implement Hospital Incident Command.	
Supporting Hospital	
1	The initial invoice will include, but is not limited to, a brief summary of the services rendered, an estimated total amount to be requested, and an official point of contact or financial representative at the Supporting hospital.
2	Reimbursement for supplies, materials, and/or equipment will be at no more than replacement cost, unless otherwise agreed upon by signatories prior to disaster event. All such costs must be documented in order to be eligible for reimbursement.
3	A Supporting hospital can make a "gift" or donation of the services provided to the Affected hospital, however, it should not be anticipated or expected. The Supporting hospital will issue a waiver in writing of any rights to reimbursement for the costs of the resources and/or items donated/gifted.

4	All documented records will be maintained, by both the Affect and Supporting hospitals until all reimbursement, insurance and disaster cost recovery processes are complete and final.
5	During the period of deployment, the Supporting hospital will continue to pay its employees according to its then prevailing rules and regulations and employment policies.
6	Equipment that is damaged beyond repair, and/or not maintained in a manner supported by the warranty, will be deemed a loss and an invoice could be issued for full replacement cost.
7	Final receipt of invoice shall include: A Summary of the assistance provided and requesting reimbursement for expenses incurred. A copy of the written request for assistance. A single invoice listing the resources provided with the total cost. Supporting documentation (copies of invoices, travel claims, etc.)
8	If there is a dispute regarding the invoice, both hospitals involved should make a every effort to resolve the dispute within thirty days of receipt of written notice of the dispute by the hospital asserting non-compliance. If resolution cannot be agreed upon, a request could be made for arbitration.

This guidance is for use when you have determined that your hospital can no longer provide safe services without the support of personnel, supplies, and/or equipment from another facility. It is recognized that based on circumstances and the threat of harm, it may not be possible for the Affected Facility to accomplish these tasks. In this case, it is suggested to designate other agencies to provide the communications/support/resources. Implement your Emergency Operations Plan Implement Hospital Incident Command.	
Affected Hospital	
1	Reimbursement for all services rendered, personnel, supplies and/or equipment is due within ninety days of receipt of invoice or as agreed upon by the signatories.
2	The Affected hospital will acknowledge receipt of invoice from the Supporting hospital in writing and provide an official point of contact or financial representative for the Affected Hospital.
3	A Supporting hospital can make a “gift” or donation of the services provided to the Affected hospital, however, it should not be anticipated or expected.
4	All documented records will be maintained, by both the Affect and Supporting hospitals until all reimbursement, insurance and disaster cost recovery processes are complete and final.
5	The Affected hospital will reimburse the Supporting hospital for all direct payroll costs and expenses incurred during the period of deployment.
6	Equipment that is damaged beyond repair, and/or not maintained in a manner supported by the warranty, will be deemed a loss and an invoice could be issued for full replacement cost.
7	If there is a dispute regarding the invoice, both hospitals involved should make every effort to resolve the dispute within thirty days of receipt of written notice of the dispute by the hospital asserting non-compliance. If resolution cannot be agreed upon, a request could be made for arbitration.

Examples of Forms

Relocation of Personnel Form

HICS 257 form – Resource Accounting Record

HICS 256 form – Procurement Summary Report

Reallocation of Personnel
Unit Specific Orientation Checklist

Name: _____ Title: _____
Unit From: _____Unit Reallocated To: _____
Campus From:_____ Campus To:_____

Orientation to Unit	**Initials**	**Date**
1. Emergency equipment Location		
2. Oxygen Shut Off Valves		
3. Clean Supply Room		
4. Soiled Utility Room		
5. Nourishment Room		
6. Medication Room		
7. Linen Room		
8. Equipment Storage		
9. Nursing and Chart Forms or EMR access		
10. How to find Policy Online		
11. Glucometers and Supplies		
12. Patient room orientation		
13. Isolation Procedures.		
14. Bathroom/Lounge		
15. Fire Plan/Extinguishers/Fire Pulls		
17. Security		
18. Code Response		
19. EMS Radios		
20. Documentation requirements		
21. Nurse Call System		
22. Emergency Paging Procedures		

This checklist will be valid for one year. This checklist should remain in the Reallocation notebook on the unit floated to.

_____ _____
Employee Signature Charge nurse/designee Signature

Legal, Accreditation and Regulatory

This section provides those teams managing legal implications with support when the MAA is activated. Note: Legal, accreditation and regulatory matters are managed by a variety of different teams within healthcare agencies. This section is intended to support those teams.	
Response Phase	
Step 1	Verify and distribute contact information for the legal teams at both sites. Send to: • Relevant teams • Incident management teams in the command centers
Step 2	Review the MAA and its current implementation.

Step 3	1. Create a 'potential issues' list with suggested solutions. Consider at least:
	  ○ EMTALA
	  ○ Reimbursement arrangements
	  ○ Bed capacity regulations
	  ○ Insurance considerations
	  ○ Credentialing, backup process during loss of communications for verification
	2. Share with the incident commander or designee.
	3. Collaborate with signatories, Logistics & Finance Chiefs and other responding agencies as appropriate

Step 4	Contact as appropriate: • The Joint Commission, DNV or other accrediting agencies • Fire Department and Fire Marshall • Health Department • State boards: medical, pharmacy, nursing etc… • Building Inspectors • NC DHSR http://www.ncdhhs.gov/dhsr/
Step 5	Implement and evaluate plan
Recovery Phase	
Step 1	Complete reimbursement procedures
Step 2	Return processes and agreements to normal or 'new normal' state
Step 3	Update procedures and policies to accommodate lessons learned

Privacy of Patient Health Information

This section provides privacy team with support when the MAA is activated.	
Response Phase	
Step 1	Verify and distribute contact information for the privacy teams at both sites. Send to: • Privacy teams • Incident management teams in the command centers

Step 2	Review the MAA and its current implementation.
Step 3	1. Create a 'potential issues' list with suggested solutions. Consider at least: ○ HIPAA, CMS, Accrediting bodies ○ Patient information sharing methods and recipients ▪ NCOEMS involvement ▪ NCSMARTT ▪ WebEOC ○ Security measures ○ Staff knowledge and policy adherence 2. Share with the incident commander or designee. 3. Collaborate with signatories, Planning and Operations Section Chiefs and other responding agencies as appropriate
Step 4	Utilize facility patient privacy procedures.
Step 5	Implement and evaluate plan
Recovery Phase	
Step 1	Return processes and agreements to normal or 'new normal' state
Step 2	Update procedures and policies to accommodate lessons learned

Additional Resources
CMS: 482.41A
TJC: EM 02.02.03 EP 10

Leasing and Staging

The following section addresses the needs of a facility during a partial or complete move of operations to another location. In these situations leasing of another facility's physical location may allow the continuation of an uninterrupted care provider relationship with their patient and billing under the affected facility license.
The following memorandum of understanding is an example document which has been successfully tested under a real world incident.

North Carolina Hospital Mutual Aid Agreement
Associated Document

Evacuation and Staging
Memorandum of Understanding (MOU)
Between

_____
Name of Affected (Evacuating) Healthcare Facility
And

_____
Name of Supporting (Staging) Healthcare Facility

Purpose: The purpose of this MOU is to provide to the health and safety of all residents and employees of *Name of Affected Facility* in the event of an emergency evacuation and/or disaster.

Term and Termination: The term of this MOU shall begin on *date* for a term of one year and shall automatically renew for two additional one-year terms, through *date*. Parties will conduct an annual review of the terms of this MOU at least annually. Any extension or revision shall be by an agreement in writing by both parties. Either party may withdraw by giving thirty days written notice to the other party of its intention to withdraw from this MOU.

Procedures: In the event of an emergency evacuation and/or disaster where *Name of Affected Facility* should require temporary shelter for *specify number* of patients , *Name of Supporting Facility* agrees to provide the temporary emergency shelter necessary at *Supporting Facility Location* or at another mutually agreed upon area during this time.
Initial contact should be made by *Name of Affected Facility* to *Name of Supporting Facility* (Administrator on Duty). The Administrator on Duty has the authority to activate emergency plans including activation of this emergency shelter agreement. If telecommunications are not available, *Name of Affected Facility* may present to *Name of Supporting Facility* Emergency Department and ask for the charge staff person.

Name of Affected Facility would provide the transportation for the relocation of the patients, staff, equipment, supplies, clothing, linens, pharmaceuticals and other resources to *Name of Supporting Facility*. *Name of Affected Facility* would also provide adequate nursing staff required for the provision of care. Should the situation be such that the resources could not be provided, agreement would be reached between the *Name of Affected Facility* and the *Name of Supporting Facility* in regards to the provision and compensation of the necessary resources.

When the emergency evacuation results in the inability for *Name of Affected Facility* to return to their facility within 48 hours, *Name of Affected Facility* has a MOU with *Name of a Second Supporting Facility* for long term provision of care until the permanent placement in a healthcare facility can be arranged. *Name of Affected Facility* would provide the transportation for the relocation of the children from *Name of Initial Supporting (Staging) Facility* to *Name of a Second Supporting Facility.*

Decision making and planning for operating the emergency shelter will occur between *Name of Affected Facility*, *Name of Supporting Facility* and other community administrative, regulatory and/or accreditation spokespersons involved in the emergency situation. Factors influencing the length of time operating the emergency shelter may include the health and safety of the patients, *Name of Supporting Facility's* capacity, impact of the emergency situation, and the accessibility of alternative locations.

Name of Affected Facility shall indemnify and hold harmless *Name of Supporting Facility* for claims, damages or losses (including reasonable attorneys' fees) suffered by *Name of Supporting Facility* solely as a result of the negligence of *Name of Affected Facility* or any employee or agent of *Name of Affected Facility* to the extent not covered by insurance.

Similarly, *Name of Supporting Facility* shall indemnify and hold harmless *Name of Affected Facility* for claims, damages or losses (including reasonable attorneys' fees) suffered by *Name of Affected Facility*

solely as a result of the negligence *Name of Supporting Facility* or any employee, contractor, or agent of the *Name of Supporting Facility* to the extent not covered by insurance.

_____	_____
Affected Facility Signature	*Supporting Facility Signature*
Title Organization	*Title Organization*
Date	*Date*

Glossary

A

ACTION PLAN
A documented outline of specific projected activities to be accomplished within a specified period of time to meet a defined need, goal or objective.

AFTER ACTION REPORT (AAR)
A narrative report that presents issues found during an incident and recommendations on how those issues can be resolved.

AFFECTED FACILITY
A hospital or health system which has been impacted by any emergency, disaster, catastrophe, mass casualty incident, public health emergency or similar disruptive event that results in a facility state of emergency as determined by an Incident Commander; or is formally declared by a unit of local, State, or the federal government. Note: a facility may be both an Affected and Supporting Facility during the same incident.

ALTERNATE SITES/FACILITIES
Locations other than the primary facility where healthcare operations will continue during an emergency.

C

COMMAND POST
The location where the administrative staff coordinates the other overall operations. The Incident Commander remains here; other area chiefs assemble here regularly for debriefings.

CONTINUITY OF OPERATIONS (COOP)
Plans and actions necessary to continue essential business functions and services and ensure continuation of decision making even though primary facilities are unavailable due to emergencies.

CRISIS
Exists when physical infrastructure is destroyed, political and social systems are ruptured, and economic activity is seriously disrupted; population displacement grows quickly and suffering increases,

particularly among the aged, disabled, children and women. Such a situation is often described as a "complex emergency".

D

DECEASED
Fourth (last) priority in patient treatment according to the S.T.A.R.T. and other triage systems.

DELAYED TREATMENT
Second priority in patient treatment according to the S.T.A.R.T. and other triage systems. These people require aid, but injuries are less severe. A hospitalized patient may be categorized from "guarded" to "serious"; a patient requiring at least minimal hospital services.

DELEGATION OF AUTHORITY
A statement provided to the Incident Manager by the clinic Executive Director delegating authority and assigning responsibility. The Delegation of Authority can include objectives, priorities, expectations, constraints and other considerations or guidelines as needed.

DISASTER
A sudden calamitous emergency event bringing great damage loss or destruction.

E

EMERGENCY
A condition of disaster or of extreme peril to the safety of persons and property caused by such conditions as air pollution, fire, flood, hazardous material incident, storm, epidemic, riot, drought, sudden and severe energy shortage, plant or animal infestations or disease, the Governor's warning of an earthquake or volcanic prediction, or an earthquake or other conditions, other than conditions resulting from a labor controversy.

EMERGENCY OPERATIONS CENTER (EOC)
The location at which management can coordinate hospital activities during an emergency. It is managed using the Incident Command System (ICS). The EOC may be established in the primary hospital facility or at an alternate site.

EMERGENCY OPERATIONS PLAN (EOP)
An All Hazards plan that the HHS organization has and maintains for responding to hazards.

EMERGENCY MANAGEMENT COORDINATOR (EMC)
The Emergency Management/Preparedness Coordinator guides the development and maintenance of the hospital's emergency management program and development of its emergency operations plan.

F

FINANCE SECTION
One of the four primary functions found in all ICS organizations which is responsible for all costs and financial considerations. The Section can include the Time Unit, Claims Unit and Cost Unit.

H

HOSPITAL EMERGENCY INCIDENT COMMAND SYSTEM (HEICS)
A management program for hospitals modeled after the Fire Service Plan; Comprised of an organization chart with a clearly delineated chain of command and a preordered job action sheet which assists the individual in focusing upon his/her assigned position function.

HAZARD VULNERABILITY ANALYSIS (HVA)
Hazard vulnerability analysis identifies ways to minimize losses in a disaster considering emergencies that may occur within the facility as well as external to the facility in the surrounding community.

I

IMMEDIATE TREATMENT
The first level of patient priority according to the S.T.A.R.T. and other triage systems. A patient who requires rapid assessment and medical intervention in order to increase chances of survival. A hospitalized patient who may be classified from "serious" to "critical" condition; requiring constant nursing care.

INCIDENT COMMAND SYSTEM (ICS)
A temporary management system used to manage and coordinate hospital activities during an emergency. ICS is designed facilitate decision-making in an emergency environment.

INCIDENT COMMANDER (IC)
The individual who holds overall responsibility for incident response and management.

INFORMATION OFFICER
A member of the Management Staff responsible for interfacing with the public and media or with other agencies requiring information directly from the incident. There is only one Information Officer per incident. This position is also referred to as Public Affairs or Public Information Officer in some disciplines. The individual at EOC level that has been delegated the authority to prepare public information releases and to interact with the media.

L

LIASON OFFICER
A member of the Management Staff responsible for coordinating with representatives from cooperating and assisting agencies. The function may be done by a Coordinator and/or within a Section reporting directly to the EOC Incident Manager.

LOGISTICS
A working group responsible for coordinating the resources and activities associated with relocation planning and deployment of operations and positions during an event. Person responsible for the organization and direction of those operations associated with maintenance of the physical environment, including adequate levels of food, shelter and supplies to support the overall objectives.

LOGISTICS SECTION

One of the five primary functions found at all SEMS levels. The Section responsible for providing facilities, services and materials for the incident or at the EOC.

M

MANAGEMENT STAFF
The Management Staff at the SEMS EOC level consists of the Information Officer, Safety Officer, and Liaison Officer. They report directly to the EOC Incident Manager.

MEMORANDUM OF UNDERSTANDING or MUTUAL AID AGREEMENT
Agreement between or among government agencies, community organizations, and other entities that define respective roles and responsibilities in preparing for and responding to emergencies.

MINOR TREATMENT
Third priority of patient in the S.T.A.R.T. and other triage systems. A patient requiring only simple, rudimentary first-aid. These patients are considered ambulatory. A hospitalized patient may be considered minor if they are in "stable" condition and capable of being treated and discharged.

MITIGATION
Pre-event planning and actions which aim to lessen the effects of potential disaster.

MULTI-HAZARD APPROACH
A multi-hazard approach to disaster planning evaluates all threats including the impacts from all natural and man-made disasters, including technological threats, terrorism, and a state of war.

N

NATIONAL INCIDENT MANAGEMENT SYSTEM (NIMS)
NIMS is the mandatory system established by HSPD-8 for managing the response of government agencies to multi-agency and multi-jurisdiction emergencies in North Carolina. NIMS incorporates the use of the Incident Command System (ICS).

O

OFFICE OF EMERGENCY MANAGEMENT (OEM)
The agency responsible for the overall coordination of resources. OEM can be a city, county, regional, or state level agency

OPERATIONS
Function in ICS organization responsible for coordination of medical personnel, treatment and triage areas, social services and evacuation of patients.

OPERATIONAL PERIOD
The period of time scheduled for execution of a given set of operation actions as specified in the EOC Action Plan. Operational Periods can be of various lengths, although usually not over 24 hours.

OPERATIONS SECTION

One of the five primary functions found in all organizations managed by the Incident Command System. The Section responsible for all tactical operations at the incident, or for the coordination of operational activities at the EOC.

P

PERSONAL PROTECTIVE EQUIPMENT
The equipment and clothing required to mitigate the risk of injury from or exposure to hazardous conditions encountered during the performance of duty. PPE includes, but is not limited to: fire resistant clothing, hard hat, flight helmets, shroud, goggles, gloves, respirators, hearing protection, and shelter.

PHASES OF EMERGENCY MANAGEMENT
Mitigation - Pre-event planning and actions which aim to lessen the effects of potential disaster.
Preparedness – Actions taken in advance of an emergency to prepare the organization for response.
Response - Activities to address the immediate and short-term effects of an emergency or disaster. Response includes immediate actions to save lives, protect property and meet basic human needs.
Recovery - Activities that occur following a response to a disaster that are designed to help an organization and community return to a pre-disaster level of function.

PLANNING SECTION (Also referred to as Planning/Intelligence) - One of the four primary functions found in all ICS organizations. Responsible for the collection, evaluation, and dissemination of information related to the incident or an emergency, and for the preparation and documentation of EOC Action Plans. The section also maintains information on the current and forecast situation, and on the status of resources assigned to the incident. The Section typically includes Situation, Resource, Documentation, Message, and Action Plan Units.

PLAN MAINTENANCE
Steps taken to ensure the plan is reviewed annually and updated whenever major changes occur.

PREPAREDNESS
The preparedness phase involves activities taken in advance of an emergency to ensure an effective response to the emergency, if it should occur.

PRIMARY FACILITY
The site of normal, day-to-day operations; the location where the employee usually goes to work.

PUBLIC INFORMATION OFFICER
An official responsible for releasing information to the public and other stakeholders, usually through the news media. (Also see Information Officer).

R

RECOVERY
Activities that occur following a response to a disaster that are designed to help an organization and community return to a pre-disaster level of function. These activities usually begin within days after the event and continue after the response activities cease. Recovery includes government individual and public assistance programs which provide temporary housing assistance, grants and loans to eligible individuals, businesses and government entities to recover from the effects of a disaster.

RELOCATION SITE
The site where all or designated employees will report for work if required to move from the primary facility.

RESPONSE
Activities to address the immediate and short-term effects of an emergency or disaster. Response includes immediate actions to save lives, protect property and meet basic human needs.

RISK COMMUNICATIONS
Communication of risks resulting from site operations and the implications for the surrounding community. Organization risk communications includes effective processes for risk assessment & management, emergency preparedness, and community dialogue.

S

SAFETY OFFICER
A member of the Management Staff within the EOC responsible for monitoring and assessing safety hazards or unsafe situations, and for developing measures for ensuring personnel safety.

SECTION
That organization level with responsibility for a major functional area at the EOC, e.g., Operations, Planning, Logistics, Finance.

"SHELTER-IN-PLACE"
The process of staying where you are and taking shelter, rather than trying to evacuate.

SITUATION REPORT (SITREP)
A written, formatted report that provides a picture of the response activities during a designated reporting period.

STAFF PROTECTION –PERSONAL PROTECTIVE EQUIPMENT
(See Personal Protective Equipment).

STANDARD OPERATING PROCEDURES (SOP)
Pre-established procedures that guide how an organization and its staff perform certain tasks. SOPs are used routinely for day to day operations and response to emergency situations. SOPs are often presented in the form of checklists or job action sheets.

SUPPORTING FACILITY
A hospital or health system that provides aid such as supplies, equipment and personnel to or that receives patients from an Affected Facility. Note: a facility may be both an Affected and Supporting Facility during the same incident.

SURGE CAPACITY
In times of disaster so called excess capacity contributes to surge capacity which provides the ability to care for large numbers of casualties. Surge capacity encompasses potential available space in which patients may be triaged, managed, vaccinated, decontaminated, or simply located; available personnel

of all types; necessary medications, supplies and equipment; and even the legal capacity to deliver health care under situations which exceed authorized capacity.

T

TRIAGE
It literally means "to sort"; commonly means prioritizing patients into categories according to the severity of their condition. Patients requiring life-saving care are treated before those requiring only first aid. The process of screening and classification of sick, wounded, or injured persons to determine priority needs in order to ensure the efficient use of medical manpower, equipment and facilities.

TRIAGE, EXPECTANT CATEGORY
A patient who requires too extensive of resuscitation for available resources, but is still alive at that time; this category is used only in catastrophic disasters where personnel and/or medical supplies are too limited to use standard resuscitation guidelines.

TRIAGE PERSONNEL
Trained individuals responsible for triaging patients and assigning them to appropriate transportation or treatment areas.

TRIAGE TAG
A tag used by triage personnel to identify and document the classification, or level, of a patient's medical condition. It is recommended that the SMARTT triage tag be utilized.

V

VITAL RECORDS AND SYSTEMS
Records necessary to maintain operations during an emergency, to recover full operations following an emergency, and to protect the legal rights and interests of citizens and the Government. The two basic categories of vital records are emergency operating records and rights and interests records.