

# Guidelines for Managing Hospital Surge Capacity



Wisconsin  
Department of Health Services

Wisconsin Healthcare Emergency Preparedness Program  
Expert Panel on Medical Surge Capacity  
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## Introduction

*Version: March 2015*

*The State Expert Panel on Hospital Surge Capacity revised the 2005 Guidelines in November 2011 and March 2015.*

*The goal for Hospital Surge Capacity, set by the United States Department of Health and Human Services Assistant Secretary for Preparedness and Response (ASPR) in FY 2002, was based on hospitals being able to treat, at a minimum, 500 adult and pediatric patients per each million in population. For the State of Wisconsin, this translates to being able to care for a minimum surge of 2,683 inpatients. The minimum surge capacity target of 120 percent would allow hospitals to surpass this number. The framework for this document is based on the Disaster Ethics Document: available at <http://www.wha.org/scarceresources.aspx>*

This document provides guidelines for hospitals to consider when planning to manage a surge of patients<sup>1</sup>. **The goal, as set by the State Expert Panel, is for hospitals to have a plan to facilitate the region's ability to surge to 120 percent of their present staffed-bed capacity.** The number of surge beds that can be established will vary for each hospital. For example, a 500-bed hospital may only be able to add 100 surge beds (120%) to increase surge capacity, whereas a smaller 25-bed hospital may be able to increase surge capacity by adding 25 surge beds (200%).

Presently, there are approximately 11,000 staffed beds among the 131 medical/surgical hospitals in the state. Current disaster preparedness planning for health care focuses on either surge-in-place strategies, where existing health care operations modify operations to permit care to be provided to significantly increased numbers of patients, or the establishment of alternative treatment facilities (other sites, apart from the hospital, such as community centers, schools and other such large buildings that could be converted into use as a surge hospital). The logistical, clinical, legal, and financial issues involved with the implementation of alternative treatment facilities are myriad.

In part due to these issues, early in the development of the Wisconsin Hospital Emergency Preparedness Program (WHEPP), hospitals decided to surge-in-place rather than rely on an alternative treatment facility strategy.

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<sup>1</sup>**NOTE: Hospitals should be familiar with the documents on the allocation of scarce resources, which provide multiple guidelines for managing a surge of patients.** The *Guidelines for the Allocation of Scarce Resources* can be found at: <http://www.wha.org/scarceResources.aspx>.

## Surge Levels

Hospitals should plan for three levels of surge: minor, moderate and crisis (see Table A).

**TABLE A: HOSPITAL SURGE LEVELS**

| LEVEL OF SURGE | DESCRIPTION   |
|----------------|---|
| Minor          | The surge of patients is such that the hospital mobilizes its existing on-site human and materiel resources. The hospital begins strategies to conserve resources.  |
| Moderate       | The surge of patients is such that the hospital needs to deploy additional human and materiel resources without changing the traditional standard of care. Incident Command may be activated and normal operations may be affected, e.g., cancellation of elective admissions and procedures, and conservation of resources.  |
| Crisis         | The surge of patients is such that the traditional standard of care <sup>2</sup> may be affected due to limited resources at the hospital and the inability of the hospital to transfer patients to other hospitals. The hospital conserves resources and may use the <i>Guidelines for the Allocation of Scarce Resources</i> <sup>3</sup> to assist in making conservation decisions. Normal operations may be significantly affected. Depending on the scope and nature of the incident, Unified/Area Incident Command may be activated. |

## Definitions

**Alternative treatment facility** means outpatient or ambulatory health care facilities, such as physician offices, clinics and urgent care centers that are identified by the hospital in its surge plan as a site, either on the hospital campus or away from the hospital campus that can be used to treat incident patients. Most often, such sites will treat minimal (GREEN) patients, although they could be additionally staffed and supplied to care for more critical patients.

**Alternative triage center** is defined as the initial location for the triage of patients that is established during a surge incident. It is typically separated physically from the hospital's emergency department.

**Available beds** are beds that are licensed, physically set up, and **available** for use.

<sup>2</sup> [www.wha.org](http://www.wha.org)

<sup>3</sup> [www.wha.org](http://www.wha.org)

**Immediate bed availability** is defined as those existing and staffed inpatient beds that are not currently occupied or can be made available through such strategies as early discharge, cancellation of elective admissions, etc.

**Allocation of scarce resources basic principles** are defined as “guidelines for health care providers to continue to provide treatment in an ethical manner to patients in a mass casualty incident, when there may be a significant imbalance between the needs of the patients and the resources available to the health care provider.”

**Local health care organization** (HCO, or “health care organization,” or “health care entity”) is a single entity providing medical services. This may include (but is not limited to) a hospital, integrated health care system, emergency medical services (EMS) agency, physician office, outpatient clinic, nursing home, or other skilled nursing facility.

**Health care coalition** (HCC or “coalition”) is a multi-disciplinary, multi-organization partnership that organizes individual health care assets/organizations into a single functional unit in order to maximize cooperative planning, information sharing, and management coordination. A coalition may include hospitals, public health agencies, long-term care or alternative treatment facilities, dialysis and other outpatient treatment centers, nursing homes and other skilled nursing facilities, private physician offices, clinics, community health centers, and any other health care asset. Coalitions may also include emergency response and public safety agencies, emergency management, community and volunteer organizations, educational institutions, and any other organization that may provide resources to care for patients during an event.

***NOTE:** The tier information includes “base hospital” in certain situations. The definition of “health care organization” is similar in concept to base hospitals. This tier is the base hospital tier.*

**Health emergency region** (or “region”) is a geographic region with borders defined by the Wisconsin Department of Health Services for the purposes of medical planning and response coordination in large-scale emergencies.

**Area medical coordinating center (AMCC)** is a health care or health care-related entity (such as public safety answering or dispatch center, transfer/access center, etc.) in the geographic area of an incident, with the ability to support the health care coalition with coordination of information and patient movement. The AMCC should be designated through planned criteria or schedule. Depending on the area and situation, an AMCC may be the initial health care organization impacted by an incident and/or may also be the regional medical coordinating center. For example, the closest trauma center to a mass casualty incident may serve as the AMCC.

**Crisis standards of care** are defined by an Institute of Medicine report as “a substantial change in usual health care operations and the level of care it is possible to deliver, which is made necessary by a pervasive...or catastrophic...disaster. This change in the level of care delivered is justified by specific circumstances and is formally declared...in recognition that crisis operations will be in effect for a sustained period.”<sup>4</sup>

**Functional needs (special needs populations)** are defined as persons who may have additional functional needs before, during, and after an incident, including, but not limited to, maintaining independence, communication, transportation, supervision, and medical care.

**Incident** is defined as an occurrence, natural or manmade, that requires a response, greater in scope or duration than normal operational activities, to protect life or property. Incidents on WI Trac are referred to as “events.” Event is a component of an incident.

**Mass casualty incident (MCI)** is defined as an event resulting in a number of patients (more than one) with medical needs beyond the current normal capabilities of a health care unit or agency. One proposed minimum standard is five or more patients going to two or more facilities. This is further defined according to triggers at the local or regional levels. Each EMS agency or hospital can decide, or a determination can be made locally among hospitals and EMS agencies.

**Medical control** is defined as the physician or designee who provides advice and direction to emergency medical services who are providing medical care at the scene of an emergency or en route to a health care facility.

**Reverse triage** is defined as the process of identifying, discharging and transferring stable and less critical patients first. Reverse triage allows a facility to focus more time and resources to the care of more critical patients and/or coordinate their transfer to facilities that have the appropriate specialized care available.

**Surge beds** are defined as additional inpatient beds, not currently operational or staffed, that can be deployed if necessary. These include traditional inpatient beds that hospitals have physically available onsite but in storage or unstaffed, beds located in non-inpatient care areas

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<sup>4</sup> *Guidance for Establishing Crisis Standards of Care for Use in Disaster Situations* draws from a broad spectrum of expertise—including state and local public health, emergency medicine and response, primary care, nursing, palliative care, ethics, the law, behavioral health, and risk communication—to offer guidance toward establishing standards of care that should apply to disaster situations, both naturally occurring and man-made, under conditions in which resources are scarce. Institute of Medicine (IOM), 2009.

(peri-operative care units, outpatient infusion area) and may also include medical/surgical cots that are pre-positioned at hospitals.

**Short duration incidents** are those time-limited incidents (e.g., multiple vehicle/high occupancy vehicle accident, building collapse, explosion, chemical spill, airplane crash, etc.) in which the patients are injured immediately at the incident occurrence or within a short period of time, and then present within a limited period of time, measured on the scale of hours.

**Sustained incidents** are those resulting in the presentation of a number of patients over days, weeks or months (such as pandemic influenza or other major infectious outbreak).

**Unified/Area Command** means the incident command structure used for incidents which involve multiple agencies or large/multiple location incidents. Incidents are managed using Incident Command System (ICS) or Hospital Incident Command System (HICS).

## Field Considerations

### Mass Casualty Triage Algorithms

Hospital staff should be familiar with the triage protocols that are used by emergency medical services (EMS) and first responders in the field in their area. These protocols provide a process for EMS to triage (“sort”) patients by their severity of injury, based on a color-code system. There are multiple systems used by EMS in Wisconsin such as START (simple triage and rapid treatment) or SALT (sort, assess, life-saving interventions, treatment and/or transport).

These systems use categories to triage patients, each associated with a color code:

- Immediate (red) designates patients that require an immediate intervention in order to survive.
- Delayed (yellow) designates patients where treatment may be postponed for a brief period of time without affecting their survivability, while more critical patients are stabilized.
- Minimal (green) designates patients with injuries of a minor nature that will not result in major disability or death, and thus can be treated after all other patients have been cared for.
- Expectant (gray) designates patients that are not expected to survive even with maximal use of the resources available (this category is used in SALT triage).
- Dead (black) designates patients that either have died or (in START triage) whose injuries are so severe that they are expected to die.

As patients arrive at the hospital, the hospital should once again triage the patients, using their MCI triage systems (see emergency department vs MCI triage clarification below).

### Considerations for EMS Transport

The basic principle is “Do Not Bring the Disaster to the Emergency Department!”

EMS agencies that transport to a hospital should be involved in the development of and familiar with a hospital surge capacity plan. EMS should be familiar with potential alternative triage centers at the hospital. To the extent possible, EMS should notify the hospital from the field of the number of immediate/red, delayed/yellow, minimal/green, and expectant/gray triaged patients it may anticipate.

### Emergency Department (ED) versus MCI Triage Considerations

Both MCI triage and emergency department triage algorithms are intended to prioritize patients for treatment. MCI algorithms are designed for rapid, initial assessment of a large number of patients to place them into one of four/five very broad categories. (See descriptions above.)

ED triage algorithms are designed to rapidly place an individual patient into one of five categories in terms of injury/illness severity and expected resource utilization. During a medical surge event, patients arriving to the ED, whether related to the event or not and by EMS or walk-in, need to be continually re-triaged at each stage of treatment. Initial triage upon arrival should use MCI type algorithms.

Subsequent triages will begin to incrementally approach traditional ED triage algorithms and daily clinical prioritization methods. Re-assessment and re-triage should occur as resource allocations change. Experienced clinicians should be responsible for triage and resource allocation decisions. For example, if multiple patients need emergent/urgent surgery, one surgeon needs to evaluate all the cases and assign priority for operating room use.

### **Field to Hospital Communication during an MCI event**

The first agency on scene (EMS, fire, law enforcement) establishes the field Incident Command Post (ICP) in response to the MCI Incident. Based on the nature of the incident and the number of victims involved, the field Incident Commander may request the activation of the local government emergency operations center (EOC).

The field Incident Command is to notify the local hospital(s) either directly or via the hospital's communication center that an MCI incident has occurred and give an estimate of the number of victims involved.

If the initial hospital cannot manage coordination of the incident (either due to lack of resources or because it is affected by the incident directly), then the initial hospital should activate Tier 2 (see tier coordination structure below) and ask the AMCC to assume coordination with the on-scene Incident Command.

The EMS dispatch or initial hospital (through its liaison officer) or AMCC should alert other hospitals in the area that an MCI has occurred and they may need assistance to manage the incident.

A bed poll event may be requested by the initial hospital (or AMCC).

- a. On WI Trac, each hospital should post under "MCI patient capacity," the number of patients it can receive by category: immediate/red, delayed/yellow, minimal/green, and expectant/gray.<sup>5</sup> The number of patients in each triage category that each hospital can

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<sup>5</sup>It is recognized that field to hospital communications may not be possible in all areas. In these areas, EMS usually has a plan on how to get messages to their destination hospitals.

accept will assist the on-scene Incident Command and transporting EMS agencies (EMS transport group supervisor) in the determination of destination hospitals.

- b. Each hospital may be requested to provide an updated bed poll of their available surge capacity beds.

**NOTE:** Use of WI Trac does not preclude the use of other communication methods. WI Trac, however, has the ability to reach many facilities at the same time, update all facilities and has other functions that could be used to manage the incident.

<https://emresource.emsystem.com/EMSystem>

- c. The Wi- Trac system provides real time information with the:
  - The names of the hospitals in the region that are prepared to receive victims
  - The number of patients by triage designation that can be accepted by each hospital

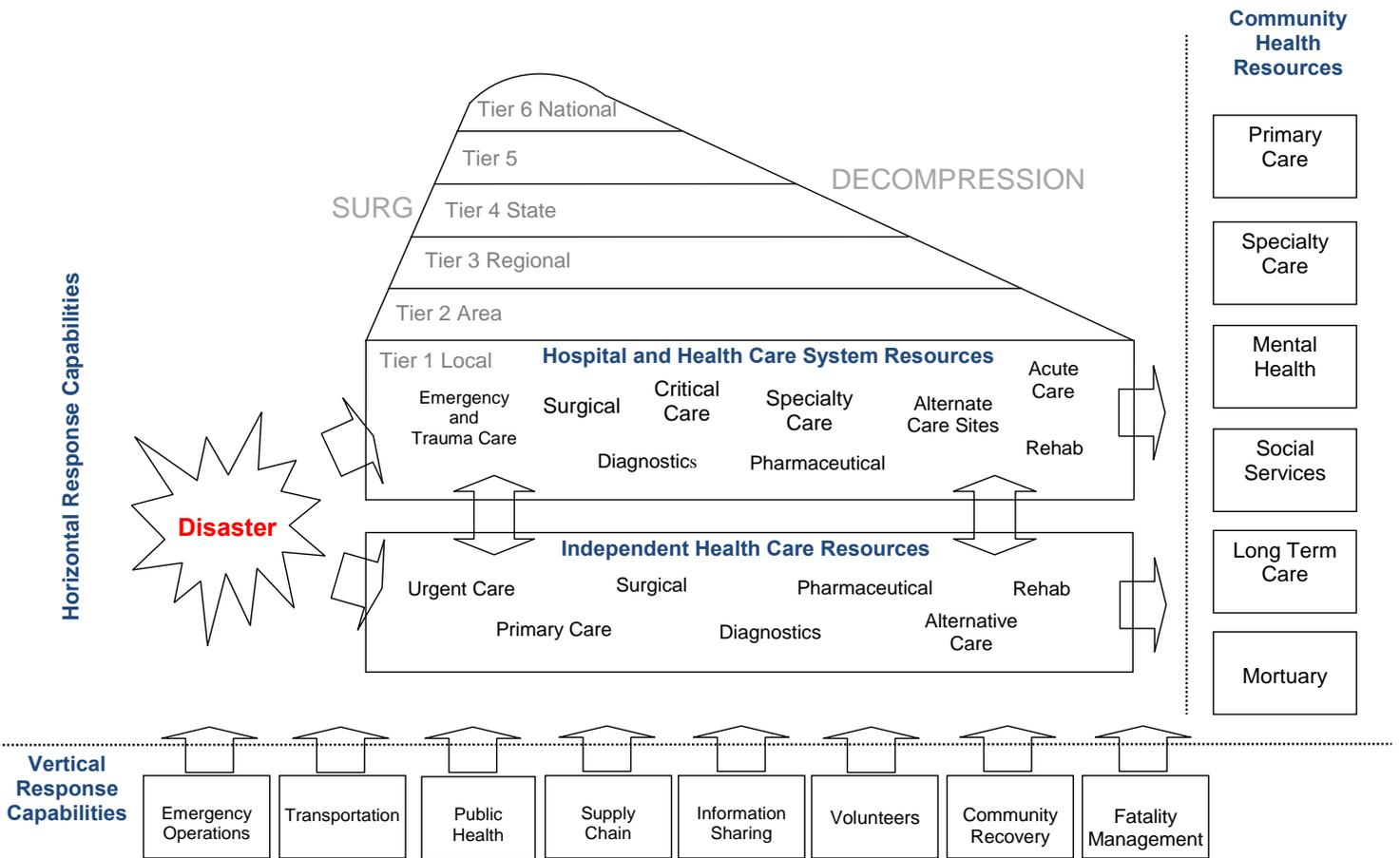
All hospitals will activate, as necessary, their emergency operations plan and Incident Command System.

The reporting hospitals should continue to update WI Trac with receiving capacity.

**NOTE:** EMS receiving capacity may be affected by patients self-presenting to hospitals, changes in patient condition en route, other emergencies occurring simultaneously, and/or changes in staffing. The hospital will, to the extent possible, assist the EMS transport group supervisor in the ongoing triage of patients to the hospitals.

See *Health Care Coalition Tiered Response* for additional information on EMS to hospital communications as the incident advances up the tier response process.

## Health care Coalition Tiered Response

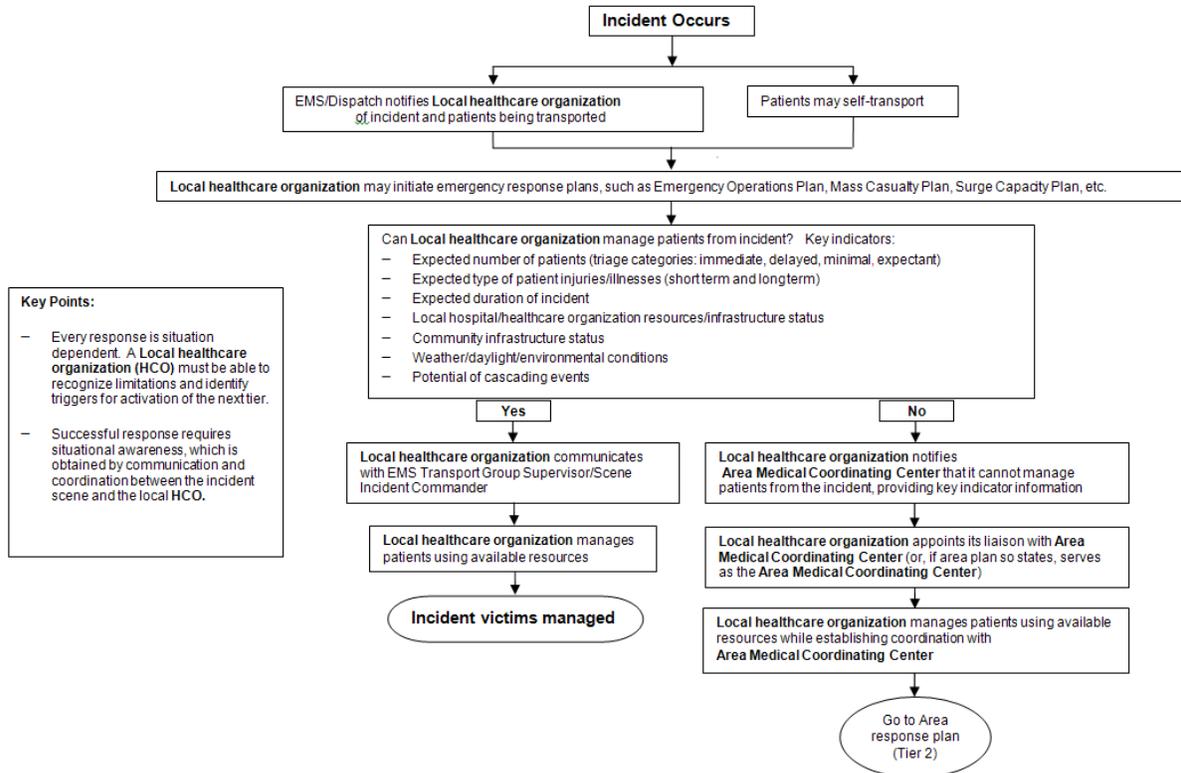


## Tiered Response Coordination

All incidents start locally and, regardless of the scope of the incident, local resources will be utilized to manage the incident. Below is the flowchart of tiered response coordination, local (Tier 1) and area (Tier 2). Please see separated Tier Response Coordination documents for additional information.

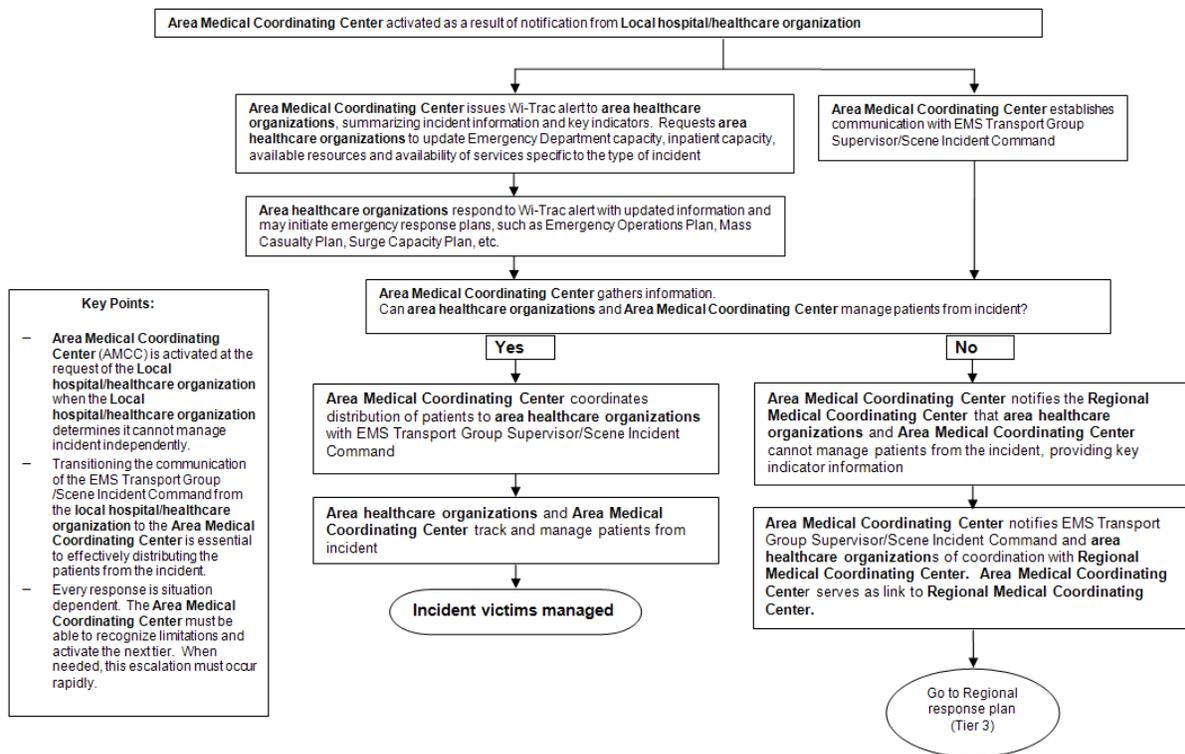
REV 5.13.2014

### Wisconsin Healthcare Emergency Preparedness Program (WHEPP) Healthcare Coalition Tiers Medical Management of Incident by local Healthcare Organization (DHHS Tier 1 Response) - Decision Tree



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**Wisconsin Healthcare Emergency Preparedness Program (WHEPP) Healthcare Coalition Tiers  
Medical Management of Incident by Area Healthcare Coalition (DHHS Tier 2 Response) - Decision Tree**



## Alternative Triage Center

The hospital should consider the deployment of an alternative triage center separate from the emergency department. The purpose of the alternative triage center is to provide initial sorting of patients with the intent of diverting less severe patients (minimal/green and possibly some delayed/yellow) to alternative care sites rather than the hospital emergency department. It also serves to maintain an easy, unobstructed access for patients being transported by ambulance to the hospital during a MCI.

Alternative care sites can include designated minor treatment areas within the hospital, or clinics either on or near the hospital campus. Such care sites should be defined as part of the hospital surge plan.

## Location of an Alternative Triage Center

In selecting an alternative triage center, several physical considerations must be taken into account:

- Located in an area close enough to, but sufficiently distant from the emergency department entrance and ambulance driveway so as not to congest the emergency department area
- Located on the hospital campus or in close proximity to the hospital campus

- Utilities (power, water, etc.) readily available
- Climate-controlled area
- Allow for unobstructed transport of patients by gurney or wheelchair from the alternative triage center to the hospital
- For infectious disease or hazardous material incidents, heating/ventilation/air conditioning (HVAC) is separate from the hospital HVAC system
- For a hazardous material incident, appropriate decontamination area(s)
- Communications capability with the hospital, especially emergency department, nursing, and admissions
- Ability to control access to and secure the alternative triage center stabilizing medical equipment

### Staffing

It is important for the hospital to pre-identify this alternative triage center and also to pre-identify staff by function when it is deployed. It is also advisable to have job action sheets for the persons who will staff the alternative triage center.

### Functional Needs Patients (Special Needs Populations)

The hospital is to consider the needs of patients with functional needs that will come to the alternative treatment center to ensure that their needs can be met, to the extent possible.

### Decontamination

Special consideration will need to be given to the decontamination of patients during hazardous materials incidents. If the hospital has a fixed decontamination room, there will need to be a plan for the flow and holding of patients. If the hospital has a portable decontamination shelter, then consideration needs to be given as to its placement relative to the alternative triage center.

**NOTE:** A portable decontamination shelter has the potential to be used as an alternative triage center under certain weather conditions.

### Vehicle Access Control, Staging, and Parking

As patients may be delivered by EMS or other vehicles, locations of the alternative triage center and ingress/egress routes should be planned in consultation with EMS, police, and fire department representatives. It is recommended that the hospital have an agreement with its municipal public works department for the use of barricades to help control vehicle and pedestrian traffic to the hospital and especially to the alternative triage center. The hospital may also want to consider the use of vehicles to set up barricades.

Because of the number of ambulances involved, there should be an area designated for staging ambulances, helicopters and other medical transport vehicles. There should also be consideration of increased parking due to staff that will be asked to report to work in addition to the vehicles that may bring self-presenting patients to the hospital.

## EMTALA and Alternative Care Sites

The Emergency Medical Treatment and Active Labor Act (EMTALA) spells out requirements for patient assessment and care before a patient can be transferred between emergency medical facilities. The provisions of EMTALA do allow for flexibility in surge/mass casualty situations. A hospital with an emergency department may not tell a patient who has presented to the emergency department to go off-site for a medical screening examination. However, in a surge incident, a hospital is allowed to establish an alternative triage center onsite for the purpose of evaluating patients. The medical screening examination still must be performed by someone qualified and authorized to make a determination regarding the existence of an emergency medical condition and the need for immediate care. If an emergency medical condition is identified, the hospital must provide stabilizing care in a treatment area onsite (though this does not have to be the emergency department). Legally, referral of a patient who has presented to the emergency department to an off-campus location is permitted **only** if an EMTALA waiver has been issued by the United States Department of Health and Human Services for the area in question.

[Appendix C](#) (CMS and EMTALA Hospitals Disaster) and [Appendix D](#) (EMTALA Pandemic) discuss details and provide options for managing extraordinary surges to emergency departments under existing emergency EMTALA requirements. Specifically, hospitals should be familiar with options and special circumstances that allow for changes in normal EMTALA procedures and requirements.

## Hospital Inpatient Surge Capacity

### Increasing Availability of Existing Inpatient Beds

There are various strategies to increase existing inpatient bed capacity. One strategy involves moving patients out of occupied beds to clear existing beds for new patients. Examples of techniques used to increase bed availability include:

1. Early discharge of patients
2. Expedited/streamlined discharge processes
3. Expedited transfer to other facilities
4. Cancellation of elective admissions
5. Cancellation of elective procedures

Reverse triage refers to the process of assessing a current patient census to determine which patients are less ill and may be discharged or transferred in order to make beds available. This process includes finding other hospitals or health care facilities to which to transfer patients. Reverse triage should be implemented immediately once it is determined a mass casualty incident/surge event is occurring.

Decompression is a common term that refers to early discharge of patients; it is the same as offloading/early discharge.

Each hospital will need to consider the value of these techniques given the circumstances of the incident. These should be implemented very early in an incident, but often will provide only a limited number of beds. In a short-duration incident, staff may be occupied with the surge of patients and may not have time initially to begin the implementation of the strategies to make occupied beds available. Patients in a traumatic incident may arrive faster than occupied beds can be made available. Also, discharged or transferred patients may not have immediate transportation to leave the hospital. The additional in-house and outside traffic created by these tactics may increase the congestion caused by an incident. In a sustained incident, such techniques may also not be as effective, since there will always be the regular flow of “normal sick and injured” and elective admissions and procedures can often only be delayed temporarily.

A hospital may consider establishing a discharge unit with a supervising discharge officer to manage discharged patients. The patients discharged can then be moved from their inpatient bed to the discharge center to make inpatient beds immediately available. The discharge unit then makes the appropriate arrangements for the patient to be discharged or transferred.

Hospitals should also consider engaging skilled nursing facilities and home health agencies to assist with discharge planning. In addition, hospitals and health care preparedness coalitions should engage skilled nursing facilities and home health agencies on how those agencies can provide care to their clients during medical surge incidents without assistance from hospitals.

### Establishing Surge Capacity Beds

The other main strategy for surge capacity involves creating new beds to receive patients. Adding surge beds remains the primary strategy for hospitals when faced with a moderate or crisis level surge incident. The following guidelines are intended to help hospitals identify which beds can best be used for which type of patient.

In order to accommodate an increased number of admitted patients, hospitals need to examine what areas of the hospital can be repurposed to expand inpatient care provision. Examples of techniques to expand patient bed space include:

- Conversion of outpatient service areas to inpatient care units (for example, outpatient procedure rooms may be utilized as an inpatient telemetry bed)
- Changing single-patient rooms into double-patient rooms
- Utilizing portion of post-anesthesia care units or similar type units as inpatient bed space
- Conversion of large rooms/spaces (such as gymnasium/physical therapy space, hallways, etc.) into multiple-patient rooms/wards

For example, a particular hospital may decide to hold some less critical patients on cots in hallways, accommodate minimal/green patients in the physical therapy department, open its post-surgical care unit for immediate/red patients, and utilize other non-traditional areas for patient care.

Determining where these color-coded surge beds should be located is not an exact science. The hospital should identify where it may want to establish its surge beds and how many beds might be made available at those locations for each level of incident. This should be pre-defined in an institutional response plan.

Because non-traditional care areas may not have resources (such as sinks, monitors, suction, oxygen) commonly found in usual patient care areas, any surge plan should address the provision of alternatives for necessary resources in such areas. This includes plans for staffing these newly created patient beds.

### **Cohorting Surge Patients**

It is recommended that hospitals cohort surge capacity patients in designated areas based on their diagnosis or type (e.g., pediatric vs. adult patients, severity/triage category, functional needs), rather than placing them wherever there are unoccupied beds. Cohorting will assist with assigning the appropriately-skilled staff and specialized supplies and equipment necessary for treating a particular patient cohort. Cohorting of patients is particularly critical when dealing with an infectious disease or hazardous materials incident, as it helps to avoid secondary infection or contamination.

### **Assignment of Staff to Triage Category Cohorts**

There is no single formula or algorithm that can define the appropriate staffing in every area of every hospital for every situation. The hospital must make do with whatever staff it has available. The hospital must plan how to best use existing staff for the care of patients. It is often necessary to reassign staff by either moving personnel from one area to another, or temporarily reassigning them to functions different from their everyday duties.

By definition, in a surge incident, a hospital will not have the necessary number or type of clinical personnel needed to manage every single patient in a usual way. The usual ratio of provider to patient will be much lower than in usual practice (i.e., each staff will be responsible for more patients than usual). The hospital will need to assign available staff and volunteers to patient care areas based on the skill sets that they possess. Hospitals should consider identifying the minimum skill sets required to provide patient care, based on the triage category designation of the patient.

The use of volunteers in a surge incident can be considered in a hospital. If volunteers are to be used, the hospital's surge plan should address activation, reception, and supervision of such volunteers. The hospital should confer with its liability insurer regarding the use of such volunteers as part of the preparation process. There must be a clearly defined process to document and verify the identity, credentials, certifications, and abilities of the person. The hospital should provide emergency credentialing that authorizes the volunteer to work in the hospital temporarily for the duration of the incident. Volunteers must always be properly supervised by regular hospital staff. They should be assigned to work with a regular hospital employee, and never alone. This will reduce issues arising from a volunteer being unfamiliar with processes or other issues unique to a particular hospital.

### **Staff Necessary to Care for Immediate/Red Patients**

These should be staff who can perform primary and secondary assessment and management of critical care patients. This includes emergency, critical care, or other specialty registered nurses (RNs), advanced practitioners, and physicians who are facile with caring for critically ill patients. The hospital can also implement a team nursing concept and use acute care licensed practical nurses (LPNs), paramedics, technicians, personal care attendants (PCAs), and allied health students to assist these RNs and physicians. This will allow for increased productivity of the limited nurse and physician labor pool. Specialty care, such as respiratory therapy or pharmacy, may also be needed in this care area.

Because of the severity of the patients, the immediate/red cohort will require the highest ratio of providers to patient.

### **Staff Necessary to Care for Delayed/Yellow Patients**

These should be staff who can perform initial and ongoing assessment and management of patients. Such nursing and medical staff are normally employed either in acute care settings or may be from non-hospital work sites. Physical therapists, respiratory care technicians, and other ancillary care providers can provide patient care and other assistance as appropriate. Team nursing as described above can also be used in this area.

### **Staff Necessary to Care for Minimal/Green Patients**

These should be staff who can perform basic initial assessment and management of non-critical patients. Such nursing and medical staff members are normally employed in outpatient settings, but may also be from inpatient units. Team nursing as described above can also be used in this area.

Because of the lower acuity of the patients, the minimal/green cohort will require the lowest ratio of providers to patient.

### **Staff Skills Necessary to Care for Expectant/Gray Patients**

These are to be staff or volunteers, who can perform basic assessment and management of patients. It is important to note that expectant/gray patients will still require care to manage and reduce symptoms and discomfort. Thus, nurses, advanced practitioners, and/or physicians will still be required in this area. Palliative medicine specialists may be useful in this cohort. In addition, having team members who are skilled in dealing with dying patients and families, such as clergy, social workers, and hospice workers, will often be of benefit.

### **Job Action Sheets**

The hospital should develop and provide job action sheets, detailing the duties/responsibilities that a position is to carry out in each of the treatment areas. In addition, these job action sheets detail a staff member's supervisor and staff supervised, as well as important hospital numbers to relevant areas, units, or ancillary services. Job action sheets are intended to provide information to personnel who often may be functioning in an area or assignment different from their usual job assignment.

### **Ancillary Services Staffing for Inpatient Surge Capacity Areas**

In addition to plans for clinical personnel and departments, it is equally important that ancillary service departments (such as food/nutrition services, environmental/ housekeeping, patient transport, registration, information technologies, central supply, medical records, etc.) also have a plan to have the staff and supplies necessary to support the hospital during a surge incident. Each ancillary service should have a Continuity of Operations Plan (COOP) for all three levels of surge.

Ancillary services need to consider not only the staffing necessary to care for patients and staff, but also to care for additional family members and visitors who may come to the hospital with the patients.

### **Inpatient Units for Special Consideration**

There are a number of inpatient areas that are not clinically suited for surge capacity use. The following list is not to be considered as inclusive and each hospital should identify the areas that may not be suitable for surge capacity use.

Obstetrics (OB) is considered as a "clean" unit – due to the risk to pregnant mothers, fetuses, and newborns, no infectious patients should be placed in an OB unit. It is not recommended to use an OB unit as a potential surge capacity area since its primary use will be for obstetrics patients. The hospital may consider using vacant OB beds for certain injured female patients, provided they are not infectious. Medical surge events are significant stressors to those directly and indirectly affected by the event, therefore it is likely there will be an increase in the number of women in labor in response to such stress.

Units for immuno-suppressed patients (such as hematology/oncology or transplant units) should also be avoided as inpatient surge capacity beds.

Pediatric beds that have smaller-sized beds or cribs may be counted as inpatient surge capacity beds, but only for pediatric patients.

Nursery beds are also considered “clean,” and used only for neonates less than 28 days old who have not left the hospital. These, therefore, should not be considered as inpatient surge capacity beds. If an infant arrives during a surge incident, the infant should be placed in a pediatric bed, and not the nursery.

Psychiatric beds may be considered by the hospital as a potential surge area for medical/surgical patients, if the hospital is able to properly staff and equip these rooms. Special arrangements are often required for the reverse triage and movement of psychiatric patients.

Palliative or comfort care units are to be designated for the palliative care of patients with terminal conditions. These rooms are often more distant from the core acute care service areas because these patients usually only receive comfort care. Such rooms may be considered for surge capacity. If properly staffed and equipped, they may be used as regular non-hospice medical/surgical beds. A better use may be for incoming surge patients triaged to the expectant/gray category. Having these rooms at a distance from the treatment areas may benefit the patients, family and staff because of the privacy provided by this physical separation. Again, it is important to note that palliative care still requires skilled medical providers to adequately assess and manage symptoms. [See Appendix F: Palliative Care in a Disaster.](#)

Other specialty areas can be used as general hospital beds if properly equipped and staffed, or can be used as specialized beds based on the needs of the situation.

### **Establishing Surge Support Areas or Zones**

The hospital should pre-identify areas that will be used for non-care purposes, such as waiting areas for family and friends, counseling areas, and rest areas. The hospital should include these areas in its surge capacity plan. Other essential room needs include holding areas for patients who are discharged, are waiting to be discharged, or waiting to be transferred.

Treatment areas may require temporary holding areas for patients where they can wait before they are cared for. This is especially true for the minimal/green category of patients, since there are likely to be greater numbers of these patients.

Special attention should be given to the needs of staff and family members who may need rest, food, and access to communications. Rest areas for staff must be considered, and are

especially important when responding to incidents that require the use of extensive protective equipment. For example, if the surge is expected to last more than a few hours, lounges should be available for their normal function, rather than be used as a patient surge area.

### Staff Support Considerations

Often, working in a surge or mass casualty incident can have physical, psychological, and emotional effects on the people involved. It also places both practical and emotional burdens on hospital staff's families. The hospital will need to be able to provide additional services such as on-site rest and meal accommodations, extended child care, and counseling and social services for its employees and their families. The hospital should consider the formation of a staff disaster support committee or have its human resources department pre-plan for these staff considerations.

Appendix B lists some considerations for hospitals when developing staffing plans and strategies. [See Appendix B: Staffing Considerations.](#)

### Equipment and Supplies

Each surge capacity area requires equipment and supplies necessary to deploy surge beds. The hospital needs to determine the type and amount of equipment that will be needed in each area and how this equipment can be relocated or obtained for each surge incident level. If possible, the surge plan should include non-conventional equipment alternatives (for example, adhesive picture hooks to hold IV bags or standard refrigerators to store medications).

The hospital should begin conservation of and triaging of supplies immediately when the surge capacity plan is implemented. The hospital should also consider implementing the process for requesting additional supplies upon activation of the surge capacity plan. If a Unified/Area Incident Command and/or AMCC is activated, access to additional equipment and supplies from the community may be coordinated through those systems.

The hospital should have in its emergency plans the procedures to access the various commercial suppliers and disaster stockpiles available to the hospital. Hospital surge preparedness plans should include components for tracking, receiving, cleaning, and redistributing supplies and critical equipment during an incident.

The hospital is also to identify the electrical power available in these surge capacity areas. Rooms that will be powered by emergency power need to be prioritized for more critical patients (immediate/red category), since these are the most likely patients to be using electrical equipment. The hospital should have flashlights or other battery-powered light sources for use in those areas that may not have emergency power.

### Special Considerations with Crash Carts

Staff should determine where crash carts will be placed when inpatient surge capacity is activated. It is recommended that placement of crash carts should take into consideration the concentration of patient population, patient severity, and distance. The hospital may also want to consider bringing in and deploying automatic electronic defibrillators (AEDs) from the community as an additional resource. The hospital may consider listing in its emergency plans an inventory of where in the community AEDs are maintained and housed.

### Surge Cots, Extra Beds, and Linen Considerations

The Wisconsin Hospital Emergency Preparedness Program has provided hospitals with more than 10,000 cots, with some pre-positioned within hospitals and others in the state stockpile. In addition, hospitals have reported that there are beds in storage or beds that could be repurposed for inpatient use. Hospitals surge plans may include the use of cots and repurposed beds to house patients or staff during an incident. However, none of these cots or storage beds are equipped with linens or pillows. Hospitals should plan for additional linen needs. [See Appendix E: Outfitting Beds with Linens.](#)

### Alternative Treatment Sites

Each hospital should consider a plan whereby it can redirect less severe patients to alternative locations for care and treatment. The hospital should work with on-scene Incident Command to transport less critical (such as minimal/green) patients to designated alternative treatment sites. The hospital should also work with the media and community/government contacts to coordinate the advertising of alternative treatment sites. It is important to note that, without a federal government authorized waiver, hospitals may not redirect patients who present to their facility off their campus for care without first conducting a medical screening examination and stabilization of any emergency medical conditions.

In most cases, alternative treatment sites will be physician offices and outpatient clinics. In some communities, it may be appropriate to use ancillary health care facilities such as free-standing physical therapy suites and dental offices, or to convert large building spaces for some care. In all cases, the emergency plan must spell out how alternative treatment sites are to be properly staffed and equipped to care for patients.

It is recommended that the hospital have a signed Memorandum of Understanding (MOU) with locations not owned/employed by the hospital,<sup>6</sup> to document the agreement to use their

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<sup>6</sup> This plan assumes that a hospital that employs its medical providers has the ability to establish alternative outpatient treatment sites without formal agreements with its medical providers. However, *(footnote continued)*

clinic/office as an alternative outpatient treatment site. If the hospital owns a building that is leased to other organizations, the hospital may consider including a clause in the lease that permits the hospital to use leased areas for disaster response purposes. See [Appendix A: Memorandum of Understanding](#).

## Public Communications

A part of a hospital's surge capacity plan should include pre-scripted news releases that the hospital can deploy when a surge incident occurs. These should be messages to the public alerting them not only to what is happening, but how to appropriately use the health care system in the disaster area. This would include information about the alternative triage center(s), including instructions for self-transporting patients to use an alternative triage center rather than the emergency department. If appropriate, the news release may also mention that there will be barriers restricting access to the emergency department and hospital. It may be advisable to prepare several versions, based on the nature and extent of the disaster, to accommodate the varying levels of surge response. The hospital may also consider patient handouts to explain what is happening at the alternative sites and why they may not be sent directly to the emergency department/hospital. A statement may also be included that the hospital is acting in accord with federal and state regulations for disaster situations.

The hospital's surge plan should address who is permitted to release information to the media. To the extent that a Unified/Area Incident Command structure is activated, media communications should be coordinated with the public information officer (PIO) appointed by the Unified/Area Incident Commander. Health care facilities may also participate in a joint information center (JIC) with health care coalition partners to coordinate information.

## Exercises

It is essential for the hospital to exercise its surge capacity plan on a regular basis. Exercises help to test surge plan concepts, and also provide important awareness and education to hospital employees. It is recommended that exercise planning should occur in accordance with established planning and documentation guidelines, such as the Homeland Security Exercise and Evaluation Program (HSEEP).

The following issues should be considered when designing and implementing an exercise:

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the template memorandum of understanding can be used to outline what is expected of these employed medical providers.

- Exercises should contemplate the loss of technology due to the disaster
- Exercise times should be rotated on different days of the week and times of day to include personnel from all shifts and to test execution at different levels of staffing
- Exercises should include not just clinical services, but also ancillary services such as housekeeping, laundry, food services and others
- Each department should be made to exercise its own departmental surge capacity plan

To reduce costs, “virtual hospital” and “tabletop” exercises can be conducted using models, architectural floor plans, or paper scenarios. For example, one hospital created enlarged paper floor plans and campus layout and had participants visually lay out the surge plan and the location of surge areas. Colored golf tees were used to represent patients and providers. However, it is essential that full-scale exercises involving real use of space, providers, and supplies/equipment are still run regularly.



## Appendix A: Memorandum of Understanding

### Key Components of a Memorandum of Understanding with Another Facility and Template Memorandum of Understanding

Attached is a sample MOU template: please review and make sure it is logical for your facility.

#### Key Components of the MOU:

The Emergency Operations Plan of the hospital states that the Hospital shall treat, to the extent possible, those patients triaged as RED, YELLOW and GRAY/BLACK (expectant) while ambulatory (GREEN) patients are referred to the alternative outpatient treatment sites. At these alternative outpatient treatment sites:

- Physicians and their office staff will treat ambulatory (GREEN) patients referred by the Triage Center or who self-present; and
- Physicians and their office staff will treat ambulatory normal (non-incident) sick and injured patients referred by the Triage Center or who self-present; and
- Physicians and their office staff will treat their own patients, whether scheduled or not, that are in need of immediate treatment.

Physicians and hospitals enter into the MOU in order to utilize not only the physician's office space, but also the physician's staff, equipment, supplies, and other services that may be available in order to treat ambulatory (GREEN) patients.

The physician offices which agree to serve ambulatory (GREEN) patients should be relatively close to the Triage Center.

In some areas, there are no clinics or other suitable sites adjacent or near to the hospital that can serve as alternative outpatient treatment sites. In these cases:

- The first option for the hospital is to choose locations on the hospital campus for the treatment of ambulatory (GREEN) patients. The hospital may need to organize with community physicians and other medical providers arrangements for on-site support to treat GREEN patients.

**NOTE:** *In coming to agreement with the physician to bring the physician and their staff onsite, the hospital should consider the logistical, legal, human resource and billing issues associated with having physicians and their staff come to the hospital campus to provide treatment.*

- Another option is for the hospital to use physician offices as alternative outpatient treatment sites even when they are off campus. It may be more feasible for the hospital to have transportation arranged for the movement of patients from the triage center to these off campus physician offices. Community disaster plans may permit the use of school buses or similar forms of transportation to transfer GREEN patients to off-campus locations.

These alternative outpatient treatment sites would, in most cases, be the offices of primary care physicians. It is assumed that most specialists will be called to serve at the hospital, particularly in Short Duration Incidents. The MOU is designed so that the hospital can determine which physicians can best serve in the alternative outpatient treatment sites and which physicians can best serve in the hospital.

Any physicians or licensed independent practitioners who are licensed, but are not credentialed or privileged at the hospital, will need to be credentialed and privileged in accordance with the hospital's disaster credentialing policy.

The hospital may assign other licensed or non-licensed office personnel to provide services at the hospital within the individual's scope of practice or as otherwise permitted by law at the time the services are rendered and according to the hospital's policy for the deployment of disaster personnel.

**NOTE:** Physicians and staff may need to triage patients that are scheduled and in need of immediate care and treatment so that these patients, if their appointments are canceled, know whether to seek care at the emergency department or other treatment centers that may be experiencing a surge.

The hospital and the physician must come to mutual agreement on the procedures for deploying these alternative outpatient treatment sites.

The physician office should also have such a plan along with the necessary education and training so that physicians and staff are aware of their role in serving as an alternative outpatient treatment site.

Both hospital and physician plans should include how notice is given that this plan is being activated, especially after normal business hours and on weekends and holidays.<sup>7</sup>

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<sup>7</sup> Most hospitals have an internal notification system. Hospitals may want to consider offering the use of mass alert technology and adding physicians and their staff to this system for alerting purposes.

Physicians and hospitals should periodically test these plans through exercises.

When the alternative outpatient treatment site is deployed, the physician should identify which of their office resources can be used to treat patients:

- Examination rooms and their equipment and supplies
- EKG machine(s)
- X-Ray machine(s)
- Basic laboratory capabilities
- Piped for medical gases (oxygen, etc.)
- Other capabilities

The hospital should have a plan in place by which it can re-supply the physician office, since physician offices usually do not maintain large inventories of supplies.

Physicians should utilize their existing office staff for the care and treatment of patients when their office is deployed as an alternative outpatient treatment site.

Physicians should have in place a procedure to call in staff if their services are required after hours or on weekends or holidays<sup>8</sup>.

Physicians must understand that the physician is responsible for payment of staff according to the established Human Resource policies of the physician.

Physicians should agree to deploy their office as an alternative outpatient treatment site as soon as possible and ideally at the same time that the Triage Center is deployed.

Patients treated at physician's office under the MOU should be considered as patients of the physician. Care should be documented in the patient's medical record, and the physician must provide such follow-up treatment in accordance with physician's legal and ethical responsibilities and pursuant to the policies of physician's practice.

The hospital is not obligated under this MOU to reimburse the physician for services rendered, since the physician will apply normal billing procedures to those patients treated.

Physician should consider "down-time" record keeping in case normal electronic medical records or billing systems are not functional.

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The Hospital should not be expected to reimburse the physician for any business lost due to the fact that the physician may have to defer or cancel appointments of regular patients in order to treat the patients involved in the disaster or other “normal sick or injured” ambulatory patients who present during the disaster and are referred to the physician’s office by the Triage Center.

As long as the physician and/or the physician's personnel are providing services at their office, it is expected that all appropriate insurances and coverage will be applicable. However, physician is advised to contact his/her insurance carriers to ensure that insurances and coverage will remain applicable while physician is acting as an alternative outpatient treatment site.

Under the MOU, hospital and physician will remain as independent contractors. Neither the physician nor the physician's employees providing services will be deemed to be an employee of the hospital, nor shall hospital be liable for any employment-related costs or expenses.<sup>9</sup>

## Memorandum of Understanding

This Memorandum of Understanding (MOU) is entered into by and between \_\_\_\_\_ (HOSPITAL) and \_\_\_\_\_ (MEDICAL PROVIDER) as of this \_\_\_\_\_ day of \_\_\_\_\_, 2011

### Definitions

**Alternative Outpatient Treatment Site** means such outpatient centers such as MEDICAL PROVIDER offices, clinics, Urgent Care Centers, Outpatient Surgical Centers, and others as identified by the HOSPITAL in its surge plan as a site, either on the HOSPITAL campus or away from the HOSPITAL campus, that will treat ambulatory (GREEN) patients.

**alternative triage center** is defined as the initial location for the triage of patients that is established during a surge incident and is typically separated physically from the Emergency Department.

**Disaster** means an unexpected or exceptional event which causes an increase in demand for medical and HOSPITAL services that exceeds the capacity of the HOSPITAL, resulting in the need for additional facilities, including space and equipment, to provide care for ambulatory (GREEN) patients.

**Medical Provider** means an individual MEDICAL PROVIDER or a group of MEDICAL PROVIDERS or any other licensed independent practitioner that practice in an office setting and who agrees \_\_\_\_\_

<sup>9</sup> This MOU is written for those physicians not employed by the hospital. It is understood that the hospital may enter into comparable agreements with its employed physicians.

to provide treatment according to the terms of this Memorandum of Understanding in an emergency.

**Surge** means an increase in the number of patients presenting to the HOSPITAL due to a disaster that may overwhelm the ability of the HOSPITAL to provide treatment to all patients presenting.

**Surge Capacity Plan** means the procedures that both the HOSPITAL and MEDICAL PROVIDERS will implement in order to manage a surge of patients.

## Recitals

Whereas, MEDICAL PROVIDER has space in a medical office building, which is on or near the campus of HOSPITAL that can be used as an alternative outpatient treatment site; and

Whereas, MEDICAL PROVIDER and HOSPITAL both recognize that, from time to time, emergencies may occur which require the implementation of surge capacity plans; and

Whereas, MEDICAL PROVIDER and HOSPITAL both desire to be prepared to treat the patients that present to the HOSPITAL in the event of a disaster; and

Whereas, the HOSPITAL is to have a plan whereby it can direct ambulatory (GREEN) patients for care and treatment in a disaster when there is a surge of patients; and

Whereas, it is expected that ambulatory (GREEN) patients will be directed from the field and through the media to go to the alternative triage center or directly to the designated alternative outpatient treatment sites.

Now, therefore, the MEDICAL PROVIDER and the HOSPITAL agree to the following:

The HOSPITAL Emergency Operations Plan states that the HOSPITAL shall treat, to the extent possible, those patients triaged as RED, YELLOW and GRAY/BLACK (expectant). Ambulatory (GREEN) patients will, to the extent possible, be referred to the alternative outpatient treatment sites. HOSPITAL may request MEDICAL PROVIDER to open, in MEDICAL PROVIDER's office, an alternative outpatient treatment site. Upon occurrence of a disaster and activation of the HOSPITAL's disaster plan, HOSPITAL may contact MEDICAL PROVIDER to request activation of an alternative outpatient treatment site at MEDICAL PROVIDER's office. Activation of particular alternative outpatient treatment sites will be based upon factors relevant given the disaster, including proximity of the proposed alternative outpatient treatment site to the disaster and/or HOSPITAL, number of alternative outpatient treatment sites needed, capabilities required of alternative outpatient treatment sites, and the overall incident response plan, as determined by the Incident Commander (if activated). Upon receiving a request to activate:

- MEDICAL PROVIDER and their office staff agree to treat ambulatory (GREEN) patients, referred by the Triage Center or patients who self-present; and
- MEDICAL PROVIDER and their office staff agree also to treat ambulatory normal sick and injured patients, referred by the Triage Center or patients who self-present; and
- MEDICAL PROVIDER and their office staff agree to treat their own patients, whether or not scheduled, who are in need of immediate treatment. MEDICAL PROVIDER may, in MEDICAL PROVIDER's discretion, cancel or delay appointments for patients who do not require immediate care.
- MEDICAL PROVIDER and HOSPITAL enter into this MOU in order to utilize not only the office space of the MEDICAL PROVIDER, but also the staff, equipment, supplies, and others services of the MEDICAL PROVIDER that may be available in order to treat ambulatory (GREEN) patients.
- MEDICAL PROVIDER agrees to provide staffing, equipment, supplies, and other resources of the MEDICAL PROVIDER as necessary to care for ambulatory (GREEN) surge patients.
- MEDICAL PROVIDER agrees to provide the following resources:
  - \_\_\_\_\_ Examination rooms and their equipment and supplies
  - \_\_\_\_\_ EKG machine(s)
  - \_\_\_\_\_ X-Ray machine(s)
  - \_\_\_\_\_ Basic laboratory capabilities
  - \_\_\_\_\_ Medical gasses (oxygen, etc.)
  - \_\_\_\_\_ Other (for example, medications. Please specify)
- MEDICAL PROVIDER agrees to utilize their existing office staff for the care and treatment of patients whenever their office is deployed as an alternative outpatient treatment site.
- MEDICAL PROVIDER agrees to deploy (open) the office for use as an alternative outpatient treatment site as soon as possible after receiving a request from HOSPITAL. MEDICAL PROVIDER shall provide to HOSPITAL contact information for designated personnel who are authorized to receive requests for deployment.

The alternative outpatient treatment site may be deployed after business hours, on weekends, or on holidays, if necessary. MEDICAL PROVIDER should have in place a procedure to staff the alternative outpatient treatment site (including physician and other staff) as required to adequately care for patients.

MEDICAL PROVIDER recognizes that the MEDICAL PROVIDER is responsible for payment of staff according to the established Human Resource policies of the MEDICAL PROVIDER.

Patients treated at the office of the MEDICAL PROVIDER under this MOU shall be considered as patients of the MEDICAL PROVIDER. MEDICAL PROVIDER shall record care provided in MEDICAL

PROVIDER's medical records; may, to the extent permitted by law or contract, bill for services rendered; and must provide such follow-up treatment in accordance with the legal and ethical responsibilities and pursuant to the policies of the practice of the MEDICAL PROVIDER.

MEDICAL PROVIDER should establish and as necessary implement "down-time" record keeping procedures in case normal electronic medical records or billing systems are not functional.

MEDICAL PROVIDER agrees to develop a disaster response plan that includes use of MEDICAL PROVIDER's office as an alternative outpatient treatment site as contemplated by this MOU.

MEDICAL PROVIDER's disaster response plan shall include provisions regarding notice to employees of the activation of the disaster response plan, employee response to activation of the disaster response plan, and similar provisions.

MEDICAL PROVIDER shall ensure that MEDICAL PROVIDER's staff are aware of and trained on the disaster response plan.

HOSPITAL and MEDICAL PROVIDER shall cooperate to develop a plan for HOSPITAL to provide additional supplies to MEDICAL PROVIDER during the Disaster, as necessary to enable MEDICAL PROVIDER to provide care as contemplated by this MOU. To the extent MEDICAL PROVIDER receives reimbursement from patients or third party payers for such supplies, MEDICAL PRACTICE shall, after the disaster, reimburse HOSPITAL for such supplies.

MEDICAL PROVIDER and HOSPITAL agree to periodically test the HOSPITAL and MEDICAL PROVIDER disaster response plans through exercises.

HOSPITAL will not reimburse the MEDICAL PROVIDER for any business lost related to MEDICAL PROVIDER's cancellation of appointments of regular patients in order to treat the patients involved in the disaster or other "normal sick or injured" ambulatory patients who present during the disaster and are referred to the office of the MEDICAL PROVIDER by the alternative triage center.

As long as the MEDICAL PROVIDER and/or the personnel of the MEDICAL PROVIDER are providing services at their office, it is expected that all appropriate insurances and coverage will be applicable. However, MEDICAL PROVIDER is advised to contact his/her insurance carriers to ensure that insurances and coverage will remain applicable while MEDICAL PROVIDER is acting as an alternative outpatient treatment site.

Under this MOU, HOSPITAL and MEDICAL PROVIDER remain as independent contractors. Neither the MEDICAL PROVIDER nor the employees of the MEDICAL PROVIDER providing

services shall be deemed to be an employee of the HOSPITAL, nor shall HOSPITAL be liable for any employment-related costs or expenses<sup>10</sup>.

This MOU shall be in effect upon signature by HOSPITAL and MEDICAL PROVIDER.

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Authorized Signature and Title of HOSPITAL

Date Signed

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Authorized Signature and Title of MEDICAL PROVIDER

Date Signed

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<sup>10</sup> This MOU is written for those MEDICAL PROVIDERS not employed by the HOSPITAL. It is understood that the HOSPITAL may enter into comparable agreements with its employed MEDICAL PROVIDERS.

## Appendix B: Staffing Considerations

The following are issues that the hospital should consider for its staffing plans and strategies. The hospital should also consider the formation of a staff disaster support committee or have its human resources department pre-plan for the following (the list is not intended to be exhaustive).

If the staff person's family is not safe, the employee will NOT come to work. Some staff will not be able to report to work due to the fact that they or their loved ones may have been directly involved in the incident. There should be a policy to address these absences and also strategies to provide support to these employees.

Some staff will refuse to report to work due to concerns about their own and their family members' safety and health. In the case of a biological incident, they may have fear of contracting the disease or bringing the disease home. There should be a policy to address these absences and also strategies to provide support and or options to these employees.

Many staff will have concerns about childcare. The normal childcare provider may not be able to provide these services in an incident. These same concerns apply to staff that may be caring for their parents or others. There should be options available for childcare/eldercare so that staff members are free to report to work.

Some staff may have concerns about the shelter and care of their pets.

Consider multiple means of notice to staff regarding activation of the disaster plan and recall of personnel to the hospital, to accommodate loss of technological capabilities due to the disaster.

The hospital should consider the provision of rooms for staff for rest and sleep and for personal hygiene needs (blankets, pillows, sheets, showers, towels, soap, shampoo, etc.). In the case of a biological incident, there may be the implementation of work quarantine in addition to staff working longer shifts or not being able to go home. The hospital may also want to consider what is available in local hotels, churches and other such organizations for sleeping accommodations and showers.

The hospital should consider the travel needs of staff, i.e., travel may be difficult and the hospital may have to arrange for emergency transport of staff to and from the hospital.

The hospital should consider areas for staff to eat and have refreshments.

Staff may be away from home for extended shifts and may need to communicate with family members and other loved ones. The hospital should consider the availability of telephones to call home and computer access for email.

For staff working extended shifts or not going home, there may be the need for the provision of laundry services or scrubs. Staff members should also consider having an “Emergency Kit” with personal items such as underwear, socks, toiletries, a supply of medications, etc., readily available.

The hospital should consider how staff, if confined to the hospital, may obtain needed medications and other essential items, if staff has not brought these with them to the hospital.

The hospital should include ongoing Crisis Intervention Team activities for debriefing staff to assure that staff are dealing effectively emotionally and psychologically with the incident, able to process the event, and able to maintain personal safety and well-being.

Staff should also have a “Family Plan” so that everyone in the family knows what will need to happen and who is responsible for various duties if a family member who works at the hospital needs to work longer shifts or is quarantined at the hospital.

The hospital should also give consideration for back-up of essential services such as food services, laundry, housekeeping and other services, especially if these services are out-sourced and the incident affects the ability of the contractor to continue to provide these services and if the surge of patients and visitors overwhelms the capacity of these contractors.

Most hospitals use “calling trees” to notify staff. The hospital should consider the use of your alert system such as SEND WORD NOW alert and notification system, or other systems such as Blackboard Connect, etc., for notifying staff. There should also be consideration of a back-up plan for reporting to the hospital should the telephone lines be down or the circuits busy.

The hospital should consider pre-identifying and training staff persons who will manage and supervise volunteers and in which areas or departments the hospital is likely to utilize volunteers.

The hospital should also consider that there may not be sufficient managers to supervise the staff in the surge capacity areas.

With staff being asked to work in the surge capacity areas, work in these areas may not necessarily involve their normal work responsibilities. It is suggested that job action sheets be available for all positions in the RED, YELLOW and GRAY/BLACK surge capacity areas so that staff can receive “just-in-time” training by reading the job action sheets.

## Appendix C: CMS and EMTALA Hospitals Disaster

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Service  
7500 Security Boulevard, Mail Stop S2-12-25  
Baltimore, Maryland 21244-1850



Center for Medicaid and State Operations/Survey and Certification Group

**Ref: S&C-09-52**

**DATE:** August 14, 2009

**TO:** State Survey Agency Directors

**FROM:** Director

Survey and Certification Group

**SUBJECT:** Emergency Medical Treatment and Labor Act (EMTALA) Requirements and Options for Hospitals in a Disaster

### *Memorandum Summary*

- **Planning for Surge in Emergency Department Services:** A brief summary of EMTALA requirements and options for hospitals experiencing an extraordinary surge in demand for ED services has been developed to assist hospitals and their communities in planning for a potential surge in ED volume this fall related to H1N1 influenza.
- **Waiver Description:** Rules governing EMTALA waivers are also described.
- **Availability and Distribution of Summary Sheet:** State Survey Agencies (SAs) are requested to distribute this summary sheet widely to hospital and emergency response planning officials.

In anticipation of a possible significant increase in demand for emergency services due to H1N1 influenza resurgence this fall several Federal agencies, State health departments, and hospitals have expressed significant concerns about compliance with EMTALA requirements during an outbreak. Many stakeholders perceive that EMTALA imposes significant restrictions on hospitals' ability to provide adequate care when EDs experience extraordinary surges in demand. The attached fact sheet clarifies options that are permissible under EMTALA and should reassure the provider community and public health officials that there is existing flexibility under EMTALA. Among other things, the fact sheet notes that an EMTALA-mandated medical screening examination (MSE) does not need to be an extensive

work-up in every case, and that the MSE may take place outside the ED, at other sites on the hospital's campus.

The fact sheet also summarizes the provisions governing EMTALA waivers. Surveyors and managers responsible for EMTALA enforcement are expected to be aware of the flexibilities hospitals are currently afforded under EMTALA and to assess incoming EMTALA complaints accordingly in determining whether an on-site investigation is required. They are also expected to keep these flexibilities in mind when assessing hospital compliance with EMTALA during a survey.

To help dispel misconceptions among the provider community concerning EMTALA requirements, SAs are requested to distribute the attached fact sheet widely to the provider community in their State, as well as to State and local public health officials responsible for emergency preparedness.

Questions about this document should be addressed to CDR Frances Jensen, M.D., at [frances.jensen@cms.hhs.gov](mailto:frances.jensen@cms.hhs.gov).

**Training:** The information contained in this letter should be shared with all survey and certification staff, their managers, and the State/RO training coordinators immediately

/s/

Thomas E. Hamilton

cc: Survey and Certification Regional Office Management

Attachment

## Appendix D: EMTALA Pandemic

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Service  
7500 Security Boulevard, Mail Stop S2-12-25  
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### FACT SHEET

#### Emergency Medical Treatment and Labor Act (EMTALA) &

#### Surges in Demand for Emergency Department (ED) Services During a Pandemic

##### I. What is EMTALA?

- EMTALA is a Federal law that requires all Medicare-participating hospitals with dedicated EDs to perform the following for **all** individuals who come to their EDs, regardless of their ability to pay:
  - An *appropriate* medical screening exam (MSE) to determine if the individual has an Emergency Medical Condition (EMC). If there is no EMC, the hospital's EMTALA obligations end.
  - If there is an EMC, the hospital must:
    - + Treat and stabilize the EMC within its capability (including inpatient admission when necessary); **OR**
    - + Transfer the individual to a hospital that has the capability and capacity to stabilize the EMC.
- Hospitals with specialized capabilities (with or without an ED) may not refuse an appropriate transfer under EMTALA if they have the capacity to treat the transferred individual.
- EMTALA ensures access to hospital emergency services; it need not be a barrier to providing care in a disaster.

##### II. Options for Managing Extraordinary ED Surges Under Existing EMTALA Requirements (No Waiver Required)

###### A. *Hospitals may set up alternative screening sites on campus*

- The MSE does not have to take place in the ED. A hospital may set up alternative sites on its campus to perform MSEs.

- Individuals may be redirected to these sites after being logged in. The redirection and logging can even take place outside the entrance to the ED.
- The person doing the directing should be qualified (e.g., an RN) to recognize individuals who are obviously in need of immediate treatment in the ED.
- The content of the MSE varies according to the individual's presenting signs and symptoms. It can be as simple or as complex, as needed, to determine if an EMC exists.
- MSEs must be conducted by qualified personnel, which may include physicians, nurse practitioners, physician's assistants, or RNs trained to perform MSEs and acting within the scope of their State Practice Act.
- The hospital must provide stabilizing treatment (or appropriate transfer) to individuals found to have an EMC, including moving them as needed from the alternative site to another on-campus department.

*B. Hospitals may set up screening at off-campus, hospital-controlled sites.*

- Hospitals and community officials may encourage the public to go to these sites instead of the hospital for screening for influenza-like illness (ILI). *However, a hospital may not tell individuals who have already come to its ED to go to the off-site location for the MSE.*
- Unless the off-campus site is already a dedicated ED (DED) of the hospital, as defined under EMTALA regulations, EMTALA requirements do not apply.
- The hospital should not hold the site out to the public as a place that provides care for EMCs in general on an urgent, unscheduled basis. They can hold it out as an ILI screening center.
- The off-campus site should be staffed with medical personnel trained to evaluate individuals with ILIs.
- If an individual needs additional medical attention on an emergent basis, the hospital is required, under the Medicare Conditions of Participation, to arrange referral/transfer. Prior coordination with local emergency medical services (EMS) is advised to develop transport arrangements.

*C. Communities may set up screening clinics at sites not under the control of a hospital*

- There is no EMTALA obligation at these sites.
- Hospitals and community officials may encourage the public to go to these sites instead of the hospital for screening for ILI. *However, a hospital may not tell individuals who have already come to its ED to go to the off-site location for the MSE.*
- Communities are encouraged to staff the sites with medical personnel trained to evaluate individuals with ILIs.

- In preparation for a pandemic, the community, its local hospitals and EMS are encouraged to plan for referral and transport of individuals needing additional medical attention on an emergent basis.

### III. EMTALA Waivers

- An EMTALA waiver allows hospitals to:
  - Direct or relocate individuals who come to the ED to an alternative off-campus site, in accordance with a State emergency or pandemic preparedness plan, for the MSE.
  - Effect transfers normally prohibited under EMTALA of individuals with unstable EMCs, so long as the transfer is necessitated by the circumstances of the declared emergency.
- By law, the EMTALA MSE and stabilization requirements can be waived for a hospital only if:
  - The President has declared an emergency or disaster under the Stafford Act or the National Emergencies Act ; *and*
  - The Secretary of HHS has declared a Public Health Emergency; *and*
  - The Secretary invokes her/his waiver authority (which may be retroactive), including notifying Congress at least 48 hours in advance; *and*
  - The waiver includes waiver of EMTALA requirements and the hospital is covered by the waiver.
- CMS will provide notice of an EMTALA waiver to covered hospitals through its Regional Offices and/or State Survey Agencies.
- Duration of an EMTALA waiver:
  - In the case of a public health emergency involving pandemic infectious disease, until the termination of the declaration of the public health emergency; *otherwise*
  - In all other cases, 72 hours after the hospital has activated its disaster plan
  - In no case does an EMTALA waiver start before the waiver's effective date, which is usually the effective date of the public health emergency declaration.

## Appendix E: Outfitting Beds with Linens

A State Expert Panel was convened to determine the best options available to hospitals to outfit surge beds with the necessary bed linens.

**Bed Linens:** The State Expert Panel suggested that the hospital should consider maintaining a linen inventory:

- Top sheet (flat)
- Bottom sheet (flat)
- Pillow (minimum need three pillows each)
- Pillow case
- Towel
- Washcloth
- Blanket
- Bath blanket
- Underpad
- Patient gown (this is the IV type gown; these make up about 95 percent of all hospital patient gowns.)

**NOTE: This is not a list of what a hospital is expected to maintain. Each hospital has different needs. This is a list of typical items that may be needed to outfit a surge bed or cot.**

**NOTE: Isolation gowns are not listed above. The Hospital PPE Stockpile has a significant number of isolation gowns available for hospital and other health care facilities.** If your hospital relies on reusable isolation gowns, consider stockpiling additional supplies.

**Options to Obtain Bed Linens:** The State Expert Panel considered eight different options:

- **Option One:** The hospital has an in-house laundry and has sufficient par levels of bed linens to outfit the surge beds.
- **Option Two:** The hospital has an in-house laundry and sufficient par levels of bed linens to outfit the surge beds with adding shifts to the in-house laundry service.
- **Option Three:** The hospital outsources its laundry and the contractor has sufficient par levels of bed linens to outfit the surge beds for all customers.
- **Option Four:** The hospital outsources its laundry and the contractor maintains sufficient par levels of bed linens to outfit the surge beds for each customer, with the contractor adding shifts to their laundry service. The hospital should ensure that they have a contract with the vendor to maintain par levels for the hospital.
- **Option Five:** Not-for-profit hospitals/organizations may contract with Badger State Industries or other private contractors for rental of surge linens.

- **Option Seven:** The hospital may consider disposable linens as an option for outfitting surge beds.
- **Option Eight:** Hospitals should consider stockpiling torn, stained or imperfect linens for use in an emergency.

### Key Laundry Issues

- **Par Level:** The State Expert Panel assumes that many hospitals may carry a minimum par level of three to five changes of bed linens.
- According to a WHEPP surge linen survey, 50 percent of all hospitals have contracted laundry services.
- Hospitals should have a plan to increase linens threefold during a surge incident.

**Contracted Laundry Providers:** There are a limited number of contract laundry providers in the state that serve hospitals and other institutions. In some areas of the state, one vendor is the sole laundry provider for most of the hospitals in that geographic area. This could be problematic in a surge incident when multiple hospitals, served by one vendor, are requesting an increased supply of linens to outfit their surge beds.

**Conservation of Laundry:** Hospitals should have in place options to conserve bed linens. These options may include, but are not limited to:

- Changing bed linens only when soiled
- Using the top sheet as the bottom sheet when changing linens
- Changing linens only at the request of the patient or family member and other such measures
- Cautioning staff on the unnecessary disposal of linens into the dirty laundry
- Using disposable linen or protector pads to prevent primary linen contamination during procedures
- Making up the bed according to the acuity of the patient
- Both in-house and contracted laundry services may increase productivity by:
  - not folding linens and simply placing them in bags
  - lower quality control to let through laundry that has small holes or tape that has not been removed
  - maintaining in storage older linens that may be stained or torn but still usable in a surge incident

### Pre-scripted Messages

The hospital should have a plan for pre-scripted messages to staff regarding the conservation of linens during any event that alters the supply or demand for linens.

**Back-Up Plan:** Each laundry service, whether a contracted service or an in-house service, should have a back-up plan on how to process and transport laundry should this service not be operable for some reason.

**Surgical Sterile Linens:** These linens typically take longer for the laundry to process. There are several options available to hospitals to manage surgical sterile linens:

- hospitals may choose to cancel elective surgeries in a surge incident
- hospital may choose to use disposable linens

**Disposable Linens:** The State Expert Panel believes that disposable linen intended to replace primary bed linen is of limited value. Disposable linens do not hold up well and would not be appropriate for inpatient usage except in emergency conditions when no other laundry is available. Since disposable linens have a shelf-life and thus an expiration date, stockpiling disposable linens would not be a cost-effective option to build a surge linen inventory. Consider the use of disposable linen or under pad to protect primary bed linens.

Surge incidents caused by traumatic incidents are usually limited geographically. Most distributors will be able to call upon other regional warehouses should their own supply of disposable linens be depleted. Surge incidents that are caused by infectious disease usually do not involve the need for increased surgeries. Thus, it is anticipated that distributors will have a sufficient supply of disposable linens for hospitals in any surge incident. Hospitals that do not use disposable linens for surgery may consider use of such disposables in a surge incident.

**Laundry for EMS:** During a surge incident there may be an increased need for EMS linens. Many hospitals supply clean linens for their EMS services. However, it is believed that most of this laundry does return to the hospital and is counted in the hospital par level. EMS is encouraged to return linens to hospitals in a timely manner.

### **Pillow Supplies**

It is understood that pillows are usually not purchased by Laundry Services and should be considered as an additional cost, although hospitals usually have a good supply of pillows since they are used also for positioning.

## Appendix F: Palliative Care in a Disaster

### Guidance for palliative care needs

Revised December 2014

In a disaster, the goal of the health care system is to save as many lives as possible. Scarce life-saving resources may need to be allocated to those most likely to survive. There will be those who are so severely ill or injured that their likelihood of survival is minimal. In addition, those already medically fragile may have their condition worsened by the disaster and thus their prognosis becomes even less tenable. These patients/residents would be provided with necessary treatment, unless the patients/residents have advance directives to the contrary or choose to forgo such treatment. In a disaster, with limited resources, the goal of the health care system is to provide, for those patients/residents that cannot be treated aggressively, comfort and care to ease adverse symptoms as much as possible. Consultation and other services may also be available on a limited basis.

### Definitions

**Allocation of Scarce Resources:** In a mass casualty incident, it is likely that there will be a lack of sufficient resources, e.g., supplies, equipment, staff. Decisions to allocate these scarce resources will result in treatment for some and limited to no treatment for others whose survivability is determined to be low in comparison to other patients/residents.

**BLACK /GRAY Beds:** Triage systems use colors to identify the severity of the victim. Most triage systems use the color BLACK to identify victims that have died. Some systems, such as START, also use BLACK to identify patients who are expectant, meaning having illness or injury that makes it likely that they will not survive. Other systems such as SALT use GRAY to identify expectant patients. Beds used for expectant patients are referred to as either Gray or Black depending on the triage system used by the hospital.

**Disaster:** In this policy, a disaster refers to any incident that overwhelms the resources of the health care system, locally or regionally.

**Disaster Ethics:** A set of principles and values that serve to direct the duties, obligations and parameters of the delivery of health care in a disaster situation. **Reference:** *Disaster Ethics* <http://www.wha.org/scarceResources.aspx>.

**Hospice Program:** This refers to agencies whose sole purpose is the care of the dying and providing a type of care and a philosophy of care that focuses on the palliation of a terminally ill patient's symptoms.

**Palliative Care:** The World Health Organization defines palliative care as “an approach which improves the quality of life of patients and family facing life-threatening illness, through the prevention, assessment and treatment of pain and other physical, psychosocial and spiritual problems.”

**Palliative Care Programs:** These are programs usually offered by the following: hospitals to their inpatients, home care to their outpatients, and hospice organizations and residential facilities to their residents.

**Residential Facilities:** This means nursing homes, assisted-living facilities and group homes that may provide care for their residents.

### **Considerations**

It is the responsibility of public health authorities, in collaboration with health care organizations, to have pre-scripted messages available for the public regarding changes in palliative care once a surge event occurs.

It is the responsibility of public health authorities to inform and educate the public regarding the effects that a mass casualty incident, such as pandemic influenza or a regional catastrophic event, may have on the community.

There needs to be education about allocation of scarce resources and how this may result in some patients/residents receiving limited or no health care services.

This education will include information that patients/residents will be frequently assessed for the appropriate treatment, to the extent possible.

For some patients/residents, appropriate treatment may be palliative care.

There are two types of patients/residents, who may require palliative care: those who are directly affected by the incident, and those who had been previously ill (the chronically ill) and whose illness may be exacerbated by the disaster and/or by the fact that there may be limited or no treatment and/or medications available.

### **Sites of Care**

During inter-agency emergency planning meetings, all palliative care programs should be informed that the hospital may not be able to admit palliative care residents from residential facilities and home care palliative care programs.

Residential facilities should be responsible, in a disaster, for their own residents, who may be in need of palliative care.

Residential facilities and other home care and hospice palliative care programs should have plans in place so that they can accept patients/residents in need of palliative care, who have no caregiver to provide for them.

The hospital home care, hospice and residential facility palliative care programs should have a tiered response for the management of patients/residents in need of palliative care:

- **Minor Surge:** Patients/residents will be admitted to established inpatient and outpatient hospital, home care, inpatient hospice and residential facility palliative care programs that have capacity to receive these patients/residents.
- **Moderate Surge:** The hospital, hospice and residential facility palliative care programs will deploy their pre-identified BLACK/GREY (“expectant”) beds to manage a surge of inpatients/residents in need of palliative care. These BLACK/GREY beds should primarily be intended for patients/residents not likely to survive transfer to another facility. Consider transfer of these patients to facilities that are able to accept and treat this type of patient.
- **Crisis:** The hospital, home care, hospice and residential facility palliative care programs will refer palliative care patients/residents to surge palliative care programs, which have outpatient or inpatient capacity and which will need to be adapted to manage an increased number of patients/residents with fewer staff and other scarce resources.

The hospital, home care, hospice and residential facility palliative care programs will provide limited direct and indirect support to patients/residents who are dying at home, and cannot be admitted to a surge hospital, home care, hospice or residential facility palliative care program due to scarce resources.

**NOTE:** *In an MCI surge incident it is to be recognized that palliative care services provided may not be optimal palliative medical services.*

### **Staffing**

The hospital, home care, hospice and residential facility palliative care programs are to assume that in any surge incident there will be limited staff to provide direct patient care for palliative care.

Consider alternative personnel such as chaplains, retired health care providers or social workers to help provide patient care.

Facilities may consider use of telephone consultations to provide remote support to personnel not normally involved in palliative care.

## Triage

The hospital, home care, hospice and residential facility palliative care programs are to have a multi-disciplinary clinical review committee or its equivalent to establish and oversee the application of allocation of scarce resources guidelines for the triage of patients/residents, including those that will be triaged to palliative care.

It is the responsibility of the hospital, home care, hospice and residential facility palliative care programs to determine their internal procedures by which they will assign persons to the appropriate level of palliative care. There are various triage systems. In some triage systems, the BLACK designation refers to dead and/or expectant patients. In other triage systems, BLACK refers to dead patients; GRAY refers to expectant patients.

## Patient Categorization

Due to the need to allocate scarce resources, the hospital, home care, hospice and residential facility palliative care programs are to categorize patients/residents in need of palliative care so that resources can be allocated to these patients/residents, based on an assessment of the patient/residents, which will include survivability and acuity of symptoms. **Reference:** *Allocation of Scarce Resources* ([www.wha.org](http://www.wha.org)).

## Support for Caregivers

The hospital, home care, hospice and residential facility palliative care programs, to the extent possible, are to work with community resources prior to any incident to determine how support can be provided to caregivers, e.g., food, errands, respite care.

The hospital, home care, hospice and residential facility palliative care programs should have a plan to educate their staff to refer caregivers to appropriate resources. Consider a call-in number such as 211 that caregivers can access for information and assistance.

The hospital, home care, hospice and residential facility palliative care programs should train their volunteers and staff to assist with the handling of these calls, as this may be the only source of support and assistance available to some caregivers. In addition, health care staff should develop a system to provide consultative services to caregivers.

**Patient Documentation:** The hospital, home care, hospice and residential facility palliative care programs are responsible for documenting the assessment, referral and disposition of all patients.

**Placement in a Residential Facility Palliative Care Program:** Follow established regulations for admission of individuals with a communicable disease. **Reference:** *Allocation of Scarce Resources* - <http://www.wha.org/scarceResources.aspx>