SACRAMENTO COUNTY HOSPITALS

EMERGENCY PREPAREDNESS PLAN
AND
MEMORANDUM OF UNDERSTANDING

August 31, 2020

Hospital Council
Northern & Central California

COUNTY OF SACRAMENTO
DHHS
CALIFORNIA
PUBLIC HEALTH

Plan Authorization

9/21/20

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Hospital Council – Northern and Central California

Date

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Sacramento County Department of Health and Human Services

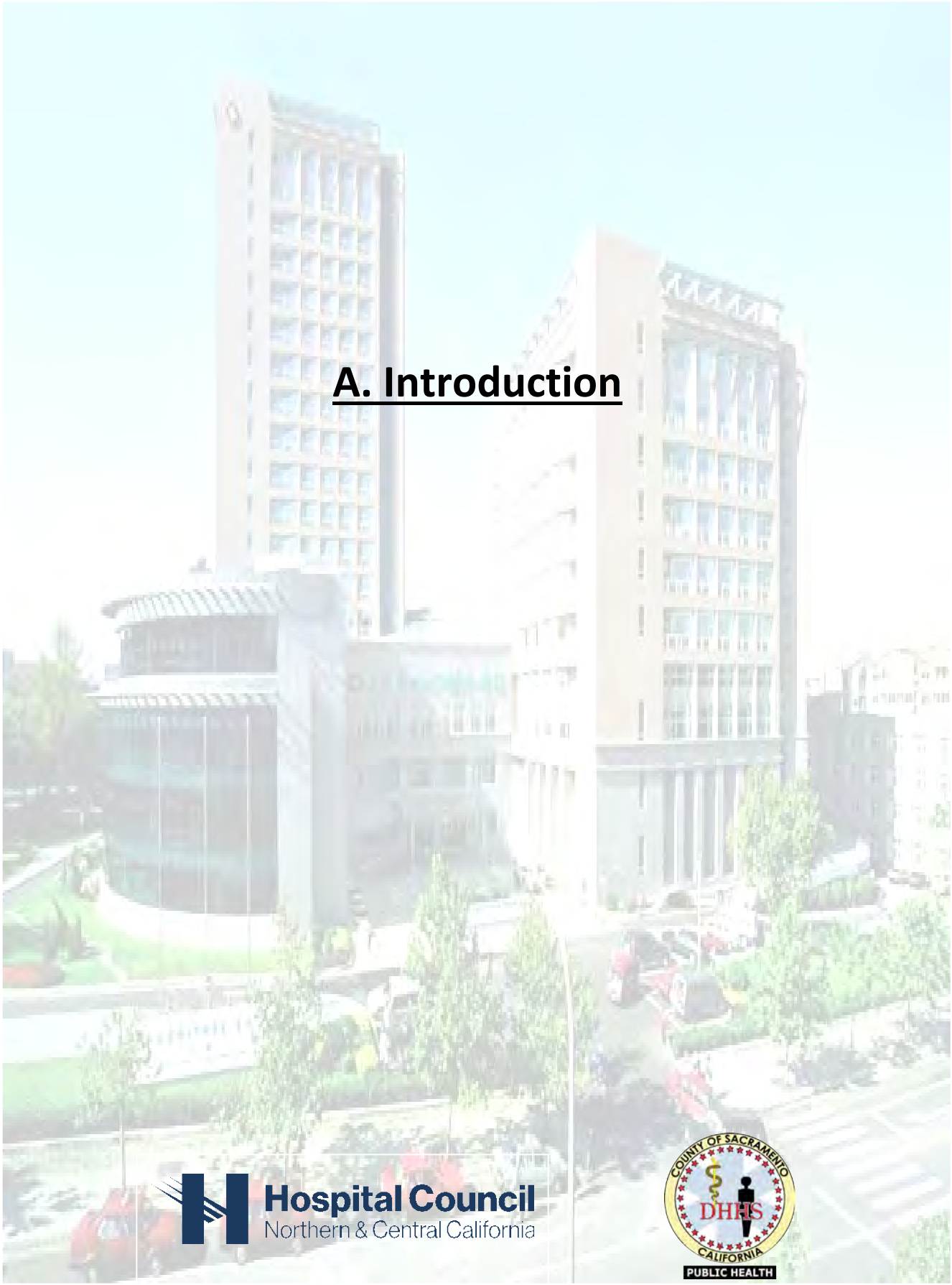
9/21/20

Date

THIS PLAN WAS DEVELOPED WITH THE SUPPORT OF HEALTH RESOURCE SERVICES ADMINISTRATION (HRSA) HOSPITAL BIOTERRORISM PREPAREDNESS GRANT FUNDS

This hospital preparedness planning document is intended to be a living document. It is the effort of a multi-disciplinary, multi-agency steering committee – ***The Sacramento Area Emergency Preparedness Coordinators*** – and will continue to meet on a regular basis to ensure that new technologies and innovations in the area of disaster preparedness are considered and incorporated into this document. Plans developed from these guidelines must be regularly reviewed, exercised, and revised to remain current and effective.

Table of Contents



A. Introduction

Hospital Council
Northern & Central California

COUNTY OF SACRAMENTO
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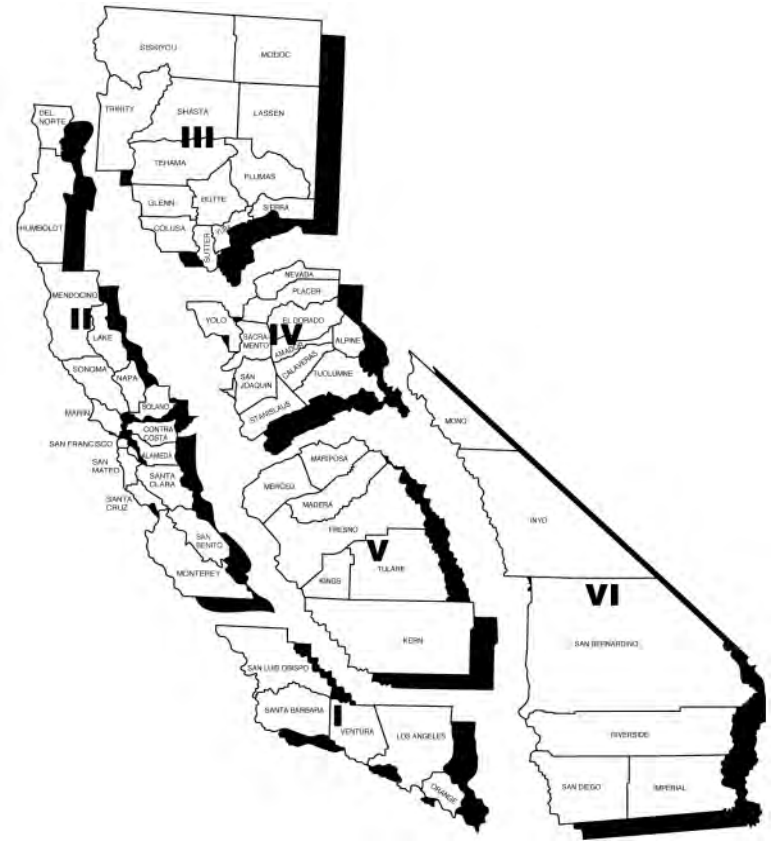
A. Introduction

Overview

This document addresses two areas: (1) the adoption of a Sacramento County Hospitals Memorandum of Understanding; and (2) the checklist outlining actions to be taken in a regional disaster surge event. Hereafter referred to as the SACRAMENTO COUNTY HOSPITALS EMERGENCY PREPAREDNESS PLAN (SCHEP Plan), this document is a product of collaborative planning to address immediate medical response requirements of hospitals in the Sacramento County area in the event of a disaster.

When disaster strikes, medical and health resources may be unavailable or inadequate to meet the demand. The California Medical/Health Mutual Aid System is designed to address these issues by identifying and facilitating the distribution of regional, state and/or federal resources to the area(s) in need. An area graduated plan with a set of triggers is required to maximize its use.

In California, the Medical/Health Mutual Aid System is composed of six regions. Each of the regions consists of several operational areas / counties and hospitals within each of the counties. If there is a shortage of resources or assistance is required during a disaster, those shortages are first filled from resources / inventories within an operational area. If needs exceed available operational area resources a request for assistance is elevated to the regional level and if necessary, then to the state level to fill those needs.



This plan will be most effective when only one or two facilities are impacted by an event and may be ineffective in a large-scale event when multiple or all hospitals in the region are impacted by the disaster.

While the California Mutual Aid System has been tested and considered reliable, hospitals in a community are encouraged to establish a Memorandum of Understanding (MOU) to share resources among themselves should an immediate need arise. Sound disaster planning, The Centers for Medicare and Medicaid Services (CMS), The Joint Commission (TJC) and the National Incident Management System (NIMS) encourage hospitals to have such agreements.

This document endorses the adoption of the Sacramento County MOU, as depicted below, developed by the members of the Sacramento Area Hospital Emergency Preparedness Coordinators.

Purpose

The purpose of this plan and mutual aid MOU is to aid hospitals in their emergency management by addressing gaps in resources needed by medical services to respond to a disaster in a timely, comprehensive, effective, and coordinated method. It is a voluntary agreement among the hospital members of *Sacramento County* but to be totally functional and effective requires participation by all member hospitals.

An incident that exceeds the effective response capability of the impacted hospital will almost always involve the *OES Region IV local area and regional Control Facilities, the local Emergency Medical Services, and the Medical Health Operational Area Coordinator.* The disaster may be an "external" or "internal" event and assumes that each affected hospital's emergency management plans have been fully implemented.

Acknowledgements of Hospitals, Agencies & Consultants

The following Hospitals, Agencies and Consultants provided valuable input, direction, and counsel regarding this plan. Its premise, information and references are recommended as a framework for planning, communication, and action when a disaster occurs.

- Hospital Council - Northern and Central California
- Kaiser Permanente Medical Center – Sacramento
- Kaiser Permanente Medical Center – Roseville
- Kaiser Permanente Medical Center - South Sacramento
- Marshall Medical Center
- Mercy General Hospital
- Mercy Hospital Folsom
- Mercy San Juan Medical Center
- Methodist Hospital of Sacramento
- Regional Disaster Medical Health Coordinator – Region IV
- Sacramento County DHHS - Public Health Division
- Sacramento County EMSA
- San Joaquin County EMSA
- Shriners Hospitals for Children – Northern California
- Sutter Davis Hospital
- Sutter Medical Center Sacramento
- Sutter Roseville Medical Center
- UC Davis Medical Center
- Veterans Affairs Medical Center
- Woodland Healthcare

Distribution

The Hospital Council is responsible for the distribution of the SCHEP Plan, annexes, and approved revisions to these plans. This plan will be distributed to the following agencies:

- Hospital Council - Northern and Central California
- Regional Disaster Medical Health Coordinator (RDMHC) – Region IV
- Sacramento Regional Office of Homeland Security
- Sacramento County, Sierra-Sacramento Valley and El Dorado County EMS Agencies
- Sacramento County and Area Hospitals
- Sacramento County Emergency Operations Office
- Sacramento County MHOAC
- Sacramento County Public Health Division, Preparedness and Response Programs
- Other agencies as required or requested.

The SCHEP plan is designed to promote cooperation among nearby health facilities in the earliest phases of disaster response, particularly prior to the initiation of formal mutual aid requests at the Operational Area level. As such, participation in this plan is not constrained by political or other boundaries. This plan may be expanded to include any health facility whose proximity to others results in interdependencies that, in a disaster, demand a more intense level of collabration than occurs on a day-to-day basis.

Sacramento County Hospitals Emergency Preparedness Plan
Record of Plan Changes

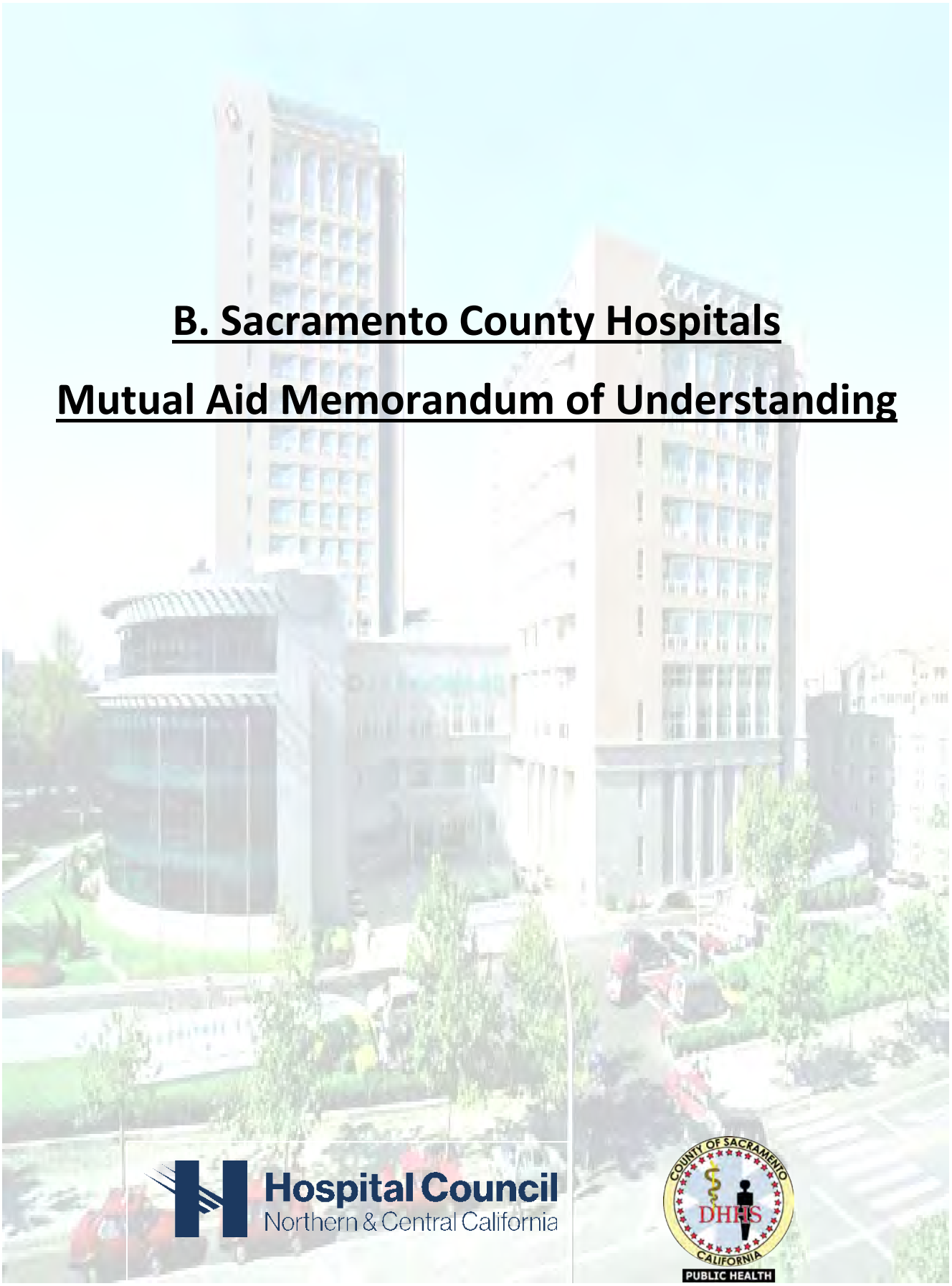
Date	Change No.	Description of Change	Person/Org. Making Change	Person Updating Plan
10/1/11	1	• Elimination of history of development project • Update County Resource Request form • Addition of collaboration with community partners • Elimination of color-coded Federal threat levels • Current signatories	CHA Hospital Council	Loni Howard Scott Seamons
5/8/14	2	• Updated MHOAC contact information • Current signatories	MHOAC Hospital Council	David Magnino Brian Jensen
12/31/14	3	• VA signatory with special provisions	VA Hospital Council	Dean Case Brian Jensen
7/26/17	4	• Updates to response staff titles and other current terminology • Addition of assumption in Intro, page A-1 • Update of various roles • Forms update • Update of hospital and Sacramento County contact information • Current signatories	Sacramento Emergency Preparedness Coordinators, Sacramento County MHOAC, Hospital Council	Ben Merin Brian Jensen
8/31/20	5	• Addition of medical/health mutual aid system and CMS to Page A-1 • Update 'healthcare facilities' to 'hospitals' • Updated MHOAC contact information • Updates to current terminology • Update of hospital contact information • Current signatories	Sacramento Emergency Preparedness Coordinators, Sacramento County MHOAC, Hospital Council	Lorraine Todden Ben Merin Brian Jensen
1/14/21	6	• Addition of Hospital Guidelines for Response to Contaminated Patients	Sacramento Emergency Preparedness Coordinators, Hospital Council	Kristina Spurgeon Brian Jensen

Plan Maintenance

1. Review – The SCHEP Plan will be reviewed biennially by the Hospital Council and the Emergency Preparedness Planning Committee or as changes are needed. Revisions or changes will be distributed to participating entities. The SCHEP Plan will be available on the Hospital Council website at https://www.hospitalcouncil.org/sacramento-sierra.

2. Update – Changes should be made to the plan and annexes when the documents are no longer current. Changes may be needed:

   - When hazard consequences or risk areas change;
   - When the concept of operations for emergencies changes;
   - When communications systems are upgraded;
   - When a training exercise or an actual emergency reveals significant deficiencies in existing planning documents; or
   - When state or federal planning standards for documents are revised.



B. Sacramento County Hospitals

Mutual Aid Memorandum of Understanding

Hospital Council
Northern & Central California

COUNTY OF SACRAMENTO
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B. Sacramento County Hospitals
Mutual Aid Memorandum of Understanding

I. Introduction and Background

Sacramento is the state capital of California located in the central region of the state. This region is susceptible to disasters, both natural and man-made, that may exceed resources of any individual hospital.

II. Purpose of Mutual Aid Memorandum of Understanding

The purpose of this mutual aid support agreement is to aid hospitals in their emergency management by addressing gaps in resources needed by medical services to respond to a disaster in a comprehensive, effective, and coordinated method and in alignment with:

- The California Public Health and Medical Emergency Operations Manual, July 2011.
- The California Disaster Medical Response Plan, California Emergency Medical Services Authority, September 2007
- The Sacramento County Healthcare Coalition, Preparedness Plan and Response Plan, 2019

This Mutual Aid Memorandum of Understanding (MOU) is a voluntary agreement among the hospital members of Sacramento County according to the California Governors Office of Emergency Services Mutual Aid and Administrative Region, Inland Region IV for the purpose of providing mutual aid at the time of a medical disaster. **Disaster** is defined as an overwhelming incident that **exceeds the effective response capability** of the impacted hospital. An incident of this magnitude will almost always involve the *OES Region IV local area and regional Control Facilities, the local Emergency Medical Services and the Medical Health Operational Area Coordinator.* The disaster may be an "external" or "internal" event for hospitals and assumes that each affected hospital's emergency management plans have been fully implemented.

This document addresses the framework among hospital and is intended to augment local, regional, and State mutual aid planning documents and plans. The MOU also provides the framework for hospitals to coordinate during planning and response. This document does not replace but rather supplements the rules and procedures governing interaction with other organizations during a disaster and is compliant with the National Response Plan (NRP), National Disaster Medical System (NDMS), National Incident Management System (NIMS), Hospital Incident Command System (HICS), Office of Emergency Services (OES), California Emergency Medical Services Authority (EMSA), Department of Public Health (DPH) and General Services MOU July 1988 and OES Region IV Multi-Casualty Plan.

III. Definition of Terms

CAHAN

California Health Alert Network (CAHAN) The web-based CAHAN system is designed to broadcast warnings of impending or current disasters affecting the ability of health officials to provide disaster response services to the public.

Control Facility (CF)

The Control Facility (CF) (referenced in this document refers to the Sacramento Co. facility) must be operational 24 hours a day. The CF uses EMResource to poll hospitals for capability in a disaster. Back-ups are the Blast phone or 800 MHz radio. The CF is that entity responsible for the dispersal of patients during all Multi-Casualty Incidents (MCI). The CF will collect a Status Report (MCM #408 or EMResource) from all receiving facilities and notify them when patients have been dispersed to them. *County – is this form # correct?*

Donor Facility

The hospital that provides personnel, pharmaceuticals, supplies or equipment to a hospital experiencing a medical disaster.

EOC

The Emergency Operations Center (EOC) - the location established by each jurisdiction to centralize coordination of all aspects of a disaster response.

EMResource

An Internet-based hospital system used by all area hospitals to report open/closed/divert status in real-time. Data request and reporting via EMResource can reach all hospitals simultaneously.

Hospital Indicators

A set of hospital resource measures that are reported to *MHOAC* during a disaster drill or actual disaster. The indicators are designed to catalogue hospital resources that could be available for other hospitals during a disaster.

HCC

Hospital Command Center (HCC). An area established in a hospital during an emergency that is the hospital's primary source of administrative authority and decision-making.

HICS

Hospital Incident Command System (HICS). The incident command structure developed to meet the needs of the hospital response to a disaster.

Impacted Hospital

The hospital where the disaster occurred or disaster victims are being treated. Referred to as the recipient hospital when pharmaceuticals, supplies, or equipment are requested or as the patient-transferring hospital when the evacuation of patients is required.

JIC

Joint Information Center (JIC). The location established for the purpose of coordinating the release of information to the press, media, and general public. The hospital will participate in providing information to the JIC and help to convey a unified message developed for release to the public.

Master Mutual Aid Agreement

The California Disaster and Civil Defense Master Mutual Aid Agreement made and entered into by and among the State of California, its various departments, and agencies of the State, in 1950. The agreement provides for support of one jurisdiction by another.

Medical Disaster

An incident that exceeds a hospital's effective response capability or that hospital cannot appropriately resolve solely by using its own resources. Such disasters will very likely involve *local and regional Control Facilities, the local MHOAC* and may involve loan of medical and support personnel, pharmaceuticals, supplies and equipment from another hospital, or the emergent evacuation of patients.

MHOAC

Medical Health Operational Area Coordinator (MHOAC) (*reference in this document refers to the Sacramento Co. entity)*. An individual appointed by a County Health Officer and LEMSA Administrator who is responsible in the event of a disaster or major incident where mutual aid is requested, for obtaining and coordinating services and allocation of resources within the Operational Area (county) as defined in Region IV Manual 3 – Medical Health Mutual Aid.

OES Region IV Multi-Casualty (MCI) Plan

The current OES Region IV Multi-Casualty (MCI) Plan is comprised of 3 interdependent manuals: Manual I – MCI Field Operations; Manual II – MCI Patient Dispersion (Control Facility Operations); and Manual III – Medical Health Mutual Aid.

Partner ("Buddy")

The designated hospital that a hospital communicates with as a hospital's "first call for help" during a medical disaster (developed through an optional partnering arrangement).

Patient-Receiving Hospital

The hospital that receives transferred patients from an impacted hospital responding to a disaster. When patients are evacuated, the receiving hospital is referred to as the patient-receiving hospital.

Patient Transferring Hospital

An impacted hospital. The hospital that evacuates patients to a patient-receiving hospital in response to a medical disaster.

Participating Hospitals

Hospitals that have fully committed to the MOU. This list of Participating Hospitals shall be maintained and disseminated by the Hospital Council NCC/CHA.

Recipient Hospital

The impacted hospital. The hospital where disaster patients are being treated and have requested personnel or materials from another hospital.

Regional Control Facility

The Regional Control Facility (RCF) will operate under the same guidelines as a county CF. The State of California is divided into six regions for purpose of mutual aid during emergency situations. Region IV consists of eleven counties:

Alpine - Amador - Calaveras - El Dorado - Nevada -Placer

Sacramento - San Joaquin - Stanislaus - Tuolumne - Yolo

The *Regional Control Facility (RCF)* must be operational 24 hours a day. The RCF uses MedNet for radio communications. Primary back up systems are other redundant communication systems.

Regional Disaster Medical Health Coordinator (RDMHC)

A volunteer local health officer, EMS agency Coordinator of Emergency Services or EMS agency administrator jointly appointed by the Directors of the California Department of Public Health (CDPH) and the Emergency Medical Services Authority (EMSA) based upon the recommendation of the local health officer for a mutual aid region. The role of the RDMHC is to plan for and coordinate medical and health resources within one of California's six mutual aid regions during times of disaster or other major event requiring medical or health mutual aid.

Regional Disaster Medical Health Specialist (RDMHS)

An individual selected by a local EMS agency, under contract with EMSA and California Department of Public Health, as a staff function to coordinate preparedness activities, and assist the RDMHC in coordinating services in the event of a disaster or in the event that medical mutual aid of some type is requested.

Sacramento County Operational Area

The operational area is the intermediate level of the state emergency services organization consisting of a county and all political subdivisions within the county geographic area. With that in mind, the primary stakeholders in this MOU are the 9 hospitals and emergency departments within the Sacramento County Operational area, in coordination with representatives from other hospitals, public safety, public health, and emergency management who meet to plan, train, and exercise together in order to best assure a coordinated timely and effective response to a disaster.

IV. General Principles of Understanding

1. Participating Hospitals: Each hospital designates a representative to attend the Area's Emergency Preparedness Coordinator meetings and to coordinate the mutual aid initiatives with the individual hospital's emergency preparedness management plans. Hospitals also commit to participating in exercises and maintaining a reliable surveillance and communications capability to detect emergencies and communicate response efforts to organization response personnel, patients, and external agencies.

   Each hospital will participate in an annual exercise that includes communicating to its MHOAC a set of hospital standardized data elements or indicators describing the hospital's resource capacity. (See attached forms). The *MHOAC* will serve as an information center for recording and disseminating the type and amount of available resources at each hospital.

   Other community partners collaborate with hospitals during disaster/surge planning events and provide resources, such as:

   Sacramento County Mental Health Treatment Center (MHTC)
   - Psychiatric services
   - Psychiatric staff and physician coverage

   American Red Cross – Sacramento
   - Patient/family reunification
   - Patient/family resource needs

   Vitalant – Sacramento
   - Surge planning expertise (blood supplies and distribution)

2. HCC: The impacted facility's Hospital Command Center is responsible for informing the *MHOAC* of its situation and defining needs that cannot be accommodated by the hospital itself or any existing partner hospital. Notifying other area hospitals of its situation can be expedited by using a common communication or reporting system such as EMResource. The hospital Incident Commander or designee is responsible for requesting personnel, pharmaceuticals, supplies, equipment, or authorizing the evacuation of patients. The Incident Commander or designee will coordinate both internally, and with the receiving hospitals, all the logistics involved in implementing assistance under this Mutual Aid MOU. Logistics include identifying the number and specific location where personnel, pharmaceuticals, supplies, equipment, or patients should be sent, how to enter the security perimeter, estimated time interval to arrival and estimated return date of borrowed equipment, supplies, and/or personnel, etc.

3. Financial & Legal Liability: The recipient hospital will assume legal responsibility for the personnel and equipment from the donor hospital during the time the personnel

equipment and supplies are at the recipient hospital. The recipient hospital will reimburse the donor hospital for the donor hospital's actual costs of providing personnel and assistance. Costs includes, but are not limited to all the use, and return costs of borrowed materials, the replacement of any damaged or lost equipment, and cost of borrowed personnel's salary and benefits. Reimbursement will be made within ninety days following receipt of the invoice. Documentation of costs incurred will be standardized throughout the participating hospitals.

4. Patient Responsibility: Patient-receiving hospitals assume the legal and financial responsibility for transferred patients upon arrival into the patient-receiving hospital.

5. Emergency Management Committee Chairperson: Each hospital's Emergency Management Committee Chairperson is responsible for disseminating the information regarding this MOU to relevant hospital personnel, coordinating and evaluating the hospital's participation in exercises of the mutual aid system, and incorporating the MOU concepts into the hospital's emergency management plan.

V. General Principles Governing Medical Operations, the Transfer of Pharmaceuticals, Staff, Supplies or Equipment, or the Evacuation of Patients

1. Partner Hospital Concept: Each hospital has the option of linking to a designated partner or "buddy" hospital as the hospital of first call for help during a disaster. The hospital comprising each partner-network should develop, prior to any medical disaster, methods for coordinating communication between themselves, responding to the media, and identifying the locations to enter their buddy hospital's security perimeter. The MHOAC needs to be made aware of any "buddy" partnerships that exist within their area of responsibility.

2. Request for Assistance and/or Request for Transfer: The Incident Commander (or designee) for the recipient hospital (patient-transferring hospital) is responsible for notifying and informing the MHOAC of its personnel or material needs (as stated in the California Public Health and Medical Emergency Operations Manual, July 2011and OES Region IV Multi-Casualty (MCI) Plan) or its need to evacuate patients and the degree to which its partner hospital is unable to meet these needs. The MHOAC will assist in contacting the other participating hospitals as required to determine the availability of additional personnel or material resources, including the availability of beds, as required by the situation. The MHOAC will inform the Incident Commander which hospitals to contact directly for assistance that has been offered. The Incident Commander (or designee) of the recipient or patient-transferring hospital will coordinate directly with the Incident Commander (or designee) of the donor or patient-receiving hospital for this assistance.

3. Donor or Patient-receiving Hospital: The Incident Commander (or designee) hospital is responsible for approving the transfer or receipt of personnel, material, or resources to and from its hospital. The Incident Commander (or designee) determines the amount and acuity of patients it can accept into its hospital.

4. Personnel Offered by Donor Hospitals: Should be limited to staff that are in good standing privileged and credentialed (when applicable) in the donor institution. Assistance can be

accepted by resident physicians, medical/nursing and allied health students, or in-training persons if desired by the recipient hospital.

The Incident Commander (or designee) of care hospital will update the MHOAC regarding the status of assistance and/or acceptance of patients it is providing.

VI. Specific Principles of Understanding

A. Medical Operations/Loaning Personnel

1. Communication of Request: The request for the transfer of personnel initially can be made verbally. The request, however, must be followed up with written documentation. Request will follow the format as defined in Region IV Manual 3 – Medical Health Mutual Aid. See Request Form in appendix. This should ideally occur prior to the arrival of personnel at the recipient hospital. The recipient hospital will identify to the donor hospital the following:

    a. The type and number of requested personnel.

    b. An estimate of how quickly the request is needed.

    c. The location where they are to report.

    d. An estimate of how long the personnel will be needed.

2. Documentation: The arriving donated personnel will be required to present their donor hospital identification badge at the check-in site designated by the recipient hospital's command center. The recipient hospital will be responsible for the following:

    a. Meeting the arriving donated personnel (usually by the recipient hospital's security department or designated employee).

    b. Providing adequate identification, e.g., "visiting personnel" badge, to the arriving donated personnel.

3. Safety Training: Recipient hospital should provide safety training and just-in-time training specific to the role and responsibilities of donated personnel.

4. Staff Support: The recipient hospital shall provide food, housing and/or transportation for donor hospital personnel asked to work for extended periods and for multiple shifts. The costs associated with these forms of support will be borne by the recipient hospital.

5. Financial Liability: The recipient hospital will reimburse the donor hospital for the salaries and benefits of the donated personnel at the donated personnel's rate as established at the donor hospital if the personnel are employees being paid by the donor hospital. The reimbursement will be made within ninety days following receipt of the invoice.

6. Labor Pool and Credentialing Unit Leader and Medical Staff Services: The recipient hospital will be responsible for providing a mechanism for granting emergency privileges for physicians, nurses, and other licensed hospitals to provide services at the recipient hospital.

7. Demobilization Procedures: The recipient hospital will provide and coordinate any necessary demobilization procedures and post-event stress debriefing.

B. Transfer of Pharmaceuticals, Supplies or Equipment

1. Communication of Request: The request for the transfer of supplies, pharmaceuticals or equipment initially can be made verbally. Request will follow the format as defined in Region IV Manual 3 – Medical Health Mutual Aid. The request, however, must be followed up with a written communication. See Request Form in appendix. This should ideally occur prior to the receipt of any material resources at the recipient hospital. The recipient hospital will identify to the donor hospital the following:

    a. The quantity and exact type of requested items.

    b. An estimate of how quickly the request is needed.

    c. Time period for which the supplies, equipment, and medications will be needed.

    d. Location to which the supplies, equipment, and medications should be delivered.

    The donor hospital will identify how long it will take them to fulfill the request. **Since response time is a central component during a disaster response, decision and implementation should occur quickly**.

2. Documentation: The recipient hospital will honor the donor hospital's standard order requisition form as documentation of the request and receipt of the materials. The recipient hospital's security office or designee will confirm the receipt of the material resources. The documentation will detail the following:

    a. The items involved.

    b. The condition of the equipment prior to the loan (if applicable).

    c. The responsible parties for the borrowed material.

    The donor hospital is responsible for tracking the borrowed inventory through their standard requisition forms. Upon the return of the equipment, etc, the original invoice will be co-signed by the Incident Commander or designee of the recipient hospital recording the condition of the borrowed equipment.

3. Transporting of Pharmaceuticals, Supplies, or Equipment: The recipient hospital is responsible for coordinating the transportation or paying the transportation cost of materials both to and from the donor hospital. This coordination may involve government and/or private organizations, and the donor hospital may also offer transport. Upon request, the receiving hospital must return and pay the transportation fees for returning or replacing all borrowed material. Assistance for government transport should also be directed through the MHOAC.

4. Supervision: The recipient hospital is responsible for appropriate safeguards, use and maintenance of all borrowed pharmaceuticals, supplies or equipment.

5. Financial Liability: The recipient hospital is responsible for reimbursing the donor hospital for all costs arising from the use, damage, or loss of borrowed pharmaceuticals, supplies, or equipment.

6. Demobilization Procedures: The recipient hospital is responsible for the rehabilitation and prompt return of the borrowed equipment to the donor hospital.

C. Transfer/Evacuation of Patients

1. Communication of Request: The request for the transfer of patients initially can be made verbally. The request, however, must be followed up with a written communication prior to the actual transferring of any patients. The patient-transferring hospital will identify to the patient-receiving hospital:

    a. The number of patients needed to be transferred.

    b. The general nature of their illness or condition.

    c. Any specialized services required, e.g., ICU bed, burn bed, trauma care, etc.

2. Documentation:

    The patient-transferring hospital is responsible for providing the patient-receiving hospital with the patient's medical records, insurance information, Medication Administration Record, emergency contact / next of kin information and other patient information necessary for the care of the transferred patient. The patient-transferring hospital is responsible for tracking the destination of all patients transferred out. Post disaster, the patient–transferring hospital will coordinate with the patient–receiving hospital for the care and return of patients transferred during the disaster event.

    Upon discharge of the transferred patient, the patient-receiving hospital will return to the patient-transferring hospital all original medical records, including X-ray films, transferred with the patient.

3. Transporting of Patients: The patient-transferring hospital is responsible for coordinating through EMS/MHOAC the transportation of patients to the patient-receiving hospital. The patient-receiving hospital's Incident Commander or designee will designate the point of entry for the receiving hospital. Once admitted, that patient becomes the patient-receiving hospital's patient and under care of the patient-receiving hospitals admitting physician until discharged, transferred, or reassigned. The patient-transferring hospital is responsible for the transferring of extraordinary drugs or other special patient needs (e.g., equipment, blood products) along with the patient if requested by the patient-receiving hospital.

4. Supervision: The patient-receiving hospital will designate the patient's admitting service, the admitting physician for each patient, and, if requested, will provide at least temporary courtesy privileges (including evaluation, treatment, and documentation) to the patient's original attending physician.

5. Patient Responsibility: Upon admission, the patient-receiving hospital is responsible for the patient's care.

6. Notification: The patient-transferring hospital is responsible for communicating with the patient and patient's family / personal representative about the transfer. The patient-receiving hospital may assist in notifying the patient's family / personal representative and the patient's personal physician.

D. Communication/Coordination

EMResource provides the means for notification to the hospitals. Communication by the Control Facility will be by EMResource, the blast phone, the 800-megahertz radio or other suitable devices.

1. In the event of a disaster or during a disaster drill, hospitals will be prepared to provide the *Control Facility* the following information:

   The total number of victims your Emergency Department can accept, and if possible, the number of victims with minor and major injuries. A simple method can be used to determine an emergency department capability to accept patients in the different categories of care: the number of immediate, delayed and minor patients the hospital can take; if the hospital agreed to take immediate patients, the name of the surgeon must be included. Report whether the hospital has decon capability.

   Each column defines the type of patient and Patient Team and resources to accept the number of patients in each type.

Immediate	**Delayed**	**Minor**
ED Physician or Surgeon	ED Physician or Surgeon	
MICN / RN	MICN / RN	MICN / RN
ICU / ED LVN	ICU / ED LVN	LVN
Resp Tech		Assistant
1 ED Bed	2 ED Bed	
For Each Immediate Patient	For Two Delayed Patients	For Five Minor Patients

2. The *MHOAC* serves as the data center for collecting and disseminating current information about equipment, bed capacity and other hospital resources during a disaster. (See Appendix forms) The information collected by the MHOAC is to be used only for disaster preparedness and response.

   a. Total number of beds currently available to accept patients in the following units:

      1) **Adult Intensive Care (ICU):** beds that can support critically ill/injured patients, including ventilator support

      2) **Medical/Surgical**: also thought of as "Ward" beds

3) **Burn**: thought of as Burn ICU beds, either approved by the American Burn Association or self-designated (These beds are NOT to be included in other ICU bed counts.)

4) **Pediatric ICU**: as for Adult ICU, but for patients 17 years and younger

5) **Pediatrics**: "Ward Medical/Surgical" beds for patients 17 and younger

6) **Psychiatric**: "ward" beds on a closed/locked psychiatric unit or ward beds where a patient will be attended by a sitter

7) **Negative Pressure/Isolation**: beds provided with negative airflow, providing respiratory isolation. NOTE: This value may represent available beds included in the counts of other types.

8) **Operating Rooms**: an operating room that is equipped and staffed and could be made available for patient care in a short period of time.

b. For the purposes of estimating institutional surge capability in dealing with patient disposition during a large mass casualty incident, bed availability estimates should be reported for each of the bed types described above, including:

- **24 hr Beds Available:** This value represents an informed estimate as to how many vacant (staffed, unoccupied) beds for each bed type above the current number that could be made available within 24 hours. This would include created institutional surge beds as well as beds made available by discharging/transferring patients.

c. The number of items currently available for loan, donation, or use by another hospital:

1) Ventilators (adult/pediatric)

2) IV infusion pumps

3) Dialysis machines

4) Hazmat decontamination equipment

5) Hazmat PPE

6) Mobile x-ray equipment

7) External pacemakers

8) Designated medications

9) Bedside monitoring device

10) Monitor defibrillators

11) Pulse ox / ETCO2

12) Transport equipment (stretcher, wheelchair, etc.)

13) Transport vehicles

d. The following number of personnel currently available for loan to another hospital:

Physicians:	Anesthesiologists
	Emergency Medicine
	General Surgeon
	Internist
	OB-GYN
	Pediatricians
	Trauma Surgeons
Registered Nurses:	Emergency
	Critical Care
	Medical/Surgical
	Operating Room
	Pediatrics
Other Personnel:	Behavioral Health Workers
	Laboratory Personnel
	Maintenance Workers
	Nurse Anesthetists
	Nurse Practitioners
	Physician Assistants
	Residents, Other Persons in Training
	Radiology Personnel
	Respiratory Therapists
	Plant Engineers
	Security Workers
	Social Workers
	Others as indicated

E. Partner Hospital Concept (Optional)

Each "buddy" hospital should standardize a set of contacts to facilitate communications during a disaster in conjunction with the MHOAC.

The procedural steps in the event of a disaster are as follows:

1. Determine the total number of patients the emergency department and hospital can accept, and if possible, the total number of patients with major and minor injuries.

2. Impacted hospital contacts partner hospital to determine availability of beds, equipment, supplies and personnel. (Contacts secondary partner hospital if primary hospital is unable to meet needs.)

3. Impacted hospital contacts the MHOAC and notifies the MHOAC of its needs, how they are being met, and any unmet needs.

4. At the request of the impacted hospital, the MHOAC will contact other hospitals to alert them to the situation and to begin an inventory for any possible or actual unmet needs.

This Memorandum of Understanding has been reviewed and endorsed by the Sacramento County EMSA, Sacramento County Public Health, and Sacramento City/County OES.

Signing this MOU is evidence that the hospital leadership intends to abide by the terms of the MOU in the event of a medical disaster as described above. The terms of this MOU are to be incorporated into the hospital's emergency response plans.

VII. General Provisions, Sacramento County Hospital's MOU

1. Term. This MOU shall commence upon execution by an authorized officer of Hospital and notification to MHOAC and shall continue until terminated. A Participating Hospital may terminate its participation in this MOU at any time upon providing 60 days written notice to Hospital Council - Northern and Central California.

2. Review. This MOU will be reviewed annually by the participating parties. Changes will be coordinated by the HCNCC and documents reissued for signature as required.

3. Miscellaneous. This MOU may not be assigned and shall be governed under California law and may be amended upon written consent of the Participating Hospitals. This MOU contains the entire agreement of the subject matter contained herein and shall give rights to no other parties except where expressly stated. In the event a court of competent jurisdiction deems one or more provisions invalid, the remaining provisions shall remain in full force and effect. Waiver of any breach shall not operate to be a waiver of any other or subsequent breach. The Participating Hospitals shall work in good faith to keep the confidentiality of patient and other records as required by law.

4. Certification. A signed copy of this MOU signature page shall be sent via mail to the Hospital Council - Northern and Central California on the date of signature.

Executed below by an authorized officer of Participating Hospital:

Chad Hickerson / C. Hick

Name & Signature

CEO

Title

Heritage Oaks Hospital

Hospital

Sacramento

City

09/23/2020

Date

VII. General Provisions, Sacramento County Hospital's MOU

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4. Certification. A signed copy of this MOU signature page shall be sent via mail to the Hospital Council - Northern and Central California on the date of signature.

Executed below by an authorized officer of Participating Hospital:

Sandy Shavon
Name & Signature

SVP+Area Manager
Title

Kaiser Permanente
Sacramento, Morse Ave.
Hospital

Sacramento
City

9-15-2020
Date

VII. General Provisions, Sacramento County Hospital's MOU

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4. Certification. A signed copy of this MOU signature page shall be sent via mail to the Hospital Council - Northern and Central California on the date of signature.

Executed below by an authorized officer of Participating Hospital:

Patricia M. Rodriguez

Name & Signature

SVP. Area Manager

Title

KP South Sacramento

Hospital

Sacramento, CA

City

9/15/2020

Date

VII. General Provisions, Sacramento County Hospital's MOU

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4. Certification. A signed copy of this MOU signature page shall be sent via mail to the Hospital Council - Northern and Central California on the date of signature.

Executed below by an authorized officer of Participating Hospital:

Michael R. Kaspiel MICHAEL R. KASPIEL

Name & Signature

President

Title

Mercy Folsom

Hospital

Folsom

City

9/2/2020

Date

VII. General Provisions, Sacramento County Hospital's MOU

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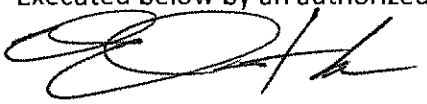
4. Certification. A signed copy of this MOU signature page shall be sent via mail to the Hospital Council - Northern and Central California on the date of signature.

Executed below by an authorized officer of Participating Hospital:



Edmundo Castaneda
Name & Signature

President
Title

Dignity Health Mercy General Hospital
Hospital

Sacramento
City

9/8/2020
Date

VII. General Provisions, Sacramento County Hospital's MOU

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4. Certification. A signed copy of this MOU signature page shall be sent via mail to the Hospital Council - Northern and Central California on the date of signature.

Executed below by an authorized officer of Participating Hospital:

Michael R. Koepsel MICHAEL R. KOEPSEL
Name & Signature

PRESIDENT
Title

Mercy San Juan Medical Center
Hospital

1 Carmichael
City

9/2/2020
Date

VII. General Provisions, Sacramento County Hospital's MOU

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4. Certification. A signed copy of this MOU signature page shall be sent via mail to the Hospital Council - Northern and Central California on the date of signature.

Executed below by an authorized officer of Participating Hospital:

Phyllis Boltz

Name & Signature

Hospital President

Title

Methodist Hospital

Hospital

Sacramento, CA

City

9/2/2020

Date

VII. General Provisions, Sacramento County Hospital's MOU

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4. Certification. A signed copy of this MOU signature page shall be sent via mail to the Hospital Council - Northern and Central California on the date of signature.

Executed below by an authorized officer of Participating Hospital:

_____
Name & Signature

CEO
_____
Title

Sacramento Behavioral Healthcare Hospital, Inc.
_____
Hospital

Sacramento
_____
City

9/17/2020
_____
Date

VII. General Provisions, Sacramento County Hospital's MOU

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4. Certification. A signed copy of this MOU signature page shall be sent via mail to the Hospital Council - Northern and Central California on the date of signature.

Executed below by an authorized officer of Participating Hospital:

Margaret Bryan

Name & Signature

Administrator / CEO

Title

Shriners Hospitals for Children Northern California

Hospital

Sacramento

City

9/9/2020

Date

VII. General Provisions, Sacramento County Hospital's MOU

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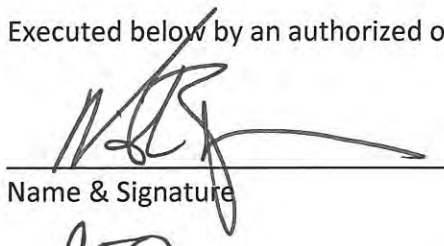
Executed below by an authorized officer of Participating Hospital:



Name & Signature

CEO

Title

SIERRA VISTA HOSPITAL

Hospital

SACRAMENTO

City

9/2/20

Date

VII. General Provisions, Sacramento County Hospital's MOU

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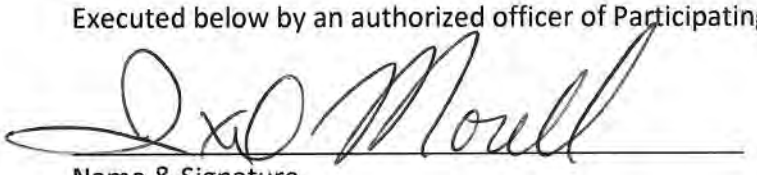

Name & Signature

Ixel Morell, Executive Director
Title

Sutter Center for Psychiatry
Hospital

Sacramento
City

9/10/2020
Date

VII. General Provisions, Sacramento County Hospital's MOU

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Executed below by an authorized officer of Participating Hospital:

__Dave Cheney_____
Name & Signature

__Chief Executive Officer_____
Title

___Sutter Medical Center, Sacramento_____
Hospital

___Sacramento_____
City

___September 10, 2020_____
Date

VII. General Provisions, Sacramento County Hospital's MOU

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Executed below by an authorized officer of Participating Hospital:

Name & Signature

Interim Chief Executive Officer
Title

UC Davis Medical Center
Hospital

Sacramento
City

9/24/20
Date

VII. General Provisions, Sacramento County Hospitals MOU

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4. The VA, an agency of the United States Government, is generally not bound by state law due to the Supremacy Clause of the United States Constitution. Where not in conflict with federal law, VA may comply with state law. Participation by the Department of Veterans Affairs is limited by certain statutory obligations that take precedence over the responsibilities under this Mutual Aid MOU. The Stafford Act (42 USC 5121 et seq) requires the Federal Government to respond to major disasters and emergencies initiated by Presidential declaration and may direct any Federal agency to use its authorities and resources to support State and local assistance efforts. The FEMA Interim Federal Response Plan [42 USC 5170a(l) and 5192(a)(l); Executive Orders 12148, 12673] requires Federal agencies to respond to the FEMA Director's request to provide assistance to support State and local efforts. The VA's ability to assist the local facility under this MOU is also subject to participation in the National Disaster Medical Systems, which provides resources for natural and man-made disasters and supports patient treatment requirements for armed conflict. Under 38 USC 811 l(a)(l), the Secretary of Veterans Affairs is required to maintain a contingency capacity of hospital beds to assist the Department of Defense in a time of war or national emergency. Finally, 38 USC 1784 requires VA to assist non-veteran patients referred to a VA facility on a humanitarian basis outside the Stafford Act.

5. VA cannot agree to the reimbursement as set forth in the MOU as it would violate the Anti-Deficiency Act. VA cannot agree to be legally liable for personnel who are not performing duties within the scope of federal employment and VA cannot ever be liable for acts that are not negligent in nature. VA cannot agree to share resources in the absence of a sharing agreement with the sharing partner. VA will act to supplement state responses in the event of a public health emergency where the Health and Human Services Secretary leads the VA to respond or where the President of the United States declares an emergency under the Stafford Act. Communication of patient information may be limited due to HIPAA and the Privacy Act.

6. Certification. A signed copy of this MOU signature page shall be sent via mail to the Hospital Council - Northern and Central California on the date of signature.

Executed below by an authorized officer of Participating Hospital:

DAVID STOCKWELL

Name & Signature

Medical Center Director

Title

Sacramento VA Medical Center

Hospital

Mather, CA

City

10/13/2020

Date

VII. General Provisions, Sacramento County Hospital's MOU

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Executed below by an authorized officer of Participating Hospital:

MARK CARDENAS
Name & Signature

Director of Plant OPERATIONS
Title

VIBRA HOSPITAL OF SACRAMENTO
Hospital

FOLSOM, CA
City

9/1/20
Date

VIII. Reports & Forms

Sacramento County MHOAC

Office Ph: 916-875-9753
MHOAC Fax: 916-854-9211
Emergency/24hr:
916-208-5958 or 916-875-6900
ask for the MHOAC or the EMS Agency Duty Officer

MHOAC Email:
MHOAC@saccounty.net

For online access to forms and additional information, please go to:

http://www.dhhs.saccounty.net/PRI/EMS/Pages/Medical-Health-Operational-Area-Corrdinator.aspx

The following forms are included in this SCHEP Plan:
1. Sacramento County Emergency Operations Center Facility Status Worksheet
2. Sacramento County Health Facility Status Report
3. Situation Report (SITREP)
4. Sacramento County Resource Request Medical and Health (RRMH) Completion Instructions
5. Resource Request: Medical and Health (FIELD/HCF2 to Op Area)
6. Order Sheet (3 pages)
7. Authorization Tracking Form
8. Personnel Available for Loan
9. Hospital Equipment Collection Form

Sacramento County Emergency Operations Center
Facility Status Worksheet

Date: _____ Time: _____ Facility: _____

Contact Name: _____ HICS position: _____

Contact phone: _____ Fax: _____

In-Patient Bed Status			
Type of bed	**Current #**	**# beds available**	**Comments**
ICU			
Med Surg			
Tele			
Neuro			
OB GYN			
Pediatric ICU			
Pediatric			
NICU			
Burn			
Psych			

Emergency Department Activity Status		
Activity	**Approx #**	**Comments**
# Patients seen		
# Immediates		
# Delayed		
# Minor		
# Surgeries		
# Deaths		
# Admitted		
# Discharged		

General Facility Status			
Item	**Functional**	**Not Functional**	**Comments**
Power			
Water/Sewer			
Other utilities			
Phones			
Security			
Supplies			
IT			

Personnel Available for Loan

Forward to MHOAC when Offered or Requested

Hospital: _____ Date: _____

When Available:_____ Incident Name: _____

Physicians:	**Quantity**	**Registered Nurses:**	**Quantity**
Anesthesiologists		Anesthetists	
Emergency Medicine		Emergency Medicine	
General Surgeon		Operating Room	
Internist		Medical/Surgical	
OB-GYN		OB-GYN	
Pediatricians		Pediatric	
Trauma Surgeons		Trauma	
Other Personnel:			
Behavioral Health Workers		Residents	
Laboratory Personnel		Radiology Personnel	
Maintenance Workers		Respiratory Therapists	
Nurse Anesthetists		Plant Engineers	
Nurse Practitioners		Security Workers	
Physician Assistants		Social Workers	
Others Identify:			

Sacramento County MHOAC
Phone: 916-208-5958 or 916-875-6900
MHOAC Fax: 916-875-9711
24/7 Email: MHOAC@saccounty.net

Example
Hospital Equipment
Collection Form

	Kaiser North	Kaiser South	Mercy General	Mercy Folsom	Mercy San Juan	Methodist	Shriners	Sutter Memorial	Sutter General	UC Davis	VA North California
Ventilators Adult/Pediatric											
IV Infusion Pumps											
Dialysis Machines											
Decon Equipment											
HazMat PPE											
Mobile X-ray Equipment											
External Pacemakers											
Designated Medications											
Bedside Monitoring Devices											
Monitor/ Defibrillator											
Pulse Ox / ETCO2											
Transport Equipment											
Transport Vehicles											

IX. Hospital Contact Information

Sacramento County Hospitals

Kaiser Permanente Sacramento Medical Center
2025 Morse Avenue
Sacramento, CA 95825
Sacramento County
916-973-5000
www.kaiserpermanente.org

Kaiser Permanente South Sacramento Medical Center
6600 Bruceville Road
Sacramento, CA 95823
Sacramento County
916-688-2000
www.kaiserpermanente.org

Mercy General Hospital
4001 J Street
Sacramento, CA 95819
Sacramento County
916-453-4545
https://www.dignityhealth.org/sacramento/locations/mercy-general-hospital

Mercy Hospital of Folsom
1650 Creek side Drive
Folsom, CA 95630
Sacramento County
916-983-7400
https://www.dignityhealth.org/sacramento/locations/mercy-hospital-of-folsom

Mercy San Juan Medical Center
6501 Coyle Avenue
Carmichael, CA 95608
Sacramento County
916-537-5001
https://www.dignityhealth.org/sacramento/locations/mercy-san-juan-medical-center

Methodist Hospital of Sacramento
7500 Hospital Drive
Sacramento, CA 95823
Sacramento County
916-423-3000
https://www.dignityhealth.org/sacramento/locations/methodist-hospital-of-sacramento

Shriners Hospitals for Children - Northern California
2425 Stockton Boulevard
Sacramento, CA 95817
Sacramento County
916-453-2000
https://www.shrinershospitalsforchildren.org/Locations/northerncalifornia

Sutter Medical Center-Sacramento
2825 Capitol Avenue
Sacramento CA 95816
Sacramento County
916-887-0000
http://suttermedicalcenter.org/

UC Davis Health System
2315 Stockton Boulevard
Sacramento, CA 95817
Sacramento County
916-734-2011
http://www.ucdmc.ucdavis.edu/medicalcenter/

VA Medical Center
10535 Hospital Way
Mather, CA 95655
916-366-7000
www.northern-california.med.va.gov

Vibra Hospital of Sacramento
330 Montrose Drive
Folsom, CA 95630
916-351-9151
https://www.vibrahealthcare.com/sacramento/

Behavioral Health Facilities

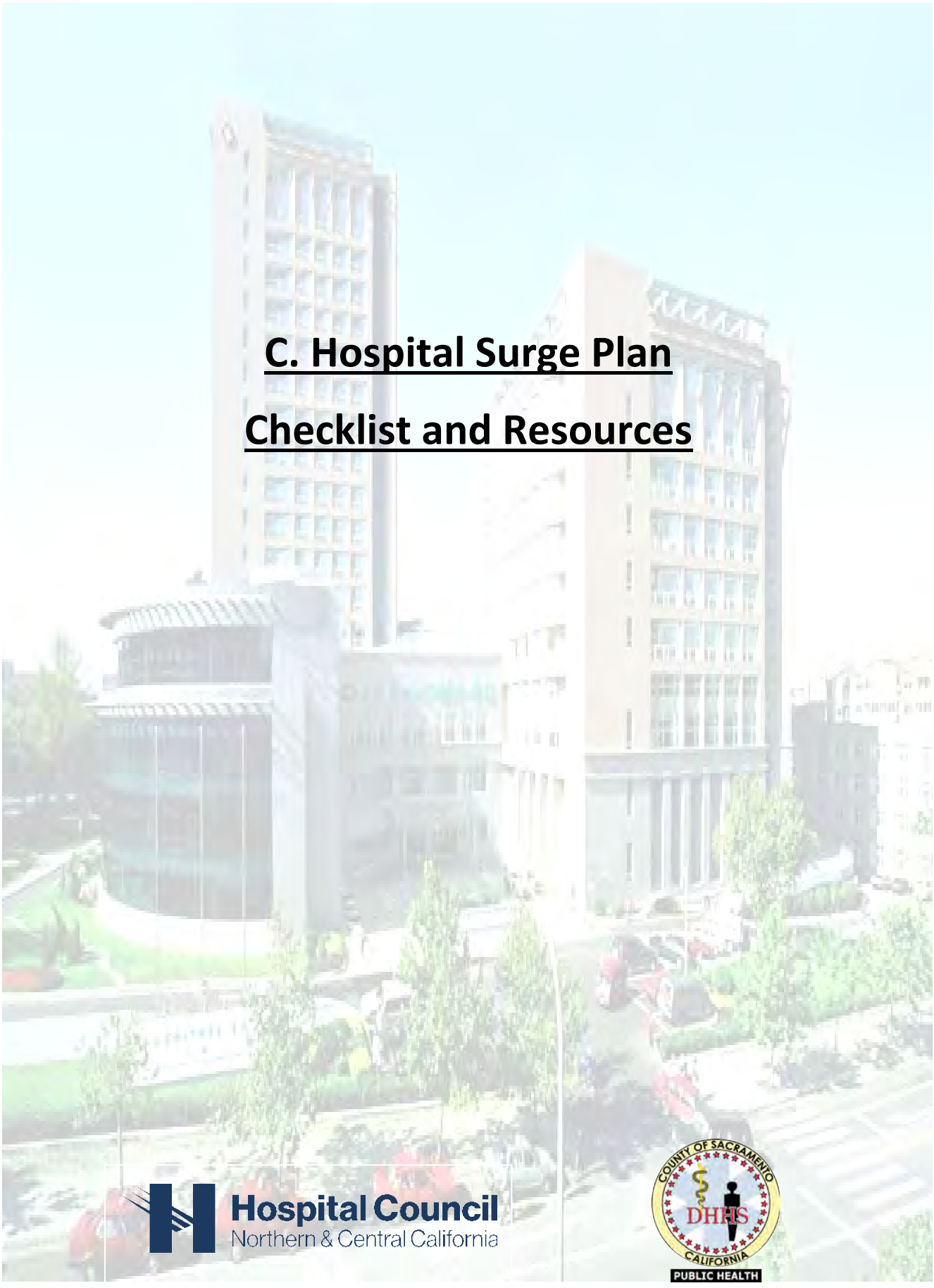
Heritage Oaks Hospital
4250 Auburn Blvd.
Sacramento, CA 95841
Sacramento County
916-489-3336
www.heritageoakshospital.com

Sacramento Behavioral Healthcare Hospital
1400 Expo Parkway
Sacramento, CA 95815
877-978-4848
https://sacramentobehavioral.com

Sacramento County Mental Health Treatment Center
2150 Stockton Blvd.
Sacramento, CA 95817
Sacramento County
916-875-1000
www.sacdhhs.com

Sierra Vista Hospital
8001 Bruceville Road
Sacramento, CA 95823
Sacramento County
916-288-0300
www.sierravistahospital.com

Sutter Center for Psychiatry
7700 Folsom Blvd.
Sacramento, CA 95826
Sacramento County
916-386-3000
www.suttermedicalcenter.org/psychiatry



C. Hospital Surge Plan

Checklist and Resources

Hospital Council
Northern & Central California

COUNTY OF SACRAMENTO
DHHS
CALIFORNIA
PUBLIC HEALTH

HOSPITAL SURGE PLAN CHECKLIST AND RESOURCES

Overview

Purpose: The purpose of the Hospital Surge Plan Checklist and Resources is to assist hospitals in developing and/or updating their plans for response to a significant surge event, as well as to provide tools, examples and guides to assist with plan development and implementation.

Definition of Surge: As defined by the State in consultation with hospitals throughout the state, a working definition is:

A Surge Event is a significant event or circumstances that impact the hospital delivery system resulting in excess demand over capacity and/or capability in hospitals, community care clinics, public health departments, other primary and secondary care providers, resources, and/or emergency medical services.

This definition does not take into consideration the scope of the event or the time between the onset of surge and a local or statewide proclamation of an emergency and/or issuance of gubernatorial executive orders waiving specific licensing and scope of practice requirements. Therefore, hospital planners need to consider the following in Surge Plan activation:

No gubernatorial waiver of existing regulations: *Local or regional event that may require mutual aid from outside the region.* Hospital activates plans to create and expand capacity within existing licensing and other regulatory requirements (e.g., discharge or transfer patients, cancel or delay admissions), or, seeks program flex approval from State Licensing and Certification for short-term expansion of capacity (e.g., surge tents, ED beds, altered/expanded use of inpatient facilities).

Gubernatorial Waiver of existing regulations*: Multi-area or statewide event(s) that require mutual aid from outside the region*. Hospital activates plans to create and expand capacity and capability using alternative treatment areas, modified/expanded use of licensed facilities, and waiver of selected regulatory requirements (e.g., altered/expanded use of inpatient facilities, nursing ratios, isolation areas, surge tents, clinics, cafeterias, auditoriums, etc.).

For planning purposes, hospitals should assume that there will be a prolonged community-wide surge of ambulatory and inpatient cases that will overwhelm existing resources.

Surge Plan Options: A hospital's Surge Plan may be incorporated into its Emergency Operations Plan (EOP), be an addendum to the EOP, or may include a series of policies, procedures and protocols referenced in the EOP. Many of the elements that should be addressed in developing Surge Plans may already be included in the EOP or other hospital plans, policies, procedures, or protocols. It is not intended that these documents be duplicated in the hospital's Surge Plan, but that surge be addressed in the EOP and other documents and the documents themselves be referenced in the Surge Plan.

Surge Plans (and policies and procedures) should address internal and external communication regarding current emergency status for surge levels, regulatory status, the type, scope and expected duration of an event, and escalation and de-escalation as new information is received. The strength of a good plan is to have adequate detail to allow implementation by staff who may not be very familiar with the plan. Job action sheets, task checklists and other tools for activating and operationalizing the surge plan can be developed for this purpose. Policy and background documentation should be referenced and available but should not serve as primary resources providing direction at the onset of a surge event.

Using the Checklist: The individual(s) responsible for disaster planning should review the Hospital Surge Plan Checklist to ensure that their plans incorporate each item listed. It may be helpful to the user to note where the specific item is addressed (e.g., EOP chapter 3, Surge Plan, Section 2, P&P Credentialing, etc.).

This checklist should be used as one of several tools for evaluating current plans or in developing a Surge Plan, including State of California Surge Standards and Guidelines. Plans should be consistent with your hospital's role in local emergency management plans for disaster response. Hospitals should ensure that their plans comply with applicable state and federal regulations and with standards set by accreditation organizations, such as The Joint Commission. Resources to assist in surge planning and with specific items are listed on the last page of the document. This checklist has been organized into five main sections that cover key aspects of a comprehensive surge plan—Command and Management; Creating Surge Capacity; Personnel; Supplies, Pharmaceuticals and Equipment; and Important Considerations along with a list of resources.

Note the status of plan elements in the "Status" columns (C-Completed, IP-In Progress, NS-Not Started) and the Location (e.g., EOP, Safety Management Plan, Infectious Disease Plan, etc).

1. Command and Management

Status*	Location	Plan Elements
		Plan identifies triggers and decision-making processes for activating the Emergency Operations Plan (EOP) and surge plan in response to a surge event.
		• Initial assessment of the event type, scope, and magnitude, estimated influx of patients, real or potential impact on the hospital, and special response needs (e.g., infectious disease, hazardous materials).
		• Activation of the Hospital Incident Command System (HICS) and determination of appropriate positions to be activated.
		• Activation of the Hospital Command Center (HCC).
		• Notification to appropriate local governmental point of contact (e.g., local health department, local emergency medical services agency, Medical and Health Operational Area Coordinator) of the surge status and activation of the EOP and surge plan.[1] The EOP identifies the local government points of contacts and 24/7 contact numbers, alternate contacts and appropriate notification priorities and processes.
		• Internal notification/communications and staff call-back protocols (call trees, contact information, etc.).
		• Processes, procedures and paperwork for contacting local or regional licensing authority (e.g., California Department of Public Health Licensing and Certification) for potential or actual request for temporary permission to exceed staffing ratios or utilize non-traditional patient care delivery areas (e.g. tents). Include the licensing authority's contact information in the plan, templates, and checklists.
		• Memoranda of Agreement (MOA) with local government, area hospitals, long term care facilities and other health providers to accept or receive patients and share resources as appropriate and possible.
		• Establish ongoing communications with local governmental point of contact to report: o Patient census and bed capacity using standardized reporting terminology (e.g., HAvBED or as established by your local government point of contact). o Hospital status, critical issues, and resource requests.
		• Activation of resource management system including inventory, tracking, prioritizing, procuring and allocating of resources.

[1] Local government point of contact is used in this document to represent the local health department, local emergency medical services agency, Medical Health Operational Area Coordinator (MHOAC) or other local contact responsible for coordinating disaster medical response in your hospital's operational area.

2. Creating Surge Capacity

		Immediate Response[2]
		Triage: Plan to activate and operate additional/alternate triage area(s) during a surge event.
		• Activation triggers for establishing alternate/additional triage areas are defined.
		• Set-up (checklists) and operations plan.
		• Identifies primary and alternate triage areas (consider external triage areas, event type, and facility damage).
		o Responsibility and processes for set-up and operation of triage area(s) are defined.
		o Communications plan for communications between triage areas, Emergency Department, other key departments, and the HCC (e.g., landlines, handi-talkies, radios).
		o Staffing of the alternate triage sites.
		o Provision of supplies and equipment for the triage area (consider scope and type of event, based on the facility HVA).
		o Infectious and/or exposed patient triage area(s) and protocols (standard precautions, staff Personal Protective Equipment, ventilation, infection control protocols for staff and patients).
		o Flow of patients to and from the triage area(s).
		o Signage for directing patients to triage area(s).
		o Communication with the HCC to identify available community resources (checklist with level of care capability and contact information).
		o Triage protocols for internal and external patient disposition (e.g., minor care, delayed care, holding, hospital or local government alternate care sites, etc.).
		Decontamination: Plan to activate and perform decontamination, as necessary.
		• Plan for set-up (checklist) and operation of holding and decontamination area(s) (list individuals responsible).
		• Plan for segregation and prioritization of contaminated individuals for decontamination.
		• Methods for directing patients to decontamination area(s) (e.g., signage, stations, cones, etc.).
		o Primary and alternative decontamination areas (consider external areas, event/agent, and facility damage potential).
		o Communications protocols within the decontamination area(s) and between other units.
		o Staffing plan.
		o Equipment and supplies.
		Holding Areas: Plan for activation and operation of holding areas for patients awaiting triage, decontamination, treatment, admission, discharge, or transport to lower levels of care.
		• Responsibility for set-up and operation of holding area(s) (identify by area).
		• Map and signage (appropriate languages) for directing staff/family and patients to holding area(s).
		• Set-up (checklists) and operations plan.
		o Primary and alternate holding area(s) (consider type of event, capacity, level of care, infectious disease, facility status).
		o Communications between treatment areas, with HCC.
		o Staffing plan considering scope and type of patient (level of care, infectious disease, etc.).
		o Equipment and supplies.

[2] In the absence of gubernatorial orders waiving specific licensing and regulatory requirements, use of facilities outside of existing licensure should trigger notification/requests to appropriate State licensing and regulatory agencies.

		Treatment Areas: Plan for activation and operation of additional treatment areas (to include identification of sites, signage, capacity, responsibility, communications, staffing, equipment and supplies, patient tracking/medical records, etc.) to allow the Emergency Department to focus on higher acuity patients.
		• Minor care area(s).
		• Delayed care area(s).
		• Additional immediate care area(s), if available or necessary.
		• Infectious disease care area (specific to type of contagion).
		Security – Facility Access: Plan(s) for securing and limiting facility access during a surge event.
		• Security assessment with plans to address vulnerabilities.
		• Plan for activating traffic control measures for access to facility (pre-planned traffic control measures, tools, etc.).
		o Road map outlining ingress, egress, and traffic controls during surge event (coordinated with law enforcement).
		o Specific staffing assignments and instructions for traffic control (who, what, how) during a surge event.
		• Plan for initiating facility(ies) lock-down and/or limited access and entry.
		o Identification/diagram of all access points in facility(ies).
		o Identification of limited access points for entry and procedures for monitoring/managing (staff).
		o Criteria and protocols for entry and exit to/from facility(ies) --including staff, volunteers, patients, family, and other individuals (e.g., who, identification requirements).
		o Staffing plan for monitoring closed entrances (which will only be locked in external entry).
		o Communication between security, manned access points and HCC.
		o Special considerations following a terrorist attack (e.g. creating a secure perimeter, restricting access to adjacent parking areas, increasing surveillance, limiting visitation, etc.).
		• Training for staff who may be utilized in security roles (including protocols, handling abusive behavior, etc.)
		• Plan and mutual aid agreements for assistance with hospital security (e.g. hospital staffing pool, local law enforcement, outside agencies, etc.).
		Direct Patient Care Areas [2]
		Specific protocols for creating surge capacity to care for a significant surge of disaster patients.
		• Plan for immediate cancellation/delay of scheduled/non-emergent admissions, procedures, and diagnostic testing.
		o Inpatient admissions (scheduled surgeries/procedures).
		o Clinic visits.
		o Outpatient surgeries and procedures (e.g., GI, Catheterization, Radiologic).
		o Diagnostic/Ancillary services (e.g., Imaging, Neurology).
		• Protocols for rapid and periodic review of patients for admission, discharge, or transfer by teams of physicians, nurses, and discharge planners for:
		o Emergency Department (ED).
		o Inpatients by unit or service.
		o Outpatient surgery and procedure areas (e.g., Colonoscopy)
		o Clinics
		• For potential/actual terrorist or criminal event, chain-of-evidence for law enforcement is addressed.
		• Communication and coordination with HCC regarding activated and available community resources to triage, discharge, or transfer to (plan should include checklist with location, level of care and contact information).

		Capacity Plan Contents: Specific protocols for expanding ambulatory and inpatient capacity beyond licensed capacity.
		• Identify how ED, inpatient units, clinics, clinical areas, and other hospital areas (e.g., cafeteria, auditorium, conference rooms, open spaces, etc.), will be utilized to expand surge capacity. Address all key elements for use (form and protocols for each area).
		o Capacity and use, considering cohorting of patients (e.g., inpatient, minor care, holding).
		o Activation (define responsibility and activation process).
		o Management and operation of the area (describe responsibilities and procedures).
		o Equipment and supplies (including re-supply).
		o Staffing (identify requirements and staffing plan).
		o Management of special needs patients (e.g., hearing impaired, blind, wheelchair dependent, other).
		o Method of triage to/ discharge from area, including transport method(s).
		Inpatient Capacity: Specific plans for increasing bed capacity to care for surge of inpatients, including expanding beyond licensed capacity on inpatient units and use of alternative care areas (dialysis, outpatient surgery, recovery, etc.) while maintaining continuity of operations and care for current patients who cannot be discharged or transferred.2
		• Trauma (assume all hospitals will receive trauma cases when trauma center capabilities are exceeded)
		• Critical care (expand bed capacity in existing units, use of other areas/units).3
		• Burn (assume all hospitals will receive burn patients when burn center capabilities are exceeded).
		• Isolation (identify specific hospital unit(s) or areas for negative pressure or isolation through independent ventilation if event involves contagious/infectious disease).
		• Medical/Surgical acute care4
		• Pediatric (assume all hospitals will be receive pediatric cases when pediatric center capabilities are exceeded).
		• Neonatal Intensive Care Unit (includes disaster victims and/or continuity of operations).
		• Maternity (assume continuity of operations).
		Ambulatory Care Capacity: Specific plans for expanding capacity to care for surge of emergency/ambulatory patients, including use of ambulatory care centers, and opening Alternative Treatment Areas (e.g., surge tents, clinics, other hospital areas and facilities).[2]
		Ancillary and Support Services
		Ancillary Services: Specific plans have been established for increasing capacity and capability for ancillary/diagnostic services during a surge event.
		• Laboratory services, including communication and reporting to and from county public health.
		• Imaging services (including MRI, CT, Ultrasound, etc.).
		• Other ancillary and diagnostic services.

[3] Consider movement of select critical care patients to step-down areas, high/low rate alarms on pulse oximitry in lieu of cardiac monitors, increased reliance on ventilator alarms for ventilated patients and portable monitors in ward rooms to upgrade capability.

[4] Consider and plan for conversion of single rooms to double, double to triple, etc. Consider use of corridors, classrooms, open space, etc.

		Mass Fatality Management: Plans have been established for management and disposition of deceased patients.
		• Plans are consistent and coordinated with Operational Area Mass Fatality Management Plan (Medical Examiner/Coroner Plans).
		• Includes mortality estimates by type of event to anticipate and secure supply needs (e.g., body bags, shroud packs, visquine, twine, etc.).
		• Plan for expanding decedent storage capacity, including alternative hospital areas (identify current and prospective capacity).
		• Agreements with external agencies for additional decedent storage capacity, consistent with local plans (contacts and capacity).
		Medical Waste: Plans have been established for storage and/or disposition of increased medical waste during a surge event.
		• Expansion of storage facilities and/or disposition capabilities.
		• Agreements with vendor(s) to increase pick-up.

3. Personnel

		Staffing: Specific plans for staffing during a significant surge event using hospital staff, contracted pools, and mutual aid resources, taking into consideration type and scope of event.
		• Identification of staffing needs by staff type, service area, and status of regulatory waivers regarding staffing ratios, licensure, and scope of practice.
		• Contingency staffing plan identifies minimum staffing needs and prioritizes critical and non-essential services.
		• Maintain up to date staff contact information and ensure availability to HCC and individuals responsible/systems used for making staff contacts.
		• Staff disaster response assignments/roles (labor pool, specific units/areas, etc.) considering type of event.
		• Staff notification and call-back protocols, including responsibility(ies). Multiple methods identified and automated if possible.
		• Agreements with staffing agencies (assume multiple organizations have agreement with the same agencies).
		• Protocols for requesting and receiving staff resources (volunteers, special needs/teams, etc.) through HCC to local government point of contact.
		• Cross-training and reassignment of staff to support critical/essential services.
		• Establish Just- in-Time (JIT) training for key areas to allow staff to be assigned where most needed (e.g., Pediatrics, Burn, Respiratory, Security, Critical Care areas).
		• Address shift change, rotation, rest areas and feeding of staff.
		o Protocols for shift changes and rotation of staff (consider type of event)
		o Specific areas designated for staff respite and sleeping (identify areas, responsibilities).
		Volunteers: Plan includes utilization of non-facility volunteers including policies and procedures for accepting, credentialing, orienting, training, and using volunteers during a surge event.
		• Volunteer check-in protocols including staffing of check-in location (single entry).
		• Registration, credentialing and privileging protocols, including use of local Medical Reserve Corps and ESAR-VHP.
		• Systems to collect, track, and maintain volunteer information (e.g., HICS form 253 Volunteer Staff Registration).
		• Issuance of identification badge and other means of identification (e.g., colored/printed armband).
		• Protocols for assignments and roles by type of volunteer (consider buddy systems as appropriate).
		• Just-in-Time (JIT) training as appropriate to volunteer role(s).

		Staff/Family Needs: Specific plans for addressing staff needs, family and domestic concerns during a surge event.
		• Internal or external arrangements for dependent care to include, if necessary, boarding, food and special needs to remove barriers that may prevent staff from coming to work (encourage staff to have family disaster plan and to pre-arrange, if possible).
		• Internal or external arrangements for pet care (encourage staff to pre-arrange).
		• Protocols and specific assignment of appropriately trained professionals to monitor and assess staff for both stress-related and physical health concerns.

4. Supplies, Pharmaceuticals and Equipment

		Plan addresses supplies, pharmaceuticals, and equipment (SPE) for patients and staff for a significant surge event. • Essential SPE have been identified and summarized (consider type of event and patient age).
		o Equipment and furnishings (e.g., beds, cots, ventilators, IV pumps, etc.).
		o Supplies.
		o Personal Protective Equipment (masks, respirators, gowns, gloves, hand hygiene products).
		o Pharmaceuticals (including prophylaxis for inpatients, staff, and family members).
		o Food and water for patients, staff, families, and volunteers.
		• Plans to meet SPE needs/requirements have been established (who, how, where).
		o Standard hospital resources/supplies.
		o Hospital caches (including pallets, trailers, and methods for transportation/delivery).
		o Agreements with vendors for surge SPE (list of contacts and deliverables) and list of alternative vendors (assume multiple organizations have agreements with the same vendors).
		o Agreements with local pharmacies and stores (list of contacts and deliverables).
		o Community/government caches (list of cached items)
		o Other resources
		o Security needs during transport, delivery, and storage of SPE.
		• Needs and plans have been shared with local government point of contact and planning partners.
		• Describe responsibilities and protocols for providing, requesting, accepting, distributing, and tracking mutual aid resources (who, where, how).
		• Strategies/protocols included for how priorities would be established if there is a need to allocate limited patient equipment, pharmaceuticals, and other resources.
		• Identified reporting process on status of SPE resources available and/or needed, and urgency of needs to local government point of contact.

5. Important Considerations

		Communication: Plan describes primary and back up internal and external communication systems, assigned frequencies and uses, maintenance and equipment locations (e.g., internet, telephone, cell, walkie-talkie, satellite, HAM radio, Reddinet, EM System, Command Aware, Live Process, WebEOC, Vocera, CAHAN).
		Behavioral Health Needs: Plan addresses how behavioral health needs of staff, patients and family members will be met.
		Media Communication: Plan includes protocols for communication with the media in coordination with County and other hospitals.
		• Protocols for communication with media and identifying media spokesperson(s).
		• Coordination with County Emergency Operations Center/Joint Information Center (JIC) to establish common messaging and information dissemination.
		• Pre-prepared templates for issuing press statements (consider key event types, common statements, and facts).

		Documentation – Patient Tracking: Plan includes minimum patient documentation requirements for use during a surge event and protocols for patient tracking (e.g., HICS form 254 – Disaster Victim Patient Tracking Form) and reporting to appropriate agencies (e.g., county, American Red Cross).
		Continuity of Operations: Hospital has Continuity of Operations Plan which identifies critical/essential services, non-essential services, and protocols for staff reassignments during a disaster or significant surge event. Manual backup processes and forms are identified.
		Prioritization of Resources: Hospital has protocols for prioritization of resources during a surge event when demand exceeds available resources.
		Care Requirements for Services not Normally Provided: Plan addresses protocols and resources for providing services not normally provided by hospital (e.g., infants and children, maternity, burn, trauma).
		• Care area(s) identified.
		• Equipment resources or adaptations identified (inventory lists).
		• Supplies identified with appropriate supply on hand (inventory lists).
		• Protocols (e.g., adapting adult beds to pediatric beds, handling burn cases).
		• Clinical expertise and Just-In-Time resources
		• Protocols for transfer of patient to a facility with appropriate capabilities when they become available.
		Prophylaxis/Vaccination Plan: Hospital has plan and, as available, pharmaceutical, and other resources to prophylax or vaccinate staff, staff family members, volunteers, and patients.

Resources

California Hospital Association (CHA) Emergency Preparedness website (www.calhospitalprepare.org)

- MOU samples http://www.calhospitalprepare.org/search/results/MOU
- Hospital Incident Command System (HICS) resource websites http://www.emsa.ca.gov/hics/ www.hicscenter.org,
- The Joint Commission, Emergency Management Chapter http://www.jointcommission.org/standards_information/standards.aspx

CHA Hospital Surge Planning Resources (http://www.calhospitalprepare.org/category/content-area/planning-topics/healthcare-surge)

- Medical Surge Capacity and Capability: A Management System for Integrating Medical and Health Resources During Large-Scale Emergencies, http://www.ncdhhs.gov/dhsr/EMS/aspr/pdf/mscc.pdf
- AHRQ Hospital Surge Model (http://hospitalsurgemodel.ahrq.gov/
- Surge Hospitals: Providing Safe Care in Emergencies (The Joint Commission 2006) http://www.jointcommission.org/assets/1/18/surge_hospital.pdf
- Operational Area Medical-Health Emergency Management/Surge Plan (Secure from OA/LEMSA)
- CDPH Standards and Guidelines for Healthcare Surge During Emergencies http://bepreparedcalifornia.ca.gov/EPO/CDPHPrograms/PublicHealthPrograms/EmergencyPreparednessOffice/EPOProgramsServices/Surge/StandGuide/SSG1.htm
- Academic Emergency Medicine 13 (11), pages 1087 - 1253. [All Surge Articles] http://onlinelibrary.wiley.com/doi/10.1197/acem.2006.13.issue-11/issuetoc
- Utilization of Surge Tents http://www.calhospitalprepare.org/2011_tents
- EMTALA Requirements and Options for Hospitals in a Disaster http://www.calhospitalprepare.org/document/centers-medicare-medicaid-services-cms

Prioritizing Resources and Care During a Surge Event (http://www.calhospitalprepare.org/category/content-area/planning-topics/altered-standards-care-/-crisis-care**)**

- IOM Guidance for Establishing Crisis Standards of Care for Use in Disaster Situations http://www.iom.edu/Reports/2009/DisasterCareStandards.aspx AND http://www.iom.edu/~/media/Files/Report%20Files/2009/DisasterCareStandards/Standards%20of%20Care%20report%20brief%20FINAL.pdf
- CHEST Definitive Care for the Critically Ill During a Disaster, May 2008 http://chestjournal.chestpubs.org/content/133/5_suppl

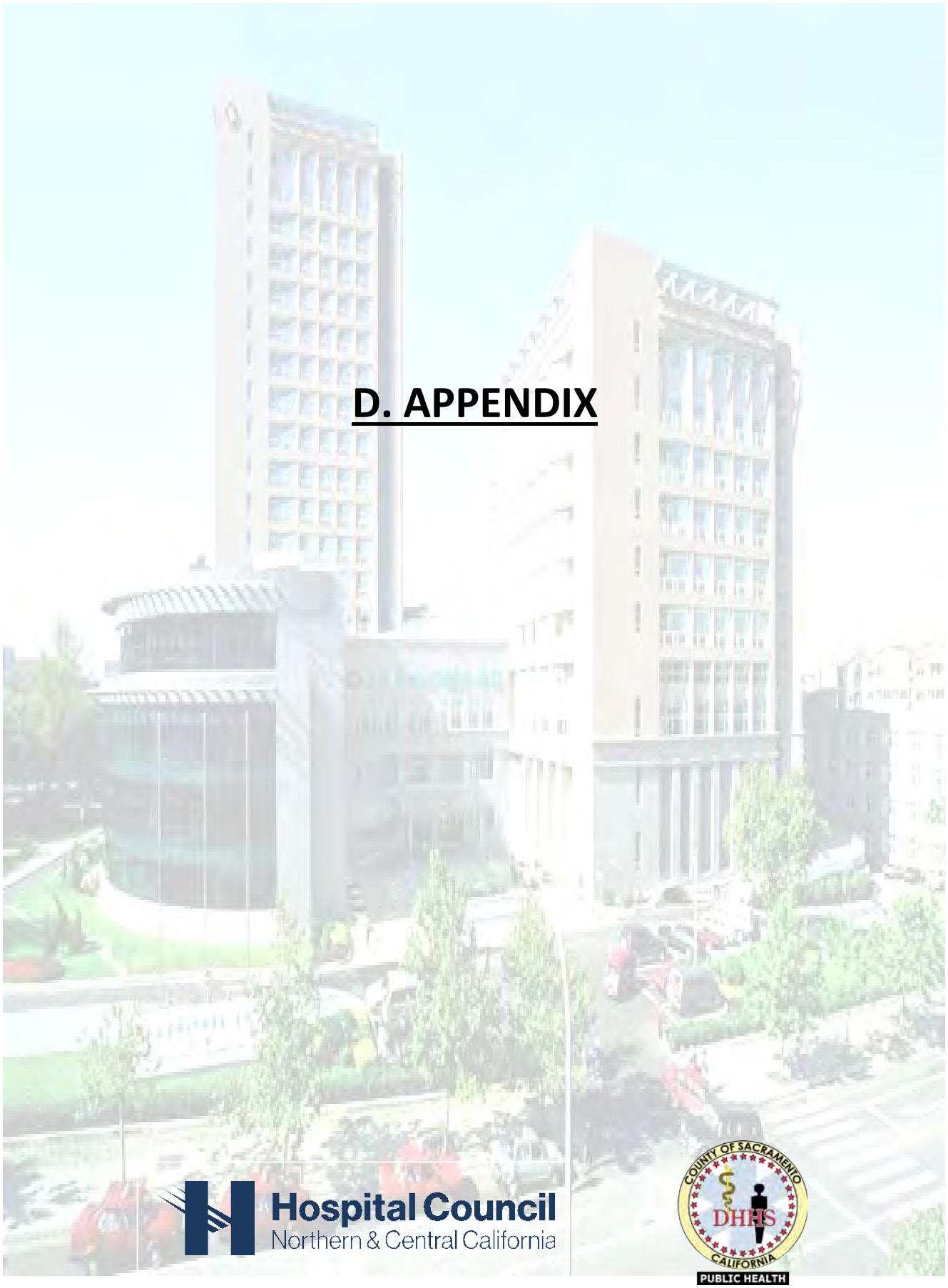
CHA Hospital Pediatric Preparedness Resources (http://www.calhospitalprepare.org/category/content-area/planning-topics/vulnerable-populations**)**

- Hospital Guidelines for Pediatric Preparedness http://www.nyc.gov/html/doh/downloads/pdf/bhpp/hepp-peds-childrenindisasters-010709.pdf
- AHRQ Pediatric Hospital Surge Capacity in PH Emergencies http://www.ahrq.gov/prep/pedhospital
- CHLA (Children's Hospital Los Angeles) Pediatric Disaster Resource and Training Center http://www.chladisastercenter.org
- Pediatric Surge Pocket Guide http://www.lapublichealth.org/eprp/docs/Emergency%20Plans/Pediatric%20Surge%20Pocket%20Guide.pdf

CHA Mass Fatality Resources http://www.calhospitalprepare.org/category/content-area/planning-topics/mass-fatality-planning

CHA Pandemic Influenza Planning Resources (http://www.calhospitalprepare.org/category/content-area/planning-topics/infectious-public-health-diseases/pandemic-influenza**)**

- Hospital Pandemic Influenza Planning Checklist http://www.flu.gov/professional/hospital/hospitalchecklist.html
- Pandemic Influenza Preparedness and Response Guidance for Healthcare Workers and Healthcare Employees (OSHA 2009) http://www.osha.gov/Publications/OSHA_pandemic_health.pdf
- CHA H1N1 Checklist http://www.calhospitalprepare.org/sites/epbackup.org/files/resources/CHA_HPP_H1N1_Expanded_Checklist_final_9.11.09.doc



D. APPENDIX

Hospital Council
Northern & Central California

COUNTY OF SACRAMENTO
DHHS
CALIFORNIA
PUBLIC HEALTH

Activation and Notifications	**Activation of the SCHEP Plan**

The SCHEP Plan should be activated if any of the following are anticipated or occur:

1. Critical infrastructure is damaged and impacts the environment of care.
2. Number of patients arriving at emergency department will or has exceeded the resources available to treat them.
3. Weather or natural events impact the environment of care.

🡻

Authorized to activate the SCHEP Plan:

1. Incident Commander
2. Chief of Staff
3. Administrator On-call

🡻

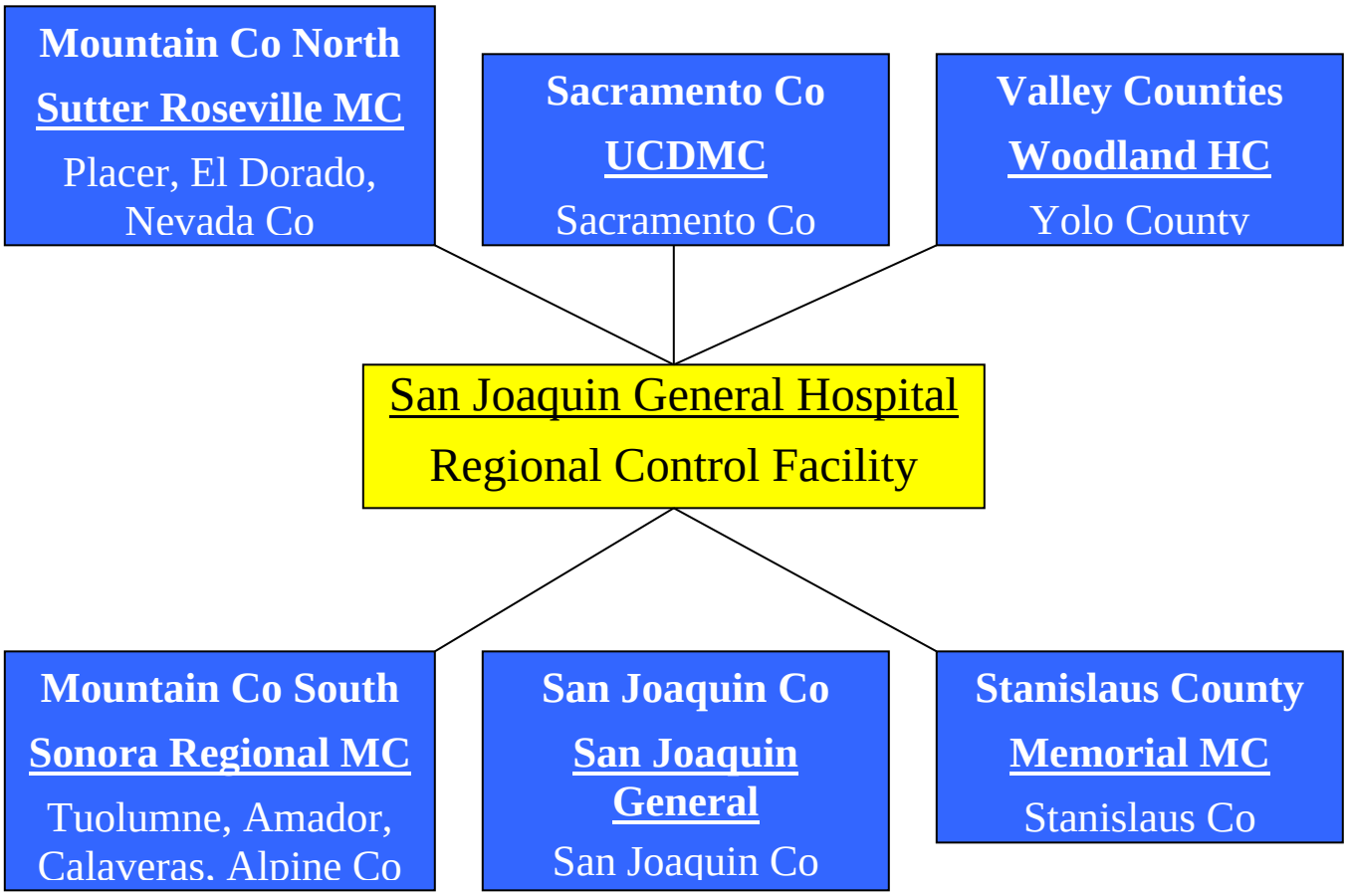
If you are the authorized person to do this:

1. Notify your immediate supervisor & Administrator On-call (AOC)
2. AOC to assume the role of Incident Commander.
3. Activate Hospital Command Center
4. Determine additional support needs including (equipment and supplies, manpower, transportation).
5. Activate Mutual Aid MOU as necessary
6. Establish contact and maintain liaison with your local MHOAC
7. Track, document and report all activities as required

Activation/Communications:

Notification of a regional emergency event will be communicated by EMResource, blast phone, emergency two-way radio system, Satellite phone or amateur radio (HAM).

Region IV Control Facilities



Region IV MEDICAL/HEALTH RESOURCES REQUEST

FEDERAL

↑

State

↑

Regional (Regional Medical Health Coordinator/Specialist)

↑

Local (Medical Health Operational Area Coordinator)

↑

SCHEPP

Sacramento County Hospital Emergency Preparedness Plan

Hospital Council of Northern & Central California

Excellence Through Leadership & Collaboration

24-Hour Emergency Services Contact Information

(For Official Use Only – Do NOT Distribute)

Hospital Council - Northern & Central CA	916-552-7656
Sacramento OES/MHOAC	
24-hour Communication Center	(916) 875-6900
Secondary	(916) 208-5958
Office (8-5 weekdays)	(916) 875-9753
Cell # Ben Merin	(916) 500-3739
Fax #	(916) 854-9211
VHF Radio-HAM Frequency	

Sacramento County EMS Air Providers

CALSTAR	Dispatch	(530) 477-8237
	IFTs only	(800) 252-5050
	Crew Quarters	(530) 887-8259
CHP H-20	Dispatch	(530) 823-4535
Reach	Dispatch	(800) 338-4045

Sacramento County LAW Enforcement

Sacramento Police Department	(916) 732-0100
Sacramento County Sheriff	(916) 874-5821
CHP for ED/Allied use ONLY	(916) 861-1299
City of Folsom Police Department	Watch Commander: (916) 355-8321, or Emergency lines (916) 355-7300 or (916) 985-7551
Elk Grove Police Department	(916) 714-5111
Rancho Cordova Police Department	(916) 362-5111
Citrus Heights Police Department	(916) 727-5500
Galt Police Department	(209) 366-7000
Isleton Police Department	(707) 421-7090 - Dispatch

Sacramento County EMS 911 System Ground Providers

AMR Dispatch – Sacramento & Placer		(800) 913-9112
Cosumnes Fire Department	Dispatch	(916) 228-3035
Sacramento Metro Fire District	Dispatch	(916) 228-3035
Folsom Fire Department	Dispatch	(916) 228-3035
Sacramento Fire Department	Dispatch	(916) 228-3035

Hospitals

Acute Hospitals	**Phone**	**Satellite Phone**	**Other Phone**
Kaiser Permanente Roseville	916-784-4000		
Kaiser Permanente Sacramento	916-973-5000		
Kaiser Permanente South Sacramento	916-688-2000	8816-5144-6109	
Marshall Medical Center	530-626-2717		
Mercy General Hospital	916-453-4545	8816-315-68927	
Mercy Hospital Folsom	916-983-7400	8816-315-66161	
Mercy San Juan Medical Center	916-537-5000		
Methodist Hospital Sacramento	916-423-3000	8816-315-80283	
Shriners Hospital for Children	916-453-2000		
Sutter Davis Hospital	530-756-6440		
Sutter Medical Center Sacramento	916-887-0000		
Sutter Roseville Medical Center	916-781-1000		
UC Davis Medical Center	916-734-2011		
VA Medical Center	916-843-7000	8816-763-27080	EOC 916-843-7915
Woodland Health Care	530-662-3961		

Behavioral Health Hospitals	**Phone**	**Satellite Phone**	**Other Phone**
Heritage Oaks Hospital (Behavioral Health)	916-489-3336		
Sacramento Co. Mental Health Treatment Ctr.	916-875-1000		
Sacramento Behavioral Healthcare Hospital	877-978-4848		
Sierra Vista Hospital (Behavioral Health)	916-288-0300		
Sutter Center for Psychiatry	916-386-3000		

Sacramento County Hospital Guidelines for Response to Contaminated Patients

PURPOSE

This plan describes hospital decontamination capabilities and how the Medical Centers in Sacramento County will safely manage patients presenting for decontamination.

Incidents requiring decontamination could be caused by internal or external sources, associated with man-caused (intentional or unintentional) emergencies, those created as a result of natural disasters, or those involving hazardous substances including chemical, biological, radiological, nuclear, and explosive (CBRNE) agents.

Staff and patient safety is the top priority and will take precedence in all decision-making. For this reason, potentially contaminated patients will be decontaminated before entering the facility.

The objective is to protect the medical center from contamination while enabling patient access to the facility for medical treatment. This is accomplished by securing the facility, separating and prioritizing patients by medical needs, and decontaminating those patients.

SCOPE

This protocol applies to patients presenting to the Medical Center by walk-in or via EMS transport. This protocol does not apply to planned decontamination operations such as during asbestos abatement.

PLANNING ASSUMPTIONS

This plan is predicated upon the following assumptions:

- *Contaminated patients will present to the ED for care, and may have associated physical injuries.*
- *Incidents can occur year round in a variety of weather conditions including extreme heat or cold, day or night.*
- *The Medical Centers may not receive advance warning of an incident prior to patients presenting for treatment.*
- *Staff have received first responder awareness (FRA) training and will act on the information delivered in that course.*
- *The substance may not be known or characterized at the time of decontamination. Regardless of the type of contaminant, the decontamination process will remain the same.*
- *Patients will be decontaminated at the scene by first responders.*
- *EMS agencies' policies state they will not transport contaminated patients in ambulances.*
- *Preservation and chain of custody of evidence should be considered but will not interfere with lifesaving medical actions.*
- *Most contaminants can be removed by removing clothing and washing the skin with water.*
- *Sacramento City and County response agencies may or may not be able to provide support to the hospital.*

- *The outside temperature and the degree of effort required to conduct decon operations will impact operations.*
- *Considerations should be given to a security and/or police response of a suspected contaminated patient is aggressive.*
- *Worried well - some people may present that feel they have been exposed or are experiencing symptoms that may or may not have been near the exposure area or exposed victims.*
- *Mutual Aid to Sacramento County will be requested immediately upon recognition that the event will be more than 4 hours duration.*

DEFINITIONS

Contamination – An actual hazardous material on a person, in orifices, in wounds, ingested, or on clothing worn by the person. To be considered contaminated, the person has to have had direct contact with the hazardous material.

Decontamination – The process of removing obvious/surface contamination from patients' skin, generally by removing clothing and showering with water.

Decontamination Team – Those individuals trained and designated to respond to the incident and who are responsible for a specific task in the decontamination of individual patients.

Exposure/Exposed – Those individuals in close proximity to a hazardous material who did not have direct contact with the hazardous material, or with contaminated individuals or objects. This category includes those with inhalation hazards that may need medical care. These individuals are not considered to be contaminated.

First Receivers – First Receivers are appropriately trained medical center staff members who may encounter and work with contaminated or potentially contaminated patients from an incident involving CBRNE agents. First Receivers are distinguished from First Responders (e.g., firefighters, law enforcement, and ambulance service personnel) in that the medical center is not the incident site, but rather is remote from the location where the hazardous substance release occurred. First Receivers can include clinicians and other medical center staff who receive and treat contaminated patients (e.g., triage, decontamination, medical treatment) and those whose roles support these functions (e.g., security/access control, and set up of decontamination equipment).

Hazardous Material – Any substance to which exposure results or may result in adverse effects on the health or safety of employees, or any chemical which is a physical hazard or a health hazard. Examples of hazardous materials include but are not limited to:

- Chemicals that cause cancer
- Chemicals that burn the skin or eyes on contact
- Biohazards or infectious materials
- Radioactive materials
- Chemicals that catch fire or explode
- Poisons
- Chemicals that can cause violent chemical reactions
- Unknown chemicals

Patient Decontamination – Any process, method, or action that leads to a reduction, removal, neutralization or inactivation of contamination on the patient in order to prevent or mitigate adverse health effects to the patient, staff, unexposed patients (secondary contamination), and to reduce the potential for secondary contamination of the health care infrastructure.

Personal Protective Equipment (PPE) – any item that is worn or used as a barrier to prevent or retard exposure to hazardous materials, biological or radiological agents.

- PPE Level "C": Used when the concentration and type of airborne substances is known and the criteria for using air-purifying respirators are met
- PPE Level "D": Street clothes, and/or a work uniform affording minimal protection: used for nuisance contamination only
- N95 Respirator: a type of face mask that filters out most particulates, but not vapors.
- PAPR – Powered air purifying respirator.

FRA –"(i) First Receiver Awareness level….individuals who are likely to witness or discover a hazardous substance release and who have been trained to initiate an emergency response sequence by notifying the authorities of the release. First receivers at the awareness level shall have sufficient training or have had sufficient experience to objectively demonstrate competency in the following areas":
Competencies:
(A) An understanding of what hazardous substances are, and the risks associated with them in an incident.
(B) An understanding of the potential outcomes associated with an emergency created when hazardous substances are present.
(C) The ability to recognize the presence of hazardous substances…
(D) The ability to identify the hazardous substances, if possible.
(E) An understanding of the role of the first receiver awareness individual in the employer's emergency response plan including site security and control and the [ERG].
(F) The ability to realize the need for additional resources, and to make appropriate notifications to the communication center.

FRO –"(ii) First Receiver Operations level….individuals who respond to releases or potential releases of hazardous substances as part of the initial response to the site for the purpose of protecting nearby persons, property, or the environment from the effects of the release. They are trained to respond in a defensive fashion without actually trying to stop the release. Their function is to contain the release from a safe distance, keep it from spreading, and prevent exposures. First receivers at the operational level shall have received at least eight hours of training or have had sufficient experience to objectively demonstrate competency in the following areas in addition to those listed for the awareness level and the employer shall so certify:"
Competencies:
(A) Knowledge of the basic hazard and risk assessment techniques.
(B) Know how to select and use proper personal protective equipment provided to the first receiver operational level.
(C) An understanding of basic hazardous materials terms.
(D) Know how to perform basic control, containment and/or confinement operations within the capabilities of the resources and personal protective equipment available with their unit.
(E) Know how to implement basic decontamination procedures.
(F) An understanding of the relevant standard operating procedures and termination procedures.

Self-Decontamination – Self-decontamination (for ambulatory victims) involves the removal of hazardous contamination from their own bodies (self-bathing/self-showering). Victims should be able to follow simple instructions and perform the removal of their own clothing (if contaminated) and the contaminating material in any way possible.

PRE-HOSPITAL CONSIDERATIONS In a large-scale event, victims needing decontamination only should not be brought to hospitals.

FIRST RECEIVER REGULATORY REQUIREMENTS Regulatory requirements for workers responding to contaminated patients are determined, in part, by the location of the worker in relation to the site of chemical release. Workers responding at the site of a hazardous substance release (first responders) are subject to the requirements of HazWOpER regulations. For those workers responding at a location remote to the initial release (first receivers), OSHA recognizes a different level of training and PPE is needed. When planning for the safety of workers during response activities, emergency plans should include predictions using worst-case scenarios to guide decision-making for appropriate training and PPE

DECONTAMINATION RESPONSE CRITERIA & CAPABILITY

For purposes of this plan, a person is considered contaminated if they are known or suspected to have been exposed to any substance that could be potentially harmful.

The following three categories indicate the capability that each medical center has to respond to a needfor patient decontamination:

1. Individual Patient Decontamination. Individual patient decontamination consists of those activities conducted for a single patient. This is the minimum capability requirement for all medical centers in Sacramento County.

2. Multi-Patient Decontamination (Resource Sufficient). Multi-patient decontamination consists of activities conducted for multiple contaminated patients in small-scale incidents in which resources are not limiting factors. Requests for additional resources or assistance should not be required for this level of patient decontamination. The number of patients that constitutes multi-patient decontamination is dependent on the jurisdiction, local responding agencies, and/or the medical center's capacity.

3. Mass Patient Decontamination. Mass patient decontamination consists of activities conducted for a number of contaminated patients that exceeds the typical receiving capacity of a medical center. This generally requires additional resources or personnel and patients often must be prioritized for the decontamination process. Mass decontamination generally requires much higher levels of resource coordination than multi-patient or individual decontamination situations. The number of patients that constitutes mass decontamination is dependent on the situation, source contaminant (if known), local responding agencies, and the medical center's system capacity.

4. Ambulatory and Non-Ambulatory Decontamination. In most events where mass decontamination is needed, ambulatory patients that are not severely impacted can self-decontaminate with minimal assistance. Victims that are severely impacted or non-ambulatory will need assistance to decontaminate prior to medical treatment.

EMS Transportation and Distribution for Mass Decontamination. The Sacramento County Control Facility should be activated for patient dispersals where multiple facilities may need to activate their decontamination plans.

Medical Centers may choose to procure patient decontamination services from another organization, rather than to provide those services itself. The particular situation dictates which legal authority and type of agreement is used. Each medical center determines if they will contract services, and how those contracts influence their capability.

Medical Center Decontamination Capability

Medical Center	Capability-Baseline	Capability-w/additional contract resources	Self-Decontamination	Ambulatory Decontamination	Non-Ambulatory
Kaiser North	Multi-patient (up to 2 ambulatory adults)	Multi/Mass Decon (RRS Contract)	Kaiser North's Decon Team to manage self-decontamination process up to 2 adults	RRS Contract will be invoked when patient count exceeds 2 adults	RRS contract will be invoked for non-ambulatory patients
Kaiser South	Multi-patient (up to 2 ambulatory adults)	Multi/Mass Decon (RRS Contract)	Kaiser South's Decon Team to manage self-decontamination process up to 2 adults	RRS Contract will be invoked when patient count exceeds 2 adults	RRS contract will be invoked for non-ambulatory patients
Mercy San Juan Medical Center	Multi-patient (up to 3 ambulatory adults)	Multi/Mass Decon (RRS Contract)	First Receivers to manage self-decontamination process up to 3 adults with adequate staffing on site	Yes - Vendor contract will be invoked for anything other than self decon	Vendor contract will be invoked for non-ambulatory patients
Mercy General Hospital	Multi-patient (up to 3 ambulatory adults)	Multi/Mass Decon (RRS Contract)	First Receivers to manage self-decontamination process up to 3 adults with adequate staffing on site	Yes - Vendor contract will be invoked for anything other than self decon	Vendor contract will be invoked for non-ambulatory patients
Mercy Hospital of Folsom	Multi-patient (up to 3 ambulatory adults)	Multi/Mass Decon (RRS Contract)	First Receivers to manage self-decontamination process up to 3 adults with adequate staffing on site	Yes - Vendor contract will be invoked for anything other than self decon	Vendor contract will be invoked for non-ambulatory patients
Methodist Hospital	Multi-patient (up to 2 ambulatory adults)	Mass Decontamination (RRS Contracted Vendor)	Yes	Yes - Vendor contract will be invoked for anything other than self decon	RRS contract will be invoked for non-ambulatory patients

Medical Center	Capability-Baseline	Capability-w/additional contract resources	Self-Decontamination	Ambulatory Decontamination	Non-Ambulatory
Sutter Sac	Individual patient decon	No additional contracted resources, small tent for decon for 3-5 patients only	Yes	Yes	No additional contracted resources for non-ambulatory patients
UC Davis	Multi-patient (up to 3 ambulatory adults)	Mass Decon (RRS Contract)			RRS contract will be invoked for non-ambulatory patients
VA Sac	Multi Patient (up to 5 ambulatory adults)	Multi/Mass Decon (RRS Contract)	VAMC FRDP team to manage self-decontamination process.	RRS Contract will be invoked when patient count exceeds 5 adults	RRS contract will be invoked for non-ambulatory patients